Preferred Provider Organization (PPO)
Student Dental Insurance Plan

Schedule of benefits

Prepared exclusively for:
Policyholder: Saint Louis University
Policyholder number: 187213
Student policy effective date: 08/15/22
Plan effective date: 08/15/22
Plan issue date: 02/23/23

Underwritten by Aetna Life Insurance Company in the state of Missouri
Schedule of benefits

This schedule of benefits lists the eligible dental services, deductibles, coinsurance, maximums, copayments, 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 reflect the deductibles and coinsurance amounts under your plan.
• You must pay any deductibles and your part of the coinsurance and copayment.
• 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 policy year maximum.
• This plan also has limits for some covered benefits. For example, these could be visit limits. They may be combined limits between or separate maximums for in-network providers and out-of-network providers unless we state otherwise.

Important note:
All covered benefits are subject to a policy 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.
• Log onto your secure member website at www.aetnastudenthealth.com.
• Call Member Services at the toll-free number on the back of your card

The coverage described in this schedule of benefits will be provided under Aetna’s student policy. This schedule of benefits replaces any schedule of benefits previously in effect under the student policy. Keep this schedule of benefits with your certificate.
General coverage provisions

This section explains the:

- Deductibles
- Coinsurance
- Maximums

Policy 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
This is the amount you pay for in-network and out-of-network eligible dental services each policy year before the plan begins to pay. Once you have reached the policy year deductible, this plan will begin to pay for eligible dental services for the rest of the policy year.

Family deductible
When you and each of your covered dependents incur eligible dental services that apply towards the individual policy year deductibles, these expenses will also count toward a family deductible.

To satisfy this family deductible for the rest of the policy year, the following must happen:

- The combined eligible dental services that you and each of your covered dependents incur towards the individual policy year deductibles must reach this family deductible in a policy year.

When this happens in a policy year, the individual policy year deductibles for you and your covered dependents are met for the rest of the policy year.

Coinsurance
Once any applicable deductibles have been met, the specific coinsurance percentage the plan pays for eligible dental services is listed below.

Policy year maximum
The most the plan will pay for eligible dental services incurred by any one covered person in a policy year is called the policy year maximum.

The policy year maximum applies to in-network and out-of-network eligible dental services combined.

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 policy year. Determinations regarding when benefits are covered are subject to the terms and conditions of the certificate.
Plan features

Policy year deductible
You have to meet your **policy year deductible** before this plan pays for benefits.

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<thead>
<tr>
<th></th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
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<tbody>
<tr>
<td>Policy year deductible</td>
<td>Individual $50</td>
<td>Individual $50</td>
</tr>
<tr>
<td></td>
<td>Family $150</td>
<td>Family $150</td>
</tr>
</tbody>
</table>

The **policy 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**.

<table>
<thead>
<tr>
<th>Type A expenses</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>100% of the negotiated charge</td>
<td>100% of the recognized charge</td>
</tr>
</tbody>
</table>

Type B expenses

<table>
<thead>
<tr>
<th>Type B expenses</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80% of the negotiated charge</td>
<td>80% of the recognized charge</td>
</tr>
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</table>

Type C expenses

<table>
<thead>
<tr>
<th>Type C expenses</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50% of the negotiated charge</td>
<td>50% of the recognized charge</td>
</tr>
</tbody>
</table>

*Excludes implants, dentures, temporomandibular joint dysfunction/disorder, orthodontic care, oral surgery, prosthodontics, endodontics, periodontics.

Policy year maximum

<table>
<thead>
<tr>
<th>Policy year maximum</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,000</td>
<td>$1,000</td>
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The **policy year maximum** applies to all eligible dental services except Type A, B, C, and orthodontia treatment expenses.
Eligible dental services

Type A expenses: Diagnostic & preventive care

Visits and exams
- Office visit during regular office hours for oral examination (2 routine visits and 2 problem focused visits per year)
- Prophylaxis (cleaning) or scaling-moderate/severe inflammation–full mouth, (2 treatments per year)
- Topical application of fluoride if you are under age 16, (1 applications per year)
- Sealant repair - per tooth (for permanent molars only and if you are under age 16)
- Sealants, per tooth (1 application every 3 years for permanent molars only and if you are under age 16)

Images and pathology
- Bitewing images (1 set per year)
- Entire dental series, including bitewings or panoramic film (1 set every 3 years)
- Vertical bitewing images (1 set every 3 years)
- Periapical images

Space maintainers - Only when needed to preserve space resulting from premature loss of deciduous teeth. (Includes all adjustments within 6 months after installation.)
- Fixed or removable (unilateral or bilateral)
- Recementation or removal

