Schedule of benefits

Preferred provider organization (PPO) dental expense insurance plan

Prepared for:

Policyholder:	State of Alaska – Political Subdivision
Policyholder number:	GP-0181163-B
Schedule of benefits:	1A
Group policy effective date:	July 1, 2022
Plan name:	PPO Dental Plan
Plan effective date:	July 1, 2022
Plan issue date:	July 2, 2022

Underwritten by Aetna Life Insurance Company in the State of Alaska – Political Subdivision

Schedule of benefits

This schedule of benefits lists the **eligible dental services**, **deductibles**, **coinsurance**, maximums, and other limits that apply to the services you get under this plan.

How to read your schedule of benefits

- When we say:
  - "In-network coverage" we mean that you get care from **in-network providers**.
  - "Out-of-network coverage" we mean that you can get care from **out-of-network providers**.
- The **deductibles** and **coinsurance** listed in the schedule of benefits below reflects the **deductibles** and **coinsurance** amounts under your plan.
- You must pay any **deductibles** and your part of the **coinsurance**.
- The **coinsurance** listed in the schedule of benefits reflects the plan **coinsurance** percentage. This is the **coinsurance** amount the plan pays. You are responsible for paying any remaining **coinsurance**.
- You must pay the full amount of any dental care services you get that are not a **covered benefit** or that exceed your **Calendar Year** and **lifetime maximums**.
- This plan also has limits for some **covered benefits**. For example, these could be visit limits. They may be combined limits between or separate limits for **in-network providers** and **out-of-network providers** unless we state otherwise. See later in this schedule of benefits for information about limits.

Important note:
All **covered benefits** are subject to a **Calendar Year deductible** and **coinsurance** unless otherwise noted in the schedule of benefits below.

How to contact us for help

We are here to answer your questions:

- Register and log onto our self-service website available 24/7 at www.aetna.com
- Call us at 1-877-238-6200

The coverage described in this schedule of benefits will be provided under **Aetna Life Insurance Company's group policy.** This schedule of benefits replaces any schedule of benefits previously in effect under the **group policy**. Keep this schedule of benefits with your booklet-certificate.

General coverage provisions

This section explains the:

- **Deductibles**
- Maximums

Calendar Year deductible

Eligible dental services applied to the out-of-network **deductibles** will be applied to satisfy the in-network **deductibles**. **Eligible dental services** applied to the in-network **deductibles** will be applied to satisfy the out-of-network **deductibles**.

Individual deductible

You pay for **eligible dental services** each **Calendar Year** before this plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. After the amount paid reaches the individual **deductible**, this plan starts to pay for **eligible dental services** for the rest of the **Calendar Year**.

Calendar Year maximum

The most the plan will pay for **eligible dental services** incurred by any one covered person in a **Calendar Year** is called the **Calendar Year maximum**.

This **Calendar Year maximum** applies to in-network and out-of-network **eligible dental services** combined.

Specific dental care lifetime maximum

This is the most this plan will pay, after you have paid any **deductible,** for specific dental care treatment expenses incurred by any one covered person during their lifetime for **eligible dental services**.

These specific dental care **lifetime maximums** apply to in-network and out-of-network **eligible dental services** combined.

Any expenses applied to satisfy a specific dental care **lifetime maximum** will not be applied to satisfy any **lifetime maximum**.

Your financial responsibility and determination of benefits provisions

Your financial responsibility for the cost of services is based on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment that occurs in more than one **Calendar Year**. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet-certificate.

Plan features

Important note:
The 95th percentile is used to determine the **recognized charge** for payment of out-of-network expenses.

Calendar Year deductible

You have to meet your **Calendar Year deductible** before this plan pays for benefits.

Deductibles	**In-network coverage Amounts**	**Out-of-network coverage Amounts**
Calendar Year deductible*	Individual $50	Individual $50
***Important note:**	The **Calendar Year deductible** applies to all **eligible dental services** except Type A expenses.	The **Calendar Year deductible** applies to all **eligible dental services** except Type A expenses.

Coinsurance

The **coinsurance** listed below reflects the plan **coinsurance** percentage. This is the **coinsurance** amount that the plan pays. You are responsible for paying any remaining **coinsurance**.

Coinsurance

Expenses	**In-network coverage Coinsurance**	**Out-of-network coverage Coinsurance**
Type A expenses	100% of the **negotiated charge**	100% of the **recognized charge**
Type B expenses	80% of the **negotiated charge**	80% of the **recognized charge**
Type C expenses	50% of the **negotiated charge**	50% of the **recognized charge**

Orthodontic treatment coinsurance

Expense	**In-network coverage Coinsurance**	**Out-of-network coverage Coinsurance**
Orthodontic treatment	50% of the **negotiated charge**	50% of the **recognized charge**

Calendar Year maximum

Maximums	**In-network coverage Amounts**	**Out-of-network coverage Amounts**
Calendar Year maximum	$1,500	$1,500

Specific dental care lifetime maximum

Eligible dental service	**In-network coverage Amounts**	**Out-of-network coverage Amounts**
Orthodontic treatment	$1,750	$1,750

Eligible dental services

Type A Expenses

- Oral exams (This includes prophylaxis, scaling, and cleaning of teeth)
- Topical application of sodium or stannous fluoride
- X-rays for diagnosis (Also other X-rays not to exceed one full mouth series per **Calendar Year**
- Sealants for permanent bicuspids and molars for persons under age 18

Type B Expenses

- Oral surgery
- Extractions
- Fillings
- General anesthetics given in connection with covered dental services
- Treatment of diseased periodontal structures
- Endodontic treatment (This includes root canal therapy)
- Injection of antibiotic drugs
- First installation of a space maintainer to replace any baby tooth which is lost prematurely
- Emergency palliative treatment
- Repair or recementing of crowns, inlays, bridgework, or dentures
- Relining of dentures
- Rebase, per denture following reline
- Adjustments to denture more than 6 months after installation following rebase
- The adding of teeth to a partial removable denture
- Inlays, gold fillings, or crowns (This includes precision attachments for dentures)

Type C Expenses

- First installation of fixed bridgework to replace one or more natural teeth extracted while the person is covered (This includes inlays and crowns as abutments)
- Replacement of an existing removable denture or fixed bridgework by new fixed bridgework, or the adding of teeth to existing fixed bridgework, subject to the *Replacement Rule*.
- First installation of removable dentures to replace one or more natural teeth extracted while the person is covered (This includes adjustments for the 6 month period following the date they were installed)
- Replacement of an existing removable denture or fixed bridgework by a new denture, , subject to the *Replacement Rule*.

Additional eligible dental services

We will provide additional **eligible dental services** if you have at least one of the following conditions:

- Pregnancy
- Coronary artery disease/cardiovascular disease
- Cerebrovascular disease
- Diabetes

The additional **eligible dental services** are:

- Prophylaxis (cleaning) (one additional per **Calendar Year**)
- Scaling and root planing, (4 or more teeth), per quadrant
- Scaling and root planing (limited to 1 to 3 teeth), per quadrant
- Full mouth debridement
- Periodontal maintenance

Payment of benefits

We will waive the **Calendar Year deductible** for the additional **eligible dental services** above.

The plan **coinsurance** applied to the additional **eligible dental services** will be:

Expense	**In-network coverage Coinsurance**	**Out-of-network coverage Coinsurance**
Additional **eligible dental services**	100%	100%