

Student Dental Insurance Plan Brochure

Aetna AdvantageTM Dental

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Important Note

Please keep this Brochure as it provides a general summary of your coverage. A complete description of the benefits may be found in the Master Policy which is on file with your College or University. If any discrepancy exists between the Brochure and the Master Policy, the Master Policy will govern and control the payment of benefits. If you have any questions about the Plan, call the toll-free Member Service number shown on your ID card.

ID Cards

Dental ID cards will be issued as soon as possible. If you need dental attention before the ID card is received, benefits will be payable according to the Master Policy. You do not need an ID card to be eligible to receive care in the event of a dental emergency. Once you have received your ID card, present it to your provider to facilitate prompt payment of your claims. (Please note that your ID card will include the term “DMO*”. This term does not affect your coverage.)

* State laws vary with regard to out-of-network benefits. In Illinois, DMO plans provide limited out-of-network benefits. However, in order to receive maximum benefits, members must select and have care coordinated by a participating primary care dentist. Illinois DMO is not an HMO.

State Mandated Benefits

The Plan will always pay benefits in accordance with any applicable State/Commonwealth Insurance Law(s).

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Eligibility

Students

You are in an Eligible Class if you are a student enrolled at a College or University, as determined by the Policyholder.

Dependents

If the Policyholder elects to offer dependent coverage and the **covered student** elects to cover eligible dependents, the dependent must meet the definition of an eligible dependent as defined in the Master Policy.

No person may be covered both as a student and dependent and no person may be covered as a dependent of more than one student. Your dependent must have the same coverage as you have.

Enrollment Procedure

Visit www.aetnastudenthealth.com, go to “Students” and “Find Your School” for specific information on how to enroll.

Policy Period and Effective Date of Coverage

Students

The coverage of each student who applies for coverage on or before the Effective Date will take effect at 12:01 AM on the Effective Date of the Master Policy, and will terminate at 12:01 AM one year after the Effective Date of the Master Policy.

Refer to the Master Policy for information regarding availability of coverage for late enrollees.

Dependents

If dependent coverage is included in the Plan, as determined by the Policyholder, and you elect to cover your eligible dependents, then dependent coverage becomes effective on the date your coverage becomes effective, or the date of the dependent’s enrollment, whichever is later. Otherwise it becomes effective on the date you acquire a dependent.

Refer to the Master Policy for information regarding availability of coverage for late enrollees. A child born to a **covered person** shall be covered for 31 days from the moment of birth. At the end of this 31 day period, coverage will cease under the Plan. To extend coverage for a newborn past the 31 days, the **covered student** must enroll the child within 31 days of birth, and pay any additional premium from the date of birth.

Coverage is provided for a child legally placed for adoption with a **covered student** for 31 days from the moment of placement, provided the child lives in the household of the **covered student** and is dependent upon the **covered student** for support. Notification of placement of such child and payment of any additional premium, if necessary, is required within 31 days from placement. To continue coverage for an adopted child past must enroll the child within 31 days of placement of such child, and pay any additional premium, if necessary, starting from the date of placement.

Late Enrollment—Students and Dependents

If an application and premium payment for insurance are made more than 30 days following the date the student or dependent become eligible, then their insurance will become effective only if and when Aetna gives its written consent.

<h2 style="text-align: center;">Description of Dental Benefits</h2>
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Dental Expense Coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that Aetna will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision contained in the Master Policy, no benefits are payable for dental expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an **accident, injury** or disease which occurred, commenced or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished. When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Aetna assumes no responsibility for the outcome of any covered services or supplies. Aetna makes no express or implied warranties concerning the outcome of any covered services or supplies.

Benefits

This Plan provides to **covered persons** the necessary dental services in the classes of dental care listed in the **covered dental expenses**.

These services and supplies must be:

- given by the **covered person's member dental provider**, including those for a dental condition requiring specialized care, at the dental office location; or
- given by another **dental provider** in the case of **Out-of-Area Emergency Dental Care**.

Providers of dental services are independent contractors and are neither agents nor employees of the College or University, Aetna Student Health or Aetna.

You need to choose a **member dental provider**, in writing, (who will then become the primary care dentist) in order to receive dental care. A complete listing of **member dental providers** is available by calling the Member Service toll-free number shown on your Dental ID card or through the internet by accessing: www.aetna.com/docfind.

