



Aetna Student Health

Aetna PPO Dental Plan Design and Benefits Summary

Arizona State University

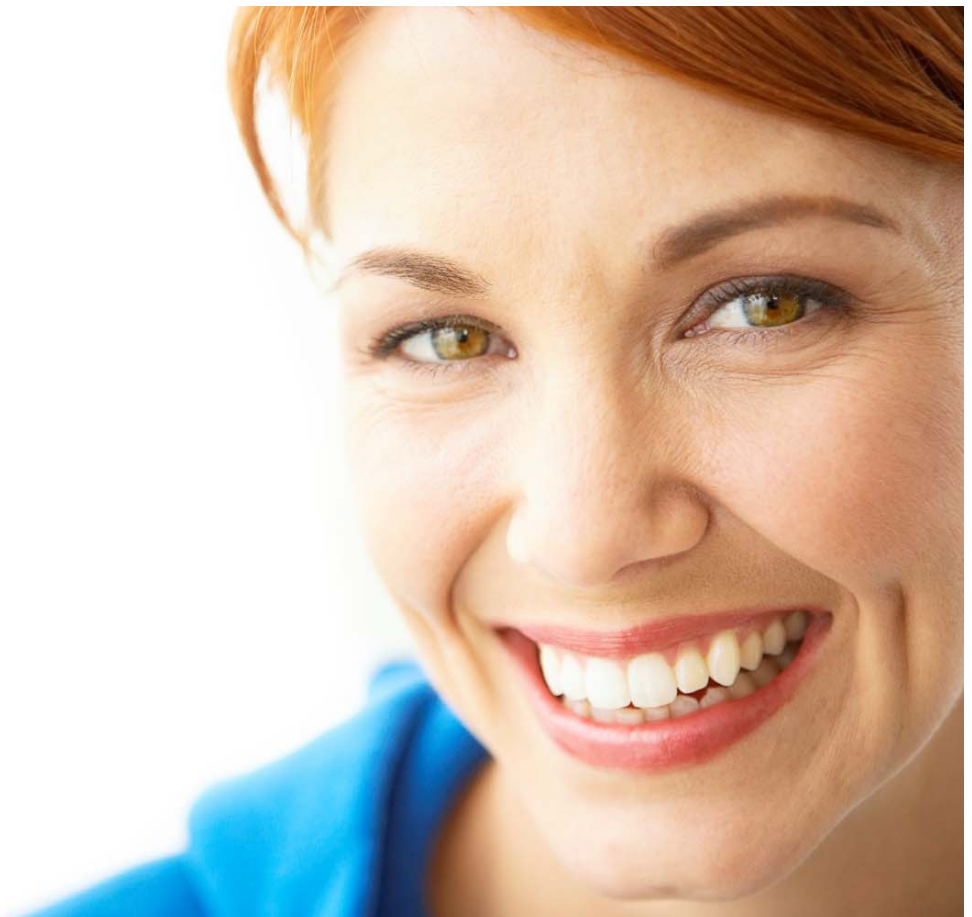
Policy Year: 2017-2018

Policy Number: 697443

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This Aetna Dental® Preferred Provider Organization (PPO) insurance plan summary is provided by Aetna Life Insurance Company (Aetna) for some of the more frequently performed dental procedures. Under this plan, you may choose at the time of service either a PPO participating dentist or any nonparticipating dentist. With the PPO plan, savings are possible because the PPO participating dentists have agreed to provide care for covered services at the negotiated fee schedule.

Coverage periods

Students: Coverage for eligible students will become effective at or after 12:00 a.m. on the coverage dates indicated on the Master Policy, and will terminate at or before 11:59 p.m. on the coverage dates on the Master Policy.

Eligible Dependents: Coverage will become effective on the same date the insured student's coverage is effective. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy.

Rates

2017-2018 Dental Plan Rates			
	Annual 08/16/17 – 08/15/18	Fall 08/16/17 – 01/03/18	Spring 01/04/18 – 08/15/18
Enrollment Deadline	08/31/17	08/31/17	01/24/18
Student Only	\$292.00	\$113.00	\$179.00
Student plus one dependent	\$584.00	\$226.00	\$358.00
Student plus two or more dependents	\$876.00	\$339.00	\$537.00

Student coverage

Eligibility

All undergraduate and graduate students who are enrolled at Arizona State University and who actively attend classes, regardless of their SHIP participation, can voluntarily enroll in this plan.

