# Non-voluntary dental (2-9)

## Alaska

| Plan name | Option 1<br>Indemnity 1500 | Option 2<br>PPO 1000 | Option 3<br>PPO 1500 | Option 4<br>PPO 2000 |
|---|---|---|---|---|
| | Indemnity 100/80/50 | PPO 100/80/50 | PPO 100/80/50 | PPO 100/80/50 |
| **Office visit copay** | | | | |
| **Annual deductible per member** (does not apply to diagnostic & preventive services) | $50; 3X Family Maximum | $50; 3X Family Maximum | $50; 3X Family Maximum | $50; 3X Family Maximum |
| **Annual maximum benefit** | $1,500 | $1,000 | $1,500 | $2,000 |
| **Diagnostic services** | | | | |
| **Oral exams** | | | | |
| Periodic oral exam | 100% | 100% | 100% | 100% |
| Comprehensive oral exam | 100% | 100% | 100% | 100% |
| Problem-focused oral exam | 100% | 100% | 100% | 100% |
| **X-rays** | | | | |
| Bitewing - single film | 100% | 100% | 100% | 100% |
| Complete series | 100% | 100% | 100% | 100% |
| **Preventive services** | | | | |
| Adult cleaning | 100% | 100% | 100% | 100% |
| Child cleaning | 100% | 100% | 100% | 100% |
| Sealants - per tooth | 100% | 100% | 100% | 100% |
| Fluoride application - child | 100% | 100% | 100% | 100% |
| Space maintainers | 100% | 100% | 100% | 100% |
| **Basic services** | | | | |
| Amalgam fillings | 80% | 80% | 80% | 80% |
| Resin fillings, anterior | 80% | 80% | 80% | 80% |
| **Oral surgery** | | | | |
| Extraction - exposed root or erupted tooth | 80% | 80% | 80% | 80% |
| Extraction of impacted tooth - soft tissue | 80% | 80% | 80% | 80% |
| ***Major services (*Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service.)** | | | | |
| Complete upper denture | 50% | 50% | 50% | 50% |
| Partial upper denture (resin base) | 50% | 50% | 50% | 50% |
| Crown - Porcelain with noble metal | 50% | 50% | 50% | 50% |
| Pontic - Porcelain with noble metal | 50% | 50% | 50% | 50% |
| Inlay - Metallic (3 or more surfaces) | 50% | 50% | 50% | 50% |
| **Oral surgery** | | | | |
| Removal of impacted tooth - partially bony | 50% | 50% | 50% | 50% |
| **Endodontic services** | | | | |
| Bicuspid root canal therapy | 50% | 50% | 50% | 80% |
| Molar root canal therapy | 50% | 50% | 50% | 50% |
| **Periodontic services** | | | | |
| Scaling & root planing - per quadrant | 50% | 50% | 50% | 80% |
| Osseous surgery - per quadrant | 50% | 50% | 50% | 50% |
| **Orthodontic services** | Not covered | Not covered | Not covered | Not covered |
| Orthodontic lifetime maximum | Does not apply | Does not apply | Does not apply | Does not apply |

**Dental insurance plans are offered and/or underwritten by Aetna Life Insurance Company (Aetna).**

14.02.059.1-AK A (6/16)

# Non-voluntary dental (2-9)

## Alaska

| Plan name | Notes |
|---|---|
| | Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services in Option 4. |
| **Office visit copay** | |
| **Annual deductible per member** (does not apply to diagnostic & preventive services) | Options 2-4: Out-of-Network plan payments are limited by geographic area to the prevailing fees at the 95th percentile. |
| **Annual maximum benefit** | |
| **Diagnostic services** | Actual plan payments on Option 1 are limited by geographic area prevailing fees at the 95th percentile. |
| **Oral exams** | |
| Periodic oral exam | PPO Plans: Deductible and Calendar Year Maximum cross-apply between In-Network and Out-of-Network |
| Comprehensive oral exam | |
| Problem-focused oral exam | The list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. |
| **X-rays** | |
| Bitewing - single film | This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits may vary by location. Dental insurance plans contain exclusions and limitations. Plan features and availability may vary by location and group size. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to dental services. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**. |
| Complete series | |
| **Preventive services** | |
| Adult cleaning | |
| Child cleaning | |
| Sealants - per tooth | |
| Fluoride application - child | |
| Space maintainers | |
| **Basic services** | |
| Amalgam fillings | |
| Resin fillings, anterior | |
| **Oral surgery** | |
| Extraction - exposed root or erupted tooth | |
| Extraction of impacted tooth - soft tissue | |
| ***Major services (*Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming** | |
| Complete upper denture | |
| Partial upper denture (resin base) | |
| Crown - Porcelain with noble metal | |
| Pontic - Porcelain with noble metal | |
| Inlay - Metallic (3 or more surfaces) | |
| **Oral surgery** | |
| Removal of impacted tooth - partially bony | |
| **Endodontic services** | |
| Bicuspid root canal therapy | |
| Molar root canal therapy | |
| **Periodontic services** | |
| Scaling & root planing - per quadrant | |
| Osseous surgery - per quadrant | |
| **Orthodontic services** | |
| Orthodontic lifetime maximum | |

