As required by Federal Healthcare Reform, your plan includes coverage for pediatric dental care. Following is a general description of the pediatric dental coverage. The coverage under your plan may vary because it includes state specific requirements. In addition, certain covered dental services may have limitations, including how often those services may be performed during a specific period of time, and the limiting age to which pediatric dental coverage is provided. Orthodontia and Jaw Joint Disorder may or may not be covered under your plan. Please check your school's Master Policy for the exact coverage provided under your school's plan of benefits.

PEDIATRIC DENTAL SERVICES EXPENSE

This pediatric dental services benefit covers a limited range of **medically necessary** dental services and supplies. It does not provide benefits for all dental care.

Covered persons have the freedom to choose the **dental provider** of their choice.

Covered dental expenses include charges made by a **dental provider** for the dental services listed in the Pediatric Dental Care Schedule below and provided to **covered persons** through age 18.

The Plan does not pay a benefit for all dental care expenses that are incurred.

Important Information:

A covered person's dental services and supplies must meet the following rules to be covered by the Plan:

- **The services and supplies must be medically necessary.**
- **The services and supplies must be covered by the Plan.**
- **A covered person must be covered by the Plan when they incur the expense.**

PEDIATRIC DENTAL CARE SCHEDULE

If:

- A charge is made for an unlisted service given for the dental care of a specific condition; and
- The list includes one or more services that, under standard practices, are separately suitable for the dental care of that condition;

Then the charge will be considered to have been made for a service in the list that **Aetna** determines would have produced a professionally acceptable result.

The Pediatric Dental Care Schedule is a list of dental expenses that are covered by the Plan. There are several categories of **covered dental expenses**:

- Diagnostic and Preventive Care
- Basic Restorative Care
- Major Restorative Care
- **Orthodontic Treatment**

These covered services and supplies are grouped as Type A, Type B, Type C and **Orthodontic Treatment.**

Type A Benefits: Diagnostic and Preventive Care

Visits and Images

- Office visit during regular office hours, for oral examination
- Routine comprehensive or recall examination (limited to 2 visits every 12 months)
- Problem-focused examination (limited to 2 visits every 12 months)
- Prophylaxis (cleaning) (limited to 2 treatments per year)
- Topical application of fluoride (limited to one course of treatment per year and to children under age 16
- Sealants, per tooth (limited to one application every 3 years for permanent molars only and to children under age 16
- Bitewing images (limited to 1 set per year)
- Periapical images (single films up to 13)
- Complete image series, including bitewings if **medically necessary** (limited to 1 set every 3 years)
- Vertical bitewing images (limited to 1 set every 3 years)

Space Maintainers

Space maintainers are covered only when needed to preserve space resulting from premature loss of primary teeth. (Includes all adjustments within 6 months after installation)

- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)

Type B Benefits: Basic Restorative Care

Visits and Images

- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Emergency palliative treatment, per visit

Images and Pathology

- Intra-oral, occlusal view, maxillary or mandibular
- Upper or lower jaw, extra-oral
- Biopsy and accession of tissue examination of oral tissue

Oral Surgery

- Extractions
  - Erupted tooth or exposed root
  - Coronal remnants
  - Surgical removal of erupted tooth/root tip
- 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, in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
- Alveoplasty, not in conjunction with extraction - per quadrant
- Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces - 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 planing and scaling, per quadrant (limited to 4 separate quadrants every 2 years)
- Root planing 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 antimicrobial agents

Endodontics

- Pulp capping
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root canal therapy including **Medically Necessary** images:
  - 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

Type C Benefits: Major Restorative Care

Surgery

- Surgical removal of 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 site, every 3 years
- Osseous surgery (including flap and closure), per quadrant, limited to 1 per quadrant, every 3 years
- Soft tissue graft procedures

Endodontics

- Molar root canal therapy including **Medically Necessary** images

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 3-8 years. (See the *Replacement Rule* provision in the Master Policy.)
- Inlays/Onlays
- Crowns
  - Resin
  - Resin with noble metal
  - Resin with base metal
  - Porcelain/ceramic substrate
  - Porcelain with noble metal
  - Porcelain with base metal
  - Base metal (full cast)
  - Noble metal (full cast)
  - 3/4 cast metallic or porcelain/ceramic

- Post and core
- Core build-up

Prosthodontics

- Replacement of existing bridges or dentures is limited to 1 every 3-8 years. (See the *Replacement Rule* provision in the Master Policy.)
- Bridge Abutments (See Inlays and Crowns)
- Pontics
  - Base metal (full cast)
  - Noble metal (full cast)
  - Porcelain with noble metal
  - Porcelain with base metal
  - Resin with noble metal
  - Resin with base metal
- 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
  - Immediate upper denture
  - Immediate 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 3 years

General Anesthesia and Intravenous Sedation

- Only when **medically necessary** and only when provided in conjunction with a covered dental surgical procedure

Orthodontics

Medically necessary orthodontic treatment

- Replacement of retainer (limit one per lifetime)

GETTING AN ADVANCE CLAIM REVIEW

The purpose of the advance claim review is to determine, in advance, the benefits the Plan will pay for proposed services. Knowing ahead of time which services are covered by the Plan, and the benefit amount payable, helps a **covered person** and their **dentist** make informed decisions about the care a **covered person** is considering.