Dependent coverage

Eligibility

Covered students may also enroll their lawful spouse and any dependent children up to the age of 19. The student must be enrolled in the voluntary dental plan in order to enroll their eligible dependents.

Preferred Provider Network

Consult Aetna Dental online provider directory, DocFind[®], for the most current provider listings. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna. The availability of any particular provider cannot be guaranteed. Provider participation may change without notice. Aetna does not provide care or guarantee access to dental services. For the most current information, please contact the selected provider or Aetna Member Services at the toll-free number on your ID card, or use our Internet-based provider directory (DocFind) available at www.aetnastudenthealth.com.

Payment made to a PPO provider is based on a negotiated charge, which is usually significantly less than the providers' standard billed charges. PPO providers cannot bill beyond the negotiated charge for covered services.

Nonparticipating benefits are also subject to recognized charge limits.

To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to use a Preferred Provider because savings may be achieved from the Negotiated Charges these providers have agreed to accept as payment for their services.

In the event of a problem with coverage, members should contact Member Services at the toll-free number on their ID cards for information on how to utilize the grievance procedure when appropriate.

All member care and related decisions are the sole responsibility of participating providers. Aetna dental does not provide health care services and, therefore, cannot guarantee any results or outcomes.

Description of benefits

The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. While this Plan Design and Benefits Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. To look at the full Plan description, which is contained in the Master Policy issued to The University of Arizona please contact Aetna Student Health at **(866) 378-0178**. If any discrepancy exists between this Benefit Summary and the Policy, the Master Policy will govern and control the payment of benefits.

*All coverage is based on Recognized Charges unless otherwise specified.

Policy Year Maximum	\$1,000	
	Preferred Care	Non-Preferred Care
DEDUCTIBLE*	Individual: \$50	Individual: \$50
*The deductible applies to: Basic & Major Services only	Family: \$100	Family: \$100
PREVENTIVE SERVICES	100% of the negotiated charge	100% of the recognized charge
BASIC SERVICES	80% of the negotiated charge	80% of the recognized charge
MAJOR SERVICES	50% of the negotiated charge	50% of the recognized charge
ORTHODONTICS	Not Covered	Not Covered
Description of Covered Service by Benefit Service Category		
Covered Preventive Services		
Visits and X-Rays <i>Office visit during regular office hours; for oral examination (limited to 2 visits every year)</i> <i>Prophylaxis (cleaning) (limited to 2 treatments per year) Adult Child</i> <i>Topical application of fluoride; (limited to 1 course of treatment per year and to children under age 14)</i> <i>Sealants; per tooth (limited to 1 application every 5 years for permanent bicuspids and molars only; and to children under age 14)</i> <i>Bitewing X-rays (limited to 1 set per year)</i> <i>Entire denture series consisting of at least 14 films; including bitewings if necessary; or panoramic film limited to 1 set every 5 years)</i>		
Covered Basic Services		
Visits and X-Rays <ul style="list-style-type: none"> <i>Professional visit after hours (payment will be made on the basis of services rendered or visit; whichever is greater)</i> 		

- *Emergency palliative treatment; per visit*

X-Ray and Pathology

- *Periapical x-rays (single films up to 13)*
- *Intra-oral; occlusal view; maxillary or mandibular*
- *Upper or lower jaw; extra-oral*
- *Biopsy and histopathologic examination of oral tissue*

Oral Surgery

- *Extractions*
- *Exposed root or erupted tooth*
- *Surgical removal of erupted tooth*
- *Impacted Teeth*
- *Removal of tooth (soft tissue)*
- *Odontogenic Cysts and Neoplasms*
 - *Incision and drainage of abscess*
 - *Removal of odontogenic cyst or tumor*
- *Other Surgical Procedures*
 - *Alveoplasty; in conjunction with extractions - per quadrant*
 - *Alveoplasty; not in conjunction with extraction - per quadrant*
 - *Sialolithotomy: removal of salivary calculus*
 - *Closure of salivary fistula*
 - *Excision of hyperplastic tissue*
 - *Removal of exostosis*
 - *Transplantation of tooth or tooth bud*
 - *Closure of oral fistula of maxillary sinus*
 - *Sequestrectomy*
 - *Crown exposure to aid eruption*
 - *Removal of foreign body from soft tissue*
 - *Frenectomy*
 - *Suture of soft tissue injury*