# Voluntary dental (3-9)

## Alaska

| Plan name | Voluntary Option 1 |
|---|---|
| | PPO Plan 100/80/50 |
| **Office visit copay** | |
| **Annual deductible per member** (does not apply to diagnostic & preventive services) | $75; 3X Family Maximum |
| **Annual maximum benefit** | $1,000 |
| **Diagnostic services** | |
| **Oral exams** | |
| Periodic oral exam | 100% |
| Comprehensive oral exam | 100% |
| Problem-focused oral exam | 100% |
| **X-rays** | |
| Bitewing - single film | 100% |
| Complete series | 100% |
| **Preventive services** | |
| Adult cleaning | 100% |
| Child cleaning | 100% |
| Sealants - per tooth | 100% |
| Fluoride application - child | 100% |
| Space maintainers | 100% |
| **Basic services** | |
| Amalgam fillings | 80% |
| Resin fillings, anterior | 80% |
| **Oral surgery** | |
| Extraction - exposed root or erupted tooth | 80% |
| Extraction of impacted tooth - soft tissue | 80% |
| ***Major services (*Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service.)** | |
| Complete upper denture | 50% |
| Partial upper denture (resin base) | 50% |
| Crown - Porcelain with noble metal | 50% |
| Pontic - Porcelain with noble metal | 50% |
| Inlay - Metallic (3 or more surfaces) | 50% |
| **Oral surgery** | |
| Removal of impacted tooth - partially bony | 50% |
| **Endodontic services** | |
| Bicuspid root canal therapy | 50% |
| Molar root canal therapy | 50% |
| **Periodontic services** | |
| Scaling & root planing - per quadrant | 50% |
| Osseous surgery - per quadrant | 50% |
| **Orthodontic services** | Not covered |
| Orthodontic lifetime maximum | Does not apply |

### Notes

Out-of-Network plan payments are limited by geographic area on Voluntary Option 1 to the prevailing fees at the 80th percentile.

If there is a lapse in coverage, members may not re-enroll in the plan for a period of two years from the date of termination. If they are eligible for coverage at that time, they may re-enroll, subject to all provisions of the plan, including, but not limited to, the Coverage Waiting Period.

Deductible and Calendar Year Maximum cross-apply between In-Network and Out-of-Network.

The list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate.

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14.02.059.1-AK A (6/16)