Important Information:

The advance claim review process is not a guarantee of benefit payment, but rather an estimate of the amount or scope of benefits to be paid.

WHEN TO GET AN ADVANCE CLAIM REVIEW

An advance claim review is recommended whenever a course of dental treatment is likely to cost more than **$100-$1,000**. The advance claim review is voluntary. It is a service that provides a **covered person** with information that a covered person and their **dentist** can consider when deciding on a course of treatment. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

SUBMITTING AN ADVANCE CLAIM REVIEW

A **covered person** is responsible for submitting the advance claim review to **Aetna**. A **covered person** should ask the **dentist** to write down a full description of the treatment needed, using either an **Aetna** claim form or an ADA approved claim form. Then, before actually treating the **covered person**, either the **covered person** or the **dentist** should send the form to **Aetna**.

Aetna may request supporting images and other diagnostic records from the **dentist**. Once all of the information has been gathered, **Aetna** will review the proposed treatment plan and provide the **covered person** and the **dentist** with a statement outlining the benefits payable by the Plan. The **covered person** and the **dentist** can then decide how to proceed.

In determining the amount of benefits payable, **Aetna** will take into account alternate procedures, services, or courses of treatment for the dental condition in question in order to accomplish the anticipated result. (See the *Alternate Treatment Rule below* for more information on alternate dental procedures.)

WHAT IS A COURSE OF DENTAL TREATMENT?

A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more **dentists** to treat a dental condition that was diagnosed by the attending **dentist** as a result of an oral examination. A course of treatment starts on the date the **dentist** first renders a service to correct or treat the diagnosed dental condition.

IN CASE OF A DENTAL EMERGENCY

If a **covered person** needs dental care for the palliative treatment (e.g., pain relieving, stabilizing) of a **dental emergency**, a **covered person** is covered 24 hours a day, 7 days a week.

A **dental emergency** is any dental condition which:

- Occurs unexpectedly;
- Requires immediate diagnosis and treatment in order to stabilize the condition; and
- Is characterized by symptoms such as severe pain and bleeding.

The Plan pays a benefit up to the dental emergency maximum.

RULES AND LIMITS THAT APPLY TO THE DENTAL BENEFITS

Several rules apply to the dental benefits. Following these rules will help a **covered person** use the Plan to their advantage by avoiding expenses that are not covered by the Plan.

Orthodontic Treatment Rule

Orthodontic treatment is covered when it is **medically necessary** for a **covered person** under the age of 19 with a fully erupted set of permanent teeth and asevere, dysfunctional, handicapping condition such as:

(A) Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement

(B) The following craniofacial anomalies:

- Hemifacial microsomia;
- Craniosynostosis syndromes;
- Cleidocranial dental dysplasia;
- Arthrogryposis; or
- Marfan syndrome

(C) Anomalies of facial bones and/or oral structures

(D) Facial trauma resulting in functional difficulties

Reimbursable orthodontic services include:

- pre-orthodontic treatment visit
- comprehensive orthodontic treatment
- orthodontic retention (removal of appliances, construction and placement of retainers(s))

This benefit does not cover charges for the following:

- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery;
- Myofunctional therapy;
- Lingually placed direct bonded appliances and arch wires (i.e., "invisible braces"); or
- Removable acrylic aligners (i.e., "invisible aligners").

Replacement Rule

Crowns, inlays, 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 crowns, inlays, onlays, veneers, dentures or bridges are covered only when a **covered person** gives proof to **Aetna** that:

- A **covered person** had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, a **covered person** needs 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 5-8 years before its replacement and cannot be made serviceable.
- A **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 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 items are needed to replace one or more natural teeth that were removed; and
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 3-8 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 current oral condition.

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

Coverage for Dental Work Completed After Termination of Coverage

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

Jaw Joint Disorder Treatment Rule

Coverage for **Jaw Joint Disorder** treatment is covered as a Type C service. This includes treatments which alter the jaw, jaw joints, or bite relationships.

The following are covered:

- Diagnosis;
- Applicable therapy; and
- Other non-surgical treatment.

Not included are charges incurred for:

- Orthodontic treatment;
- Crowns, bridges and dentures;
- Treatment of periodontal disease;
- Implants; and
- Root canal therapy.