Periodontics

- *Occlusal adjustment (other than with an appliance or by restoration)*
- *Root planning and scaling; per quadrant (limited to 4 separate quadrants every 2 years)*
- *Root planning and scaling – 1 to 3 teeth per quadrant (limited to once per site every 2 years)*
- *Gingivectomy; per quadrant (limited to 1 per quadrant every 3 years)*
- *Gingivectomy; 1 to 3 teeth per quadrant; limited to 1 per site every 3 years*
- *Gingival flap procedure - per quadrant (limited to 1 per quadrant every 3 years)*
- *Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)*
- *Periodontal maintenance procedures following active therapy (limited to 2 per year)*
- *Localized delivery of chemotherapeutic agents*

Endodontics

- *Pulp cap*
- *Pulpotomy*
- *Apexification/recalcification*
- *Apicoectomy*
- *Root canal therapy including necessary X-rays*
 - *Bicuspid Anterior*
 - *Bicuspid*

Restorative Dentistry Excludes inlays; crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in 1 surface will be considered as a single restoration.)

- *Amalgam restorations*
- *Resin-based composite restorations (other than for molars)*
- *Pins*
- *Pin retention—per tooth; in addition to amalgam or resin restoration*
- *Crowns (when tooth cannot be restored with a filling material)*
- *Prefabricated stainless steel*
- *Prefabricated resin crown (excluding temporary crowns)*
- *Recementation*
 - *Inlay*
 - *Crown*
 - *Bridge*

Covered Major Services

Oral Surgery

- *Impacted Teeth*
 - *Removal of tooth (partially bony)*
 - *Removal of tooth (completely bony)*

Periodontics

- *Osseous surgery (including flap and closure); 1 to 3 teeth per quadrant; limited to 1 per quadrant; every 5 years*
- *Osseous surgery (including flap and closure); per quadrant; limited to 1 per site; every 5 years*
- *Soft tissue graft procedures*

ENDODONTICS

- *Root canal therapy including necessary X-rays*
- *Molar*

Restorative *Inlays; onlays; labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge (limited to 1 per tooth every 10 years- see Replacement Rule)*

- *Inlays/Onlays-Metallic or Porcelain/Ceramic*
 - *Inlay; 1 or more surfaces*
 - *Onlay; 2 or more surfaces*
- *Inlays/Onlays-Resin-based composite*
 - *Inlay; 1 or more surfaces*
 - *Onlay; 2 or more surfaces*
- *Labial Veneers*
 - *Laminate-chairside*
 - *Resin laminate – laboratory*
 - *Porcelain laminate – laboratory*
- *Crowns*
- *Resin*
 - *Resin with noble metal*
 - *Resin with base metal*
- *Porcelain*
 - *Porcelain with noble metal*
 - *Porcelain with base metal*
- *Base metal (full cast)*

- Noble metal (full cast)
- Metallic (3/4 cast)
- Post and core

Prosthodontics: First installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 10 years old. (See Tooth Missing But Not Replaced Rule.) Replacement of existing bridges or dentures is limited to 1 every 10 years. (See Replacement Rule.)

- Bridge Abutments (See Inlays and Crowns)
- Pontics
 - Base metal (full cast)
 - Noble metal (full cast)
 - Base metal (full cast)
 - Porcelain with noble metal
 - Porcelain with base metal
 - Resin with noble metal
 - Resin with base meta
- Removable Bridge (unilateral)
- One piece casting; chrome cobalt alloy clasp attachment (all types) per unit; including pontics
- Dentures and Partials (Fees for dentures and partial dentures include relines; rebases; and adjustments; within 6 months after installation.
- Fees for relines and rebases include adjustments within 6 months after installation. (Specialized techniques and characterizations are not eligible.)
 - Complete upper denture
 - Complete lower denture
 - Partial upper or lower; resin base (including any conventional clasps; rests and teeth)
 - Partial upper or lower; cast metal base with resin saddles (including any conventional clasps; rests and teeth)
- Stress breakers
- Interim partial denture (stayplate); anterior only
- Office reline
 - Laboratory reline
 - Special tissue conditioning; per denture
 - Rebase; per denture
 - Adjustment to denture more than 6 months after installation
- Full and partial denture repairs
- Broken dentures; no teeth involved
- Repair cast framework
- Replacing missing or broken teeth; each tooth
- Adding teeth to existing partial denture
 - Each tooth
 - Each clasp
- Repairs: crowns and bridges
- Occlusal guard (for bruxism only); limited to 1 every 5 years

SPACE MAINTAINERS Only when needed to preserve space resulting from premature loss of deciduous teeth. (Includes all adjustments within 6 months after installation.)

- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)
- Removable inhibiting appliance to correct thumbsucking

- *Fixed or cemented inhibiting appliance to correct thumbsucking*

GENERAL ANESTHESIA AND INTRAVENOUS SEDATION (*only when provided in conjunction with a covered surgical procedure*)

Emergency Dental Care*

If you need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week. When emergency services are provided by a participating PPO dentist, your coinsurance amount will be based on a negotiated fee schedule. When emergency services are provided by a non-participating dentist, you will be responsible for the difference between the plan payment and the dentist's usual charge. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

*Covered emergency services may vary, based on state law.

Exclusions

Not every dental care service or supply is covered by the plan, even if prescribed; recommended; or approved by the **covered person's physician; or dentist**. The plan covers only those services and supplies that are included in the Dental Care Schedule. Charges made for the following are not covered. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered; or are subject to special limitations.

1. Apicoectomy (dental root resection); root canal treatment.
2. 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 Dental Care Schedule.
3. 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.
4. 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.
5. Services and supplies provided for the covered person's personal comfort or convenience, or the convenience of any other person, including a provider.
6. Services and supplies provided in connection with treatment or care that is not covered under the plan.
7. 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.

8. 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.
9. 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 covered person was not covered.
10. Any instruction for diet; plaque control; and oral hygiene.
11. General anesthesia and intravenous sedation; unless specifically covered and only when done in connection with another medically necessary covered service or supply.
12. Except as covered in the Dental Care Schedule section, non-surgical 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.
13. **Orthodontic treatment**, except as covered in the Dental Care Schedule.
14. Pontics; crowns; cast or processed restorations; made with high noble metals (gold or titanium).
15. Prescribed drugs; pre-medication; or analgesia.
16. 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.
17. Removal of soft bony impactions.
18. Surgical removal of impacted wisdom teeth when only for orthodontic reasons.
19. 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; and
 - Cleaning of teeth.
20. Treatment of alveolectomy.
21. Treatment of periodontal disease.
22. Expense incurred for services normally provided without charge by the Policyholder's Health Service; Infirmary or Hospital; or by health care providers employed by the Policyholder.
23. Expense incurred as a result of injury due to participation in a riot. "Participation in a riot" means taking part in a riot in any way; including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense; so long as they are not taken against persons who are trying to restore law and order.
24. Expense incurred as a result of an accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation; except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.
25. Expense incurred for injury or sickness resulting from declared or undeclared war or any act thereof.
26. Expense incurred as a result of an injury or sickness due to working for wage or profit or for which benefits are payable under any Workers' Compensation or Occupational Disease Law.
27. Expense incurred as a result of an injury sustained or sickness contracted while in the service of the Armed Forces of any country. Upon the covered person entering the Armed Forces of any country; the unearned pro-rata premium will be refunded to the Policyholder.
28. Expense incurred for treatment provided in a governmental hospital unless there is a legal obligation to pay such charges in the absence of insurance.