Office Visit Copay

The **covered dental expenses** show those services and supplies for which an office visit **copay** must be paid. An office visit **copay** also must be paid for **Out-of-Area Emergency Dental Care**. The office visit **copay** must be made to the **member dental provider**, or **dental provider**, in the case of **Out-of-Area Emergency Dental Care**, at the time the dental care is received. The **covered dental expenses** list those services and supplies for which this payment is required. The Brochure shows the office visit **copay** amount. The office visit **copay** does not apply to Reduced Fee Services.

Covered Dental Expenses

Certain dental expenses are covered. You will pay an office visit **copay** at the **member dental provider's** office for services and supplies listed below.

Diagnostic Care

- Office visit for oral exam not to exceed 2 visits in any one **policy year**.
- Emergency exam.
- Diagnostic casts.
- Bitewing X-rays not to exceed 2 sets in any one **policy year**.
- Entire X-ray series or panoramic equivalent not to exceed one series in any 3-year period.
- Periapical X-rays (individual tooth) and other dental X-rays as necessary.
- Pulp vitality tests.
- Consultation with **member dental provider**.

Preventive Care

- Prophylaxis, including cleaning and polishing, not to exceed 2 treatments in any one **policy year**.
- Topical application of fluoride for **covered persons** under age 18 not to exceed 2 treatments in any one **policy year**.
- Sealants for permanent bicuspid and molars for **covered persons** under age 18 not to exceed one application in any 3-year period.
- Oral hygiene instruction
- Dietary advice and counseling
- Minor occlusal (bite) adjustments

Restorative Care

- Amalgam restorations and related medication
- Composite restorations and related medication
- Retention pins as necessary
- Sedative fillings

- Minor denture adjustment

Periodontic Care

- Scaling and root planing

Oral Surgery

- Non-surgical extractions and related medications

Reduced Fee Services

Other dental services are available at reduced fees from your **member dental provider**. Ask your **member dental provider** for the appropriate fees for the services you need. These dental services are not **covered dental expenses** under this Plan. You must pay the full reduced fee for these services directly to the **dental provider**.

Dental services available at reduced fees include but are not limited to:

- crowns, bridges, and dentures.
- endodontics.
- periodontics.
- orthodontics.

Out-of-Area Emergency Dental Care

Out-of-Area Emergency Dental Care consists of **medically necessary** covered dental services given to **covered persons** by a **dental provider** that is not a **member dental provider** for palliative treatment of an **emergency medical condition**.

When care of an **emergency medical condition** is received, a benefit will be paid for the **reasonable charges** incurred by a **covered person** for such care.

The amount paid will not be more than \$50; regardless of the number of treatments needed for each separate **emergency medical condition**. An office visit **copay** must also be paid. (Please note that the \$50 amount mentioned above may be changed, or waived, based on specific state requirements. Please refer to the State Specific Section of this Coverage Information Brochure for more information.)

The maximum may be waived by the **dental consultant**.

Payment will be made only if all of the following rules are met:

- Care is rendered outside the **covered person's member dental provider Service Area**.
- The care given is for the speedy relief of the **emergency medical condition** until the person can be seen by the **member dental provider**.
- The person provides an itemized bill to Aetna. It must describe the care involved.
- The dental service given is listed in the **covered dental expenses**.

Exclusions and Limitations

The Plan neither covers nor provides benefits for the following:

1. Those for services and supplies, which are covered in whole or in part:
 - Under any other part of this Plan; or
 - Under any other plan of group benefits provided by or through your College or University.
2. Those for services and supplies furnished to diagnose or treat a disease or **injury** that is not **nonoccupational disease** or **non-occupational injury**.
3. Those for services not listed in **covered dental expenses**.
4. Those for services and supplies not furnished by a **member dental provider**, except if provided as **Out-of-Area Emergency Dental Care**.
5. Those for plastic, reconstructive, or cosmetic surgery, or other dental services or supplies which:
 - Improve;
 - Alter; or
 - Enhance appearance;whether or not for psychological or emotional reasons.
6. Those for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:
 - There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or **injury** involved; or
 - If required by the FDA, approval has not been granted for marketing; or
 - A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or
 - The written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.
7. Those for services that Aetna defines as not necessary for the diagnosis, care, or treatment of the condition involved.
8. Those for services intended for treatment of any **jaw joint disorder**.
9. Those for maintainers; except when needed to preserve space resulting from the premature loss of deciduous teeth.
10. Those for replacement of lost or stolen appliances.