# Voluntary and Non-voluntary dental (10+)

## Alaska

| Plan name | Option 1A PPO 80/80/50 | Option 2A PPO 80/80/50 Plus | Option 3A PPO 1000 | Option 4A PPO 1000 Plus | Option 5A PPO 1500 | Option 6A PPO 1500 Plus |
|---|---|---|---|---|---|---|
| | PPO 80/80/50 | PPO 80/80/50 | PPO 100/80/50 | PPO 100/80/50 | PPO 100/80/50 | PPO 100/80/50 |
| **Office visit copay** | | | | | | |
| **Annual deductible per member** (does not apply to diagnostic & preventive services) | $50; 3X Family Maximum | $50; 3X Family Maximum | $50; 3X Family Maximum | $50; 3X Family Maximum | $50; 3X Family Maximum | $50; 3X Family Maximum |
| **Annual maximum benefit** | $1,500 | $1,500 | $1,000 | $1,000 | $1,500 | $1,500 |
| **Diagnostic services** | | | | | | |
| **Oral exams** | | | | | | |
| Periodic oral exam | 80% | 80% | 100% | 100% | 100% | 100% |
| Comprehensive oral exam | 80% | 80% | 100% | 100% | 100% | 100% |
| Problem-focused oral exam | 80% | 80% | 100% | 100% | 100% | 100% |
| **X-rays** | | | | | | |
| Bitewing - single film | 80% | 80% | 100% | 100% | 100% | 100% |
| Complete series | 80% | 80% | 100% | 100% | 100% | 100% |
| **Preventive services** | | | | | | |
| Adult cleaning | 80% | 80% | 100% | 100% | 100% | 100% |
| Child cleaning | 80% | 80% | 100% | 100% | 100% | 100% |
| Sealants - per tooth | 80% | 80% | 100% | 100% | 100% | 100% |
| Fluoride application - child | 80% | 80% | 100% | 100% | 100% | 100% |
| Space maintainers | 80% | 80% | 100% | 100% | 100% | 100% |
| **Basic services** | | | | | | |
| Amalgam fillings | 80% | 80% | 80% | 80% | 80% | 80% |
| Resin fillings, anterior | 80% | 80% | 80% | 80% | 80% | 80% |
| **Endodontic services** | | | | | | |
| Bicuspid root canal therapy | 80% | 80% | 80% | 80% | 80% | 80% |
| **Periodontic services** | | | | | | |
| Scaling & root planing - per quadrant | 80% | 80% | 80% | 80% | 80% | 80% |
| **Oral surgery** | | | | | | |
| Extraction - exposed root or erupted tooth | 80% | 80% | 80% | 80% | 80% | 80% |
| Extraction of impacted tooth - soft tissue | 80% | 80% | 80% | 80% | 80% | 80% |
| ***Major services (*Coverage Waiting Period applies to Voluntary Plans: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services.)** | | | | | | |
| Complete upper denture | 50% | 50% | 50% | 50% | 50% | 50% |
| Partial upper denture (resin base) | 50% | 50% | 50% | 50% | 50% | 50% |
| Crown - Porcelain with noble metal | 50% | 50% | 50% | 50% | 50% | 50% |
| Pontic - Porcelain with noble metal | 50% | 50% | 50% | 50% | 50% | 50% |
| Inlay - Metallic (3 or more surfaces) | 50% | 50% | 50% | 50% | 50% | 50% |
| **Oral surgery** | | | | | | |
| Removal of impacted tooth - partially bony | 80% | 80% | 50% | 80% | 80% | 80% |
| **Endodontic services** | | | | | | |
| Molar root canal therapy | 80% | 80% | 50% | 80% | 80% | 80% |
| **Periodontic services** | | | | | | |
| Osseous surgery - per quadrant | 80% | 80% | 50% | 80% | 80% | 80% |
| ***Orthodontic services** | 50% | 50% | 50% | 50% | 50% | 50% |
| Orthodontic lifetime maximum | $1,000 | $1,000 | $1,000 | $1,000 | $1,000 | $1,000 |

**Dental insurance plans are offered and/or underwritten by Aetna Life Insurance Company (Aetna).**

14.02.059.1-AK A (6/16)

# Voluntary and Non-voluntary dental (10+)

## Alaska

| Plan name | Option 7A PPO 2000 | Option 8A PPO 2000 Plus | Option 9A Indemnity 1500 |
|---|---|---|---|
| | PPO 100/80/50 | PPO 100/80/50 | Indemnity 100/80/50 |
| **Office visit copay** | | | |
| **Annual deductible per member** (does not apply to diagnostic & preventive services) | $50; 3X Family Maximum | $50; 3X Family Maximum | $50; 3X Family Maximum |
| **Annual maximum benefit** | $2,000 | $2,000 | $1,500 |
| **Diagnostic services** | | | |
| **Oral exams** | | | |
| Periodic oral exam | 100% | 100% | 100% |
| Comprehensive oral exam | 100% | 100% | 100% |
| Problem-focused oral exam | 100% | 100% | 100% |
| **X-rays** | | | |
| Bitewing - single film | 100% | 100% | 100% |
| Complete series | 100% | 100% | 100% |
| **Preventive services** | | | |
| Adult cleaning | 100% | 100% | 100% |
| Child cleaning | 100% | 100% | 100% |
| Sealants - per tooth | 100% | 100% | 100% |
| Fluoride application - child | 100% | 100% | 100% |
| Space maintainers | 100% | 100% | 100% |
| **Basic services** | | | |
| Amalgam fillings | 80% | 80% | 80% |
| Resin fillings, anterior | 80% | 80% | 80% |
| **Endodontic services** | | | |
| Bicuspid root canal therapy | 80% | 80% | 80% |
| **Periodontic services** | | | |
| Scaling & root planing - per quadrant | 80% | 80% | 80% |
| **Oral surgery** | | | |
| Extraction - exposed root or erupted tooth | 80% | 80% | 80% |
| Extraction of impacted tooth - soft tissue | 80% | 80% | 80% |
| ***Major services (*Coverage Waiting Period applies to Voluntary Plans: Must be an enrolled member of the Plan for 12 r** | | | |
| Complete upper denture | 50% | 50% | 50% |
| Partial upper denture (resin base) | 50% | 50% | 50% |
| Crown - Porcelain with noble metal | 50% | 50% | 50% |
| Pontic - Porcelain with noble metal | 50% | 50% | 50% |
| Inlay - Metallic (3 or more surfaces) | 50% | 50% | 50% |
| **Oral surgery** | | | |
| Removal of impacted tooth - partially bony | 80% | 80% | 80% |
| **Endodontic services** | | | |
| Molar root canal therapy | 80% | 80% | 80% |
| **Periodontic services** | | | |
| Osseous surgery - per quadrant | 80% | 80% | 80% |
| ***Orthodontic services** | 50% | 50% | 50% |
| Orthodontic lifetime maximum | $1,500 | $1,500 | $1,000 |