29. Expense incurred for elective treatment or elective surgery except as specifically provided elsewhere in this Policy and performed while this Policy is in effect.
30. Expense for injuries sustained as the result of a motor vehicle accident to the extent that benefits are payable under other valid and collectible insurance whether or not claim is made for such benefits.
31. Expense incurred as a result of preventive medicines; serums; vaccines or oral contraceptives.
32. Expense incurred as a result of commission of a felony.
33. Expense incurred after the date insurance terminates for a covered person except as may be specifically provided in the Extension of Benefits Provision.
34. Expense incurred for services normally provided without charge by the school and covered by the school fee for services.
35. Expense incurred for any services rendered by a member of the covered person's immediate family or a person who lives in the covered person's home.
36. Expense incurred for injury resulting from the play or practice of collegiate or intercollegiate sports; including collegiate or intercollegiate club sports and intramurals.
37. Expenses for treatment of injury or sickness to the extent that payment is made; as a judgment or settlement; by any person deemed responsible for the injury or sickness (or their insurers).
38. Expense incurred for which no member of the covered person's immediate family has any legal obligation for payment.
39. Expense incurred by a covered person; not a United States citizen; for services performed within the covered person's home country; if the covered person's home country has a socialized medicine program.
40. Expense for injuries sustained as the result of a motor vehicle accident; to the extent that benefits are payable under other valid and collectible insurance; whether or not claim is made for such benefits. The Policy will only pay for those losses; which are not payable under the automobile medical payment insurance Policy.
41. Expense incurred when the person or individual is acting beyond the scope of his/her/its legal authority.
42. Expense for care or services to the extent the charge would have been covered under Medicare Part A or Part B; even though the covered person is eligible; but did not enroll in Part B.
43. Expense for telephone consultations; charges for failure to keep a scheduled visit; or charges for completion of a claim form.
44. Expense for charges that are not recognized charges; as determined by Aetna; except that this will not apply if the charge for a service; or supply; does not exceed the recognized charge for that service or supply; by more than the amount or percentage; specified as the Allowable Variation.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

Your Dental Care Plan Coverage Is Subject to the Following Rules:

Replacement Rule

Crowns, inlays and onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the plan's replacement rule. That means certain replacements of, or additions to, existing dentures or bridges are covered only when the **covered person** provides proof to Aetna that:

- While covered by the plan, the **covered person** had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, the **covered person** needed to replace or add teeth to their denture or bridge.
- The present crown, inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least 10 years before its replacement and cannot be made serviceable.
- The **covered person** had a tooth (or teeth) extracted while they were covered by the plan. The **covered person's** present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Tooth Missing But Not Replaced Rule

The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges or other prosthetic services are needed to replace one or more natural teeth that were removed while the covered person is covered by the plan; and
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 10 years. The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Alternate Treatment Rule

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the plan's coverage will be limited to the cost of the least expensive service or supply that is:

- Customarily used nationwide for treatment, and
- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account the covered person's current oral condition.

The **covered person** should review the differences in the cost of alternate treatment with their **dental provider**. The **covered person** and their **dental provider** can still choose the more costly treatment method. The **covered person** is responsible for any charges in excess of what the plan will cover.

Coverage for Dental Work Begun Before The Covered Person is Covered by the Plan

The plan does not cover dental work that began before the covered person was covered by the plan. This means that the following dental work is not covered:

- An appliance, or modification of an appliance, if an impression for it was made before the covered person was covered by the plan;
- A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before the covered person was covered by the plan; or
- Root canal therapy, if the pulp chamber for it was opened before the covered person was covered by the plan.

Coverage for Dental Work Completed After Termination of Coverage

Dental coverage may end while the covered person is in the middle of treatment. The plan does not cover dental services that are given after the coverage terminates. There is an exception. The plan will cover the following services if they are ordered while the covered person was covered by the plan, and installed within 30 days after the coverage ends.

- Inlays;
- Onlays;
- Crowns;
- Removable bridges;
- Cast or processed restorations;
- Dentures;
- Fixed partial dentures (bridges); and
- Root canals.

"Ordered" means:

- For a denture: the impressions from which the denture will be made were taken.
- For a root canal: the pulp chamber was opened.
- For any other item: the teeth which will serve as retainers or supports, or the teeth which are being restored:
- Must have been fully prepared to receive the item; and
- Impressions have been taken from which the item will be prepared.

Late Entrant Rule

The plan does not cover services and supplies given to a person age 5 or more if that person did not enroll in the plan:

- During the first 31 days the person is eligible for this coverage, or
- During any period of open enrollment agreed to by the Policyholder and **Aetna**.

This exclusion does not apply to charges incurred:

- After the **covered person** has been covered by the plan for 12 months, or
- As a result of **injuries** sustained while covered by the plan, or
- For services listed as Visits and X-rays, Visits and Exams, and X-ray and Pathology in the Dental Care Schedule.

The Arizona State University Dental® Preferred Provider Organization (PPO) Student Dental Plan is underwritten and administered by Aetna Life Insurance Company (ALIC). Aetna Student HealthSM is the brand name for products and services provided by these companies and their applicable affiliated companies.