AlaskaCare Retiree DVA Plan

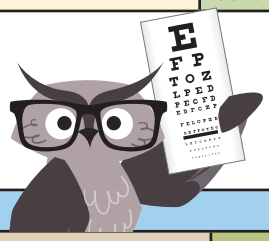
2025 Benefit Comparison

AlaskaCare Retiree Dental-Vision-Audio (DVA) plan members have a choice between the Standard DVA Plan and the Legacy DVA Plan for the 2025 benefit year. You can choose the plan that works best for you and your family.

This comparison provides an overview of the two plans and highlights some, but not all, of the dental and vision benefit provisions. For complete coverage details, please consult the plan booklets available at AlaskaCare.gov.

Plan Structure and Annual Deductible		
	Standard DVA Plan	**Legacy DVA Plan**
Covered household member options	Retiree only Retiree and spouse Retiree and child(ren) Retiree and family	Retiree only Retiree and spouse Retiree and child(ren) Retiree and family
Plan funding	100% funded by member-paid premiums.	100% funded by member-paid premiums.
Vision annual benefit deductible	No deductible	No deductible
Dental annual benefit deductible	$50 per individual. Applies to class II (restorative) and class III (prosthetic) services.	$50 per individual. Applies to class II (restorative) and class III (prosthetic) services.

Vision Benefit Comparison



Vision Benefit Maximums		
	Standard Plan - Vision	**Legacy Plan - Vision**
Examinations	One per benefit year	One per benefit year
Lenses	Two per benefit year (one per eye)	Two per benefit year (one per eye)
Frames	Every other benefit year	One set every two consecutive years
Aphakic and contact lens lifetime maximum	N/A	$400
Network Provisions		
Access to a broad network of vision providers	Yes	No
Recognized charge: In-Network	Lesser of 100% of negotiated fees, billed charges, or covered expense.	No network applicability; lesser of 100% of provider's billed charge for the service or supply, or the 90th percentile. Members may be billed for additional charges.

Vision Coinsurance, Out-of-Pocket Costs, Lenses, Allowances, Lens Enhancement		
	Standard Plan - Vision Benefits within VSP Network	**Legacy Plan - Vision**
Coinsurance/Copayment		
Examination	$10 Copay	20% member coinsurance for allowed amount, plus 100% of any not covered amount. Members may need to pay out of pocket at time of service and manually submit claim for reimbursement.
Contact Lens Examination	$60 Copay	
Essential Medical Eyecare	$20 Copay	
Lenses/Frame or Medically Necessary Contact Lenses	$10 Copay	
Lenses		
Single Vision	Covered	20% member coinsurance for allowed amount, plus 100% of any not covered amount
Lined Bifocal	Covered	
Lined Trifocal	Covered	
Allowances		
Retail Frame	$200	20% member coinsurance for allowed amount, plus 100% of any not covered amount
Featured Frame Brand	$220	
Walmart/Sam's Club/Costco Frame Allowance	$200	
Elective Contact Lenses (in lieu of lenses or frames)	$150	
Lens Enhancement Out-of-Pocket Cost		
Anti-Reflective	Covered	20% member coinsurance for allowed amount, plus 100% of any not covered amount
Polycarbonate Lenses	Covered	
Scratch-Resistant	Covered	
Standard Progressive	Covered	Not covered
Custom and Premium Progressive	Covered	Not covered
Photochromic & Tints	Up to 40% discount	Not covered
All other Lens Enhancements	Up to 40% discount	Not covered

Vision Out-of-Network Costs and Allowances		
	Standard Plan - Vision	**Legacy Plan - Vision**
Examination	$100 benefit allowance.*	No network applicability; coverage provided at 80% of either what the provider bills for the service or supply, or the 90th percentile, whichever is lower. Members may be billed for additional charges.
Single Vision	$75 benefit allowance.*	
Lined Bifocal	$115 benefit allowance.*	
Lined Trifocal	$130 benefit allowance.*	
Lenticular	$185 benefit allowance.*	
Frame	$70 benefit allowance.*	
Necessary Contact Lenses	$210 benefit allowance.*	
Elective Contact Lenses (in lieu of lenses or frames)	$135 benefit allowance.*	
Anti-Reflective Coating	$37 benefit allowance.*	
Polycarbonate Lenses	$33 benefit allowance.*	
Scratch-Resistant Coating	$15 benefit allowance.*	
Progressives	$115 benefit allowance.*	Not covered

* Members may be billed for additional charges from out-of-network providers. Additional coverage may be provided based on VSP provider availability.