11. Those for orthodontic treatment.
12. Those for general anesthesia and intravenous sedation.
13. Those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services to increase vertical dimension.
14. Those for topical application of fluoride; except when given to **covered persons** under age 18. Advantage Dental Plan coverage is limited to 2 treatments in any 1 **policy year**.
15. Those for sealants; except when given to **covered persons** under age 18 for permanent bicuspid and molars only. Advantage Dental Plan coverage is limited to 1 application in any 3-year period.
16. Those for more than 2 office visits for an oral exam in any 1 **policy year**.
17. Those for more than 2 sets of bitewing X-rays in any 1 **policy year**.
18. Those for more than 1 entire X-ray series or panoramic equivalent, not to exceed 1 series in any 3-year period.
19. Those for more than 2 prophylaxis treatments, including cleaning and polishing, in any 1 **policy year**.
20. Those for dental services given after the person's coverage in the Advantage Dental Plan ends.
21. Those for out-of-area charges that Aetna determines are not **reasonable charges**.
22. Those for out-of-area charges that are made only because coverage exists.
23. To the extent allowed by the law of the jurisdiction where the group contract is delivered, those for services and supplies:
 - Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any individual in the armed forces of a government.
 - Furnished, paid for, or for which benefits are provided or required under any law of a government. (This does not include a plan established by a government for its own employees or their dependents or Medicaid).

Any exclusion listed will not apply to the extent that coverage is specifically provided by name in the Policy; or coverage of the charges is required under any law that applies to the coverage.

General Information About Your Coverage

Termination of Insurance

Benefits are payable under the Policy only for those **covered dental expenses** incurred while the Policy is in effect as to the **covered person**. No benefits are payable for expenses incurred after the date the insurance terminated.

Refund of Premium

If withdrawal from school is for reasons other than entering the armed forces, no premium refund will be made. Coverage for any **covered persons** will be continued for the term for which they are enrolled and for which premium has been paid.

Type of Coverage

Coverage under this Plan is non-occupational. Only non-occupational accidental injuries and nonoccupational diseases are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a **covered person** while the insurance is in effect.

Claim Procedures For Reporting Out-of-Area Emergency Dental Care

A claim must be submitted to Aetna in writing. It must give proof of the nature and extent of the loss. You can obtain a claim form by calling the toll-free Member Service number on your Dental ID card. All claims should be reported promptly. The deadline for filing a claim for any benefits is 90 days after the date of the loss causing the claim.

If, through no fault of your own, you are unable to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 2 years after the deadline.

Appeals and Complaints Procedure

Our complaints and appeals process is designed to address member coverage issues, complaints, and problems. If you have a coverage issue or other problem, call the Member Service toll-free number shown on your Dental ID card or review your Plan documents for more information. If you are dissatisfied with the outcome of your initial contact, you may appeal the decision. Your appeal will be decided in accordance with the procedure applicable to your Plan.

You may also submit your request in writing, along with all pertinent information to the address shown on your Dental ID card.

Certain states mandate external review or the use of their own external review process for medical necessity and experimental/investigation coverage decisions. These state mandates may extend to additional benefit or service issues and may require a filing fee. For further details regarding state-mandated external review, you may call the Member Service toll-free number on your Dental ID Card or your state insurance health department.

Definitions

The following definitions of certain words and phrases will help you understand the dental benefits to which the definitions apply. If a definition appears in the Benefits section and also appears in the Definitions section of the Brochure, the definition in the Benefits section will apply in lieu of the definition in the Definitions section.

Accident: An occurrence, which is unforeseen, is not due to or contributed to by **sickness** or disease of any kind, and causes **injury**.

Copay: This is a fee charged to a person for **covered dental expenses**.

Covered Dental Expenses: Those charges for any treatment, service, or supplies covered by the Policy which are:

- Not in excess of the **reasonable charges**; or
- Not in excess of the charges that would have been made in the absence of the coverage in the Policy;
- And incurred while the Policy is in force as to the **covered person**.

Covered Dependent: A **covered student's** dependent that is insured under the Policy.