### Notes

All Oral Surgery, Endodontic and Periodontic services are covered as Basic Services in Options 1A, 4A, 5A, 7A & 9A. General anesthesia along with all Oral Surgery, Endodontic and Periodontic services are covered as Basic Services in Options 2A, 6A & 8A.

Coverage for Implants is included as a Major Service in Option 8A.

Out-of-Network plan payments are limited by geographic area to the prevailing fees at the 95th percentile

Orthodontic coverage is optional to dependent children only.

Deductible and Calendar Year Maximum cross-apply between In-Network and Out-of-Network.

Voluntary Plans; If there is a lapse in coverage, members may not re-enroll in the plan for a period of two years from the date of termination. If they are eligible for coverage at that time, they may re-enroll, subject to all provisions of the plan, including, but not limited to, the Coverage Waiting Period.

The list of covered services is representative. Full list with limitations as determined by Aetna appears in the plan booklet/certificate.

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits may vary by location. Dental insurance plans contain exclusions and limitations. Plan features and availability may vary by location and group size. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to dental services. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to www.aetna.com.



14.02.059.1-AK A (6/16)

# Limitations & Exclusions

## Additional items not covered by a health plan

**Not every health service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are medically necessary and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What The Plan Covers* section or by amendment attached to this Booklet.**

Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Plan Covers* section.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet.

Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider's license.

Charges submitted for services that are not rendered, or not rendered to a person not eligible for coverage under the plan.

Court ordered services, including those required as a condition of parole or release.

Any dental examinations:

- required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
- required by any law of a government, securing insurance or school admissions, or professional or other licenses;
- required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
- any special medical reports not directly related to treatment except when provided as part of a covered service.

Experimental or investigational drugs, devices, treatments or procedures, except as described in the What the Plan Covers section.

Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

Miscellaneous charges for services or supplies including:

- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
- Care in charitable institutions;
- Care for conditions related to current or previous military service; or
- Care while in the custody of a governmental authority.

Non-medically necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary, as determined by Aetna, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.

Routine dental exams and other preventive services and supplies, except as specifically provided in the What the Plan Covers section.

Services rendered before the effective date or after the termination of coverage, unless coverage is continued under the Continuation of Coverage section of this Booklet.

Work related: Any illness or injury related to employment or self-employment including any injuries that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational" regardless of cause.

## Exclusions That Apply to Basic Comprehensive Dental Insurance

**Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section or by amendment attached to this Booklet-Certificate. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations. This includes services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services. These dental exclusions are in addition to the exclusions listed under your medical coverage.**

Apicoectomy, (dental root resection), root canal treatment.

Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery; personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance, augmentation and vestibuloplasty; and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *What the Plan Covers* section. Facings on molar crowns and pontics will always be considered cosmetic. This exclusion does not apply to external bleaching.

# Limitations & Exclusions

Crown, inlays and onlays, and veneers unless:
- It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
- The tooth is an abutment to a covered partial denture or fixed bridge.

Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.
Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider, provided in connection with treatment or care that is not covered under the plan.
Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

Dental services and supplies that are covered in whole or in part:
- Under any other part of this plan; or
- Under any other plan of group benefits provided by the policyholder.

Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion.
First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered.

Any instruction for diet, plaque control and oral hygiene.
General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply.
Except as covered in the *What the Plan Covers* section, non-surgical and surgical treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

Orthodontic treatment except as covered in the *What the Plan Covers* section.
Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium) except as covered in the *What the Plan Covers* section.
Prescribed drugs, pre-medication or analgesia.
Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.
Replacement of teeth beyond the normal complement of 32.
Removal of soft bony impactions.
Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services.

Surgical removal of impacted wisdom teeth when only for orthodontic reasons.
Topical application of fluoride.
Treatment by other than a dentist. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a dentist. These are:
- Scaling of teeth;
- Cleaning of teeth; and
- Topical application of fluoride.

Treatment of alveolectomy.
Treatment of periodontal disease.

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**Waiting periods, limitations and exclusions may not apply to all plans or all states.**

**Dental insurance plans are offered and/or underwritten by Aetna Life Insurance Company (Aetna).**
14.02.059.1-AK A (6/16).