You can find examples of the cost for services under each plan at drb.alaska.gov/events/dvaenrollment.html

Dental Benefit Comparison

Dental Coinsurance and Maximum Benefit		
	Standard Plan - Dental	**Legacy Plan - Dental**
Coinsurance	Class I (preventive): 100% Class II (restorative): 80% Class III (prosthetic): 50%	Class I (preventive): 100% Class II (restorative): 80% Class III (prosthetic): 50%
Annual individual benefit maximum	**NEW!** Plan will pay up to $3,000 for dental services each benefit year.	Plan will pay up to $2,000 for dental services each benefit year.
Network Provisions		
Access to Delta Dental's broad Premier network of dental providers	Yes	Yes
Access to an additional exclusive dental network, Delta Dental's PPO network, with deeper discounts for the same services	Yes	No
Recognized charge: In-Network	Lesser of 100% of negotiated fees, billed charges, or covered expense.	Lesser of 100% of negotiated fees, billed charges, or covered expense.
Recognized charge: Out-of-Network	75% of the 80th percentile; members may be billed for additional charges. You can find examples of the cost of services under each plan at ***drb.alaska.gov/events/dvaenrollment.html***	100% of the 90th percentile; members may be billed for additional charges. You can find examples of the cost of services under each plan at ***drb.alaska.gov/events/dvaenrollment.html***
Dental Necessity Requirements		
To be eligible for coverage, dental services and supplies must meet these dental necessity requirements and be a covered service or supply under the plan.	The Retiree Standard Dental Plan covers dental services and supplies when performed by a dentist or dental care provider and when determined to be dentally necessary.	The Retiree Legacy Dental Plan does not provide benefits for dental services or supplies that are not necessary for diagnosis or treatment of dental condition as determined by the claims administrator even if prescribed, recommended, or approved by a dental professional.

Covered Dental Services: Class I - Preventive		
	Standard Plan - Dental	**Legacy Plan - Dental**
Impact on annual maximum benefit	**NEW:** Charges for class I preventive services do not count toward annual maximum benefit	No change, charges for class I preventive services do count toward annual maximum benefit.
Diagnostic		
Oral exam	Covered two times per benefit year.	Covered
Complete series x-rays/panoramic	Covered once every five years.	Covered if required for diagnosis; not more than one full mouth or series per year.
Bitewing x-rays	Covered once per benefit year.	Covered
Diagnostic casts and study models	Not covered	Covered

Continued: Covered Dental Services: Class I - Preventive		
Preventive		
Cleanings (prophylaxis)	Covered two times per benefit year; additional cleanings available for persons with diabetes, periodontal disease, or in last trimester of pregnancy. Other exceptions allowed.	Covered
Periodontal maintenance	Covered as a class I service at 100% and no deductible. Two times per benefit year; additional cleanings available for persons with diabetes, periodontal disease, or in last trimester of pregnancy. Other exceptions allowed.	Covered as a class II service at 80% and $50 deductible.
Topical fluoride: 18 years or younger	Covered two times per benefit year.	Covered
Topical fluoride: 19 years or older	Covered two times per benefit year if recent periodontal surgery or high risk of decay due to chemotherapy or medical disease.	Covered
Sealants: 18 years or younger	Covered once every five years with tooth limitations.	Covered
Sealants: 19 years or older	Covered once every five years with tooth limitations.	Not covered
Space maintainers	Covered for 14 years and younger, once per tooth space with tooth limitations.	Covered as a class II service at 80% and $50 deductible.

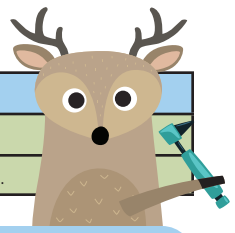
Covered Dental Services: Class II - Restorative		
	Standard Plan - Dental	**Legacy Plan - Dental**
Restorative		
Fillings	Covered	Covered
Inlays	Covered, considered an optional service. Alternate benefit of composite filling. Covered as a class II service at 80% and $50 deductible.	Covered as a class III service at 50% and $50 deductible.
Crown buildups	Covered as a class II service at 80% and $50 deductible if necessary for tooth retention.	Covered as a class III service at 50% and $50 deductible.
Oral Surgery		
Extractions (including surgical)	Covered	Covered
Alveoplasty (procedure to smoothen or re-shape jaw bone)	Covered when performed as part of other covered service. Not covered as a separate charge.	Covered
Brush Biopsy	Covered two times per benefit year.	Covered
Endodontic		
Root canal and treatment	Covered; retreatment not covered for same tooth by same dentist within 24 months. Initial service should include retreatment within this timeframe if necessary.	Covered
Pulpal therapy (pulp capping)	Covered when pulp is exposed.	Covered