Covered Person: A **covered student** or any **covered dependent** while coverage under the Policy is in effect.

Covered Student: A student of the Policyholder who is insured under the Policy.

Deductible: The amount of **covered dental expenses** that are paid by each **covered person** during the **Policy Year** before benefits are paid.

Dental Consultant: A **dentist** who has agreed to provide consulting services in connection with the dental expense benefit.

Dental Provider: Any **dentist**, group, organization, dental facility, or other institution or person legally qualified to furnish dental services or supplies.

Dentist: A legally qualified **dentist**. Also, a **physician** who is licensed to do the dental work he or she performs.

Emergency Medical Condition: A recent and severe medical condition, including but not limited to severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury, is of such a nature that failure to get immediate medical care could result in:

- Placing the person's health in serious jeopardy; or
- Serious impairment of bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Injury: A bodily injury caused by an **accident**. This includes related conditions and recurrent symptoms of such **injury**.

Jaw Joint Disorder: A Temporomandibular Joint Dysfunction or any similar disorder in the relationship between the jaws or jaw joint and the muscles and nerves.

Medically Necessary: A service or supply that is: necessary and appropriate for the diagnosis or treatment of a sickness or injury based on generally accepted current medical practice.

In order for a treatment, service or supply to be considered medically necessary, the service or supply must:

- Be care or treatment that is likely to produce as significant positive outcome as any alternative service or supply; both as to the sickness or injury involved and the person's overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the sickness or injury involved and the person's overall health condition
- Be a diagnostic procedure, which is indicated by the health status of the person. It must be as likely to result in information that could affect the course of treatment as any alternative service or supply, both as to the sickness or injury involved and the person's overall health conditions. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the sickness or injury involved and the person's overall health condition; and
- As to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take in to consideration:

- Information relating to the affected person's health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved; and any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be medically necessary:

- Those that do not require the technical skills of a medical, mental health, or dental professional; or
- Those furnished mainly for: the personal comfort or convenience of the person, any person who cares for him or her, or any person who is part of his or her family, any healthcare provider, or healthcare facility; or
- Those furnished solely because the person is an inpatient on any day on which the person's sickness or injury could safely and adequately be diagnosed or treated while not confined; or

- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a **physician's** or **dentist's** office, or less costly setting.

Member Dental Provider: Any **dental provider** who has entered into a written agreement to provide to **covered persons** the dental care described under the Dental Expense Benefit. A **covered person's member dental provider** is a **member dental provider** currently chosen, in writing, by the **covered person**, to provide dental care to the **covered person**. A **member dental provider** chosen by a **covered person** takes effect as the **covered person's member dental provider** on the effective date of that **covered person's** coverage.

Member Dental Provider Service Area: The area within a 50 mile radius of the covered person's member dental provider.

Negotiated Charge: The maximum charge a **member dental provider** has agreed to make as to any service or supply for the purpose of the benefits under the Policy.

Non-Occupational Disease: A non-occupational disease is a disease that does not arise out of (or in the course of) any work for pay or profit, or result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the covered student is covered under any type of workers' compensation law, and is not covered for that disease under such law.

Non-Occupational Injury: A non-occupational injury is an accidental bodily injury that does not arise out of (or in the course of) any work for pay or profit, or result in any way from an injury that does.

Orthodontic Treatment: Any medical service or supply or dental service or supply furnished to prevent or to diagnose or to correct a misalignment of the teeth, or of the bite, or of the jaws or joint relationship, whether or not for the purpose of relieving pain. Not included is the installation of a space maintainer or surgical procedure to correct malocclusion.

Out-of-Area Emergency Dental Care: **Medically necessary** care or treatment for an **emergency medical condition** that is rendered outside a 50 mile radius of the **covered person's member dental provider**. Such care is subject to specific limitations set forth in the Master Policy.

Policy Year: The period of time from anniversary date to anniversary date, except in the first year when it is the period of time from the effective date to the first anniversary date.

Reasonable Charge: *Only that part of a charge that is reasonable is covered. The reasonable charge for a service or supply is the lowest of:*

- The provider's usual charge for furnishing it; and
- The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or

supply are made; and the charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In some circumstances, Aetna may have an agreement, either directly or indirectly through a third party, with a provider who sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the **reasonable charge** is the rate established in such agreement.