Type B expenses: Basic restorative care

Visits and exams
- Office visit after hours (we will pay either for the office visit charge or for the eligible dental services performed, whichever is more)
- Emergency palliative treatment, per visit

Images and pathology
- Intra-oral, occlusal view
- Extra-oral
- Accession of tissue

Restorative - Excluding inlays, onlays and crowns. Multiple restorations in 1 surface will be considered as a single restoration.
- Amalgam restorations
- Resin-based composite restorations, (other than for molars)
- Protective restoration
- Reattachment of tooth fragment, incisal edge or cusp
- Interim therapeutic restoration – primary dentition
- Pin retention, per tooth, in addition to restoration
- Recementation
- Prefabricated crowns, primary teeth only (excluding temporary crowns)

Periodontics
- Periodontal maintenance (following active therapy, 1 per year)
- Occlusal adjustment, (other than with an appliance or by restoration)
• Root planing and scaling, 1 to 3 teeth per quadrant, (1 per site every 2 years)
• Root planing and scaling, 4 or more teeth per quadrant, (1 separate quadrant every 2 years)
• Surgical revision procedure, per tooth
• Gingivectomy/gingivoplasty, 1 to 3 teeth per quadrant, (1 per site every 5 years)
• Gingivectomy/gingivoplasty, 4 or more teeth per quadrant, (1 per quadrant every 5 years)
• Gingival flap procedure, 1 to 3 teeth per quadrant, (1 per site every 5 years)
• Gingival flap procedure, 4 or more teeth per quadrant, (1 per quadrant every 5 years)
• Apically positioned flap
• Unscheduled dressing change (by someone other than treating dentist or their staff).

Endodontics
• Pulp cap
• Pulpal debridement
• Pulpal therapy
• Pulpotomy
• Apexification/recalcification
• Apicoectomy
• Root canal therapy and retreatment once per lifetime
  - Anterior
  - Bicuspid
• Pulpal regeneration
• Periradicular surgery without apicoectomy
• Hemisection
• Retrograde filling
• Root amputation
• Treatment of root canal obstruction
• Incomplete endodontic surgery
• Internal root repair of defect

Oral surgery
• Extractions – coronal remnants – deciduous tooth
• Extractions erupted tooth or exposed root
• Surgical removal of erupted tooth
• Surgical removal of residual tooth roots
• Primary closure of a sinus perforation
• Oroantral fistula closure
• Tooth transplantation
• Surgical access of unerupted tooth
• Mobilization of erupted or malpositioned tooth to aid eruption
• Placement of device to facilitate eruption of impacted tooth
• Biopsy of oral tissue
• Exfoliative cytological sample collection
• Alveoloplasty
• Removal of odontogenic cysts or tumors
• Removal of exostosis
• Removal of torus
• Surgical reduction of osseous tuberosity
• Incision and drainage of abscess
• Removal of foreign body
• Sequestrectomy
• Suture of wounds
• Frenectomy/frenuloplasty
• Excision of hyperplastic tissue per arch
• Excision of pericoronal gingiva
• Surgical reduction of fibrous tuberosity
• Removal of impacted tooth-Soft tissue
• Sialolithotomy
• Closure of salivary fistula

**Type C expenses: Major restorative care**

**Restorative** – Inlays, onlays, labial veneers and crowns (excludes temporary 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. Coverage is limited to 1 per tooth every 8 years. (See the Replacement rule.)
- Inlays
- Onlays
- Labial veneers
- Crowns
- Post and core
- Repairs - inlay, onlay, veneer, crown

**Endodontics**
- Root canal therapy and retreatment once per lifetime
  - Molar

**Periodontics**
- Osseous surgery, (including flap and closure), 1 to 3 teeth per quadrant (1 per site every 3 years)
- Osseous surgery, (including flap and closure), 4 or more per teeth per quadrant (1 per quadrant every 3 years)
- Soft tissue graft procedures
- Full mouth debridement (1 per lifetime)

**Prosthodontics** – The 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 8 years old. (See the Tooth missing but not replaced rule.) Replacement of existing bridges, implants, or dentures is limited to 1 every 8 years. (See the Replacement rule.)
- Bridge abutments
- 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 and lower denture
  - Partial upper and lower (including any conventional clasps, rests and teeth)
  - Removable unilateral partial denture
- Stress breakers
- Interim partial denture (stayplate), anterior only
- Reline (partial or complete)
- Rebase, per denture
• Special tissue conditioning, per denture
• Adjustment to denture more than 6 months after installation
• Repairs, full and partial denture
• Adding teeth and clasps to existing partial denture
• Repairs, bridges
• Occlusal guard for bruxism (1 every 3 years)
• Adjustments, repair or reline of occlusal guard
• Cleaning and inspection of a removable appliance