Covered Dental Services: Class II - Restorative Continued		
	Standard Plan - Dental	Legacy Plan - Dental
Periodontics		
Gum disease and supporting tissue treatment	Covered	Covered
Periodontal maintenance	Covered as a class I service, 100% and no deductible. Two per benefit year; additional cleanings available for persons with diabetes, periodontal disease, or in last trimester of pregnancy. Other exceptions allowed.	Covered as a class II service at 80% and $50 deductible.
Periodontal scaling & root planing	Once per quadrant in any two-year period.	Covered
Periodontal splinting	Not covered	Covered
Full mouth debridement	Covered once in a three-year period if no cleaning (prophylaxis) occurred within preceding 24 months.	Covered
Anesthesia		
Nitrous oxide	Covered	Covered
General anesthesia / IV sedation	Covered for surgical procedures only or if needed due to a medical condition.	Covered
Other		
Palliative care	Covered	Covered
Apicoectomy (surgical removal of root tip)	Covered	Covered
Denture repair	Covered as a class III service, 50% coverage and $50 deductible	Covered
Denture reline	Covered as a class III service, 50% coverage and $50 deductible	Covered
Denture adjustments	Covered as a class III service, 50% coverage and $50 deductible	Covered
Tissue conditioning	Covered as a class III service, 50% coverage and $50 deductible	Covered

Covered Dental Services: Class III - Prosthetic		
	Standard Plan - Dental	Legacy Plan - Dental
Restorative		
Crowns (cast restoration)	Covered once in seven-year period on any tooth.	Covered
Onlays (cast restoration)	Covered once in seven-year period on any tooth.	Covered
Lab veneers (cast restoration)	Covered once in seven-year period on any tooth.	Covered
Crown buildups	Covered as a class II service at 80% and $50 deductible if necessary for tooth retention.	Covered as a class III service at 50% and $50 deductible.
Inlays	Covered, considered an optional service. Alternate benefit of composite filling. Covered as a class II service at 80% and $50 deductible.	Covered as a class III service at 50% and $50 deductible.
Porcelain restorations	Covered for visible teeth. Coverage limited to cost of metallic prosthetic if placed on upper second or third molars or lower first, second, or third molars.	Not covered if tooth can be restored with amalgam (metallic) filling. Coverage limited to appropriate charges for amalgam or similar material.

Covered Dental Services: Class III - Prosthetic Continued		
	Standard Plan - Dental	**Legacy Plan - Dental**
Prosthodontic		
Bridges	Covered once in seven-year period if tooth, tooth site, or teeth have not received a cast restoration benefit in last seven years.	Covered
Dentures, full and partial	Covered once in seven-year period if tooth, tooth site, or teeth have not received a cast restoration benefit in last seven years.	Covered once every five years if previous dentures cannot be made serviceable or if previous denture was temporary and installed within previous 12 months.
Dentures, temporary	Partial denture covered if placed within two months of anterior tooth extraction. Additional limitations may apply.	Covered
Denture adjustment	Covered twice in 12-month period, unless received within first six months of initial placement (this is included in the initial placement charge).	Covered as a class II service, 80% coverage and $50 deductible.
Denture repairs	Covered unless received within first six months of initial placement (this is included in the initial placement charge).	Covered as a class II service, 80% coverage and $50 deductible.
Denture reline	Covered once in 12-month period, unless received within first six months of initial placement (this is included in the initial placement charge).	Covered as a class II service, 80% coverage and $50 deductible.
Tissue conditioning	Covered twice per denture in a 36-month period.	Covered as a class II service, 80% coverage and $50 deductible.
Implants	Covered. Limited to once per lifetime per tooth space. Some implant charges may be eligible for coverage under medical plan. Associated cast restoration over implant and other implant related procedures are covered as a class III prosthetic service.	No coverage for implants under dental plan. Some implant charges may be eligible for coverage under medical plan. Associated cast restoration over implant and other implant related procedures are covered as a class III prosthetic service.
Other		
Athletic mouthguards	Covered once per year if 15 or younger; covered once every two years if 16 or older.	Not covered
Orthodontics	Orthodontic services are not covered in the AlaskaCare Dental Plan.	Orthodontic services are not covered in the AlaskaCare Dental Plan.

Other Benefits		
	Standard Plan	**Legacy Plan**
Audio Benefits	No changes to plan benefits.	No changes to plan benefits.



For information about dental benefits or questions about how specific services may be covered under each plan, contact Delta Dental of Alaska toll-free at (855) 718-1768.

Review the DVA Network Comparison document at **alaskacare.gov/dva** to find examples of the cost of service under each plan when you visit a network or out-of-network provider. For information about Legacy Vision and Audio benefits, contact Aetna Concierge toll-free at (855) 784-8646 and for Standard Vision contact VSP at (800) 877-7195.

Contact the AlaskaCare Member Education Center

In Juneau: (907) 465-4460
Toll-free outside Juneau: (800) 821-2251
E-mail: **doa.drb.benefits@alaska.gov**

P.O. Box 110203, Juneau, AK 99811-0203

Monday - Thursday, 8:30 a.m. to 4 p.m.
Friday, 8:30 a.m. to 3 p.m. (Alaska Time)