In determining the **reasonable charge** for a service or supply that is unusual, or not often provided in the area, or provided by only a small number of providers in the area, Aetna may take into account factors such as:

- Complexity;
- The degree of skill needed;
- The type of specialty of the provider;
- The range of services or supplies provided by a facility; and
- The prevailing charge in other areas.

Notice

Aetna considers nonpublic personal member information confidential and has policies and procedures in place to protect the information against unlawful use and disclosure. When necessary for your care or treatment, the operation of your health Plan, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, Pharmacies, hospitals, and other caregivers), vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating Providers are also required to give you access to your medical records within a reasonable amount of time after you make a request. By enrolling in the plan, you permit us to use and disclose this information as described above on behalf of yourself and your dependents. To obtain a copy of our Notice of Privacy Practices describing in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Service number on your Dental ID card or visit www.aetna.com or visit Aetna Student Health's Student Connection Link at www.aetnastudenthealth.com.

This material is for information only. Dental benefits plans contain exclusions and limitations. 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.

State Variations

The following identifies specific sections of the preceding document that must be amended to comply with specific state mandates.

District of Columbia

No changes needed.

Georgia

Refer to the Certificate of Coverage document that you will be receiving under separate cover for specific Plan information.

Illinois

The 3rd paragraph in the *Out-Of-Area Emergency Dental Care* section on page 8 is deleted and does not apply.

Indiana

No changes needed.

Massachusetts

1. The 2nd paragraph under *Benefits* section on page 6 is replaced by the following:

These services and supplies must be:

Given by the **covered person's member dental provider**, including those for a dental condition requiring specialized care, at the dental office location.

This coverage also provides benefits for services given by providers who are not **member dental providers**.

2. The 2nd paragraph in the *Office Visit Copay* section on page 6 is replaced by the following:

The office visit **copay** must be made to the **member dental provider**, or **dental provider** in the case of **Emergency Dental Care**, at the time the dental care is received. The **covered dental expenses** list those services and supplies for which this payment is required. The Coverage Information Brochure shows the office visit **copay** amount. The office visit **copay** does not apply to Reduced Fee Services, or services provided by a provider who is not a **member dental provider**.

3. The heading for *Covered Dental Expenses* on page 7 is replaced by *Covered Dental Expenses By Member Dental Providers*.

4. The following section is added above the *Reduced Fee Services* section on page 8:

Benefits Provided By Providers Who Are Not Member Dental Providers

A **copay** may apply to the dental services provided by providers who are not **member dental providers**. The **copay** is shown on the Dental Care Schedule that applies.

Payment made to the providers who are not **member dental providers** will be at least 80% of the benefit level for the same **covered dental expenses** rendered by the **member dental providers**. Payments made to providers who are not **member dental providers** will be a percentage of the fee up to the reasonable charge, excluding any **copay** amount. Any amounts that exceed the payment amount are the obligation of the **covered person**. A **deductible** may apply to services performed by a provider who is not a **member dental provider**. Refer to the Policy for specific Plan information with respect to the applicable **copay** percentage and **deductible** amount.

5. The *Out-Of-Area Emergency Dental Care* section on page 8 is replaced by the following:

Emergency Dental Care

Emergency Dental Care consists of **medically necessary** covered dental services given to **covered persons** for palliative treatment of an **emergency medical condition**. Emergency dental care is subject to the limitations described in the Policy.

When care of an **emergency medical condition** is received, a benefit will be paid as if the care had been provided by a **member dental provider**.

An office visit **copay** must also be paid.

Payment will be made only if all of the following rules are met:

- The care is for the speedy relief of the **emergency medical condition** until the **covered person** can be seen by the **member dental provider**.
- The **covered person** provides an itemized bill to Aetna. It must describe the care given.
- The dental service given is listed in the **covered dental expenses**.

6. In the *Exclusions* section on page 9, replace #4 with the following:

Those for services given by a provider who is not a **member dental provider** to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.

7. The heading for *Claim Procedures For Reporting Out-Of-Area Emergency Dental Care* on page 11 is replaced by *Claim Procedures For Reporting Emergency Dental Care*.

8. The Definition of **member dental provider service area** shown on page 14 is deleted and does not apply.

Maryland

Refer to the Certificate of Coverage document that you will be receiving under separate cover for specific Plan information.