Oral surgery
• Surgical removal of impacted tooth (bony, including wisdom teeth)
• Removal of impacted tooth
  – Partially bony
  – Completely bony
• Coronectomy

General anesthesia and intravenous sedation
• General anesthesia and intravenous sedation are covered when provided as part of a covered surgical procedure
• Evaluation by anesthesiologist for deep sedation or general anesthesia
Preferred Provider Organization (PPO)
Student Dental Insurance Plan
Certificate of Coverage

Prepared exclusively for

Policyholder: Saint Louis University
Policyholder number: 187213
Student policy effective date: 08/15/22
Plan effective date: 08/15/22
Plan issue date: 02/23/23

Underwritten by Aetna Life Insurance Company
Welcome

Thank you for choosing Aetna.

This is your certificate of coverage, or “certificate.” It is one of three documents that together describe the benefits covered by your Aetna plan for in-network and out-of-network coverage.

This certificate will tell you about your covered benefits – what they are and how you get them. It is your certificate of coverage under the student policy, and it replaces all certificates describing similar coverage that we sent to you before. The second document is the schedule of benefits. It tells you how we share expenses for eligible dental services and tells you about limits – like when your plan covers only a certain number of visits.

The third document is the student policy between Aetna Life Insurance Company (“Aetna”) and the policyholder. Ask the policyholder if you have any questions about the student policy.

Sometimes, we may send you documents that are amendments, endorsements, attachments, inserts or riders. They change or add to the documents that they’re part of. When you receive these, they are considered part of your Aetna plan for coverage.

Where to next? Try the Let’s get started! section. Let’s get started! gives you a summary of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your Aetna plan.
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Let’s get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details – and this is very important – you need to read this entire certificate of coverage and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

Some notes on how we use words in the certificate and schedule of benefits

- When we say “you” and “your”, we mean the covered student and any covered dependents.
- When we say “us”, “we”, and “our”, we mean Aetna.
- Some words appear in bold type and we define them in the Glossary section.

Sometimes we use technical dental language that is familiar to dental providers.

What your plan does – providing covered benefits

Your plan provides in-network and out-of-network covered benefits. These are eligible dental services for which your plan has the obligation to pay.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after the eligibility and enrollment process is completed. To learn more see the Who the plan covers section.

Your coverage typically ends when you are no longer a student. Family members can lose coverage for many reasons. To learn more see the When coverage ends section.

How your plan works while you are covered in-network

Your in-network coverage helps you:

- Get and pay for a lot of – but not all – dental care services. These are called eligible dental services.
- Pay less cost share when you use an in-network provider.

Important note:
See the schedule of benefits for any deductibles, coinsurance, and maximum age or visit limits that may apply.

Eligible dental services

Eligible dental services meet these requirements:

- They are listed in the Eligible dental services section in the schedule of benefits.
- They are not carved out in the What your plan doesn’t cover – eligible dental service exceptions and exclusions section. (We refer to this section as the “Exceptions” section.)
- They are not beyond any limits in the schedule of benefits.

Aetna’s network of dental providers

Aetna’s network of dental providers is there to give you the care you need. You can find in-network providers and see important information about them most easily on our online provider directory. Just log into your secure member website at www.aetnastudenthealth.com.

You can choose any dental provider who is in the dental network.

Your plan often will pay a bigger share for eligible dental services that you get through in-network providers, so choose in-network providers as soon as you can.
For more information about the provider directory and the role of your dental provider, see the Who provides the care section.

Paying for eligible dental services – the general requirements
There are general requirements for the plan to pay any part of the expense for an eligible dental service. They are:

- The eligible dental service is medically necessary
- You get the eligible dental services from in-network or out-of-network providers

You will find details on medical necessity requirements in the Medical necessity section.

Paying for eligible dental services – sharing the expense
Generally your plan and you will share the expense of your eligible dental services when you meet the general requirements for paying.

But sometimes your plan will pay the entire expense; and sometimes you will. For more information see the What the plan pays and what you pay section, and see the schedule of benefits.

How your plan works while you are covered out-of-network
The section above told you how your plan works while you are covered in-network. You also have coverage when you want to get your care from providers who are not part of the Aetna network. It’s called out-of-network coverage.

Your out-of-network coverage:
- Means you can get care from dental providers who are not part of the Aetna network.
- Means you may have to pay for services at the time that they are provided. You may be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of eligible dental services that you paid directly to a dental provider.
- Means you will pay a higher cost share when you use an out-of-network provider.

You will find details on:
- Out-of-network providers and any exceptions in the Who provides the care section
- Cost sharing in the What the plan pays and what you pay section, and your schedule of benefits
- Claim information in the When you disagree – claim decisions and grievance procedures section
How to contact us for help
We are here to answer your questions. You can contact us by:

- Logging onto your secure member website at www.aetnastudenthealth.com
- Registering for our secure Internet access to reliable dental information, tools and resources

Online tools will make it easier for you to make informed decisions about your dental care, view claims, research care and treatment options, and access information.

You can also contact us by:

- Calling Aetna Member Services at the toll-free number on the back of your ID card
- Writing us at Aetna Life Insurance Company, 151 Farmington Ave, Hartford, CT 06156

Your member ID card
We issued to you a digital ID card which you can view or print by going to the secure website at www.aetnastudenthealth.com. When visiting dental providers, you don’t need to show them an ID card. Just provide them with your name, date of birth and either your printed ID card or social security number. The dental office can use that information to verify your eligibility and benefits.

If you don’t have internet access, call Member Services at the toll-free phone number in the How to contact us for help section. You can also access your digital ID card when you’re on the go. To learn more, visit us at www.aetnastudenthealth.com.

Remember, only you and your covered dependents can use your digital ID card. If you misuse your card by allowing someone else to use it, that is fraud and we may end your coverage. See the Honest mistakes and intentional deception section for details.
Who the plan covers

You will find information in this section about:
- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible
The policyholder decides and tells us who is eligible for dental care coverage.

When you can join the plan
As a student you can enroll yourself and your dependents:
- During the enrollment period
- At other special times during the year (see the Special times you and your dependents can join the plan section below)

If you do not enroll yourself and your dependents when you first qualify for dental benefits, you may have to wait until the next enrollment period to join.

Who can be on your plan (who can be your dependent)
You can enroll the following family members on your plan. (They are referred to in this certificate as your “dependents”.)
- Your legal spouse
- Your dependent children – your own or those of your spouse
  - Under age 26 or
  - Under age 26, as long as they are students and they include:
    - Biological children
    - Stepchildren
    - Legally adopted children, including any children placed with you for adoption
    - Foster children
    - Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)

We will not refuse to enroll your child because they:
- Were born out of wedlock
- Are not claimed as a dependent on your federal income tax return
- Do not live with you

A dependent does not include an eligible student listed above in the Who is eligible – When you can join the plan section.
Adding new dependents
You can add the following new dependents any time during the year:

- A spouse – If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask the policyholder when benefits for your spouse will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information
    - Within 31 days of the date of your marriage.

- A newborn child – Your newborn child is covered on your dental plan from the moment of birth and for the first 31 days after birth.
  - To keep your newborn covered, you must notify us (or our agent) of the birth and pay any required premium contribution during that 31 day period.
  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional premium contribution for the newborn.
  - If you miss this deadline, your newborn will not have dental benefits after the first 31 days.

- An adopted child or a child legally placed with you for adoption – A child that you, or that you and your spouse adopt or is placed with you for adoption is covered on your plan from:
  - The date of birth if a petition if filed within 30 days of birth
  - The date of placement for the purpose of adoption if a petition is filed within 30 days of placement or
  - For the first 31 days after the adoption or the placement is complete.
    - To keep your adopted child covered, we must receive your completed enrollment information within 31 days after the adoption or placement for adoption.
    - You must still enroll the child within 31 days of the adoption or placement for adoption even when coverage does not require payment of an additional premium contribution for the child.
    - If you miss this deadline, your adopted child or child placed with you for adoption will not have dental benefits after the first 31 days.

- A stepchild – You may put a child of your spouse on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage with your stepchild’s parent.
  - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage or the first day of the month following the date we receive your completed enrollment information.

Inform us of any changes
It is important that you inform us of any changes that might affect your benefit status. This will help us effectively deliver your benefits. Please contact us as soon as possible with changes such as:

- Change of address or phone number
- Change in marital status
- Change of covered dependent status
- You enroll in any other dental plan
Special times you and your dependents can join the plan
You can enroll in these situations:

- When you did not enroll in this plan before because:
  - You were covered by another group dental plan, and now that other coverage has ended.
  - You had COBRA, and now that coverage has ended.
- You have added a dependent because of marriage, birth, adoption, placement for adoption or foster care. See the Adding new dependents section for more information.
- When a court orders that you cover a current spouse or a minor child on your dental plan.

We must receive your completed enrollment information from you within 31 days of that date on which you no longer have the other coverage mentioned above.

Effective date of coverage

Enrollment

Student coverage
If you enrolled on or before the effective date of the student policy, you are covered on the effective date of the student policy. Your coverage begins only if we received your completed enrollment application and you paid any required premium contribution.

If you enroll after the effective date of the student policy, your coverage begins on the date you enroll as long as:

- We agree
- We receive your completed enrollment request
- You pay any premium contribution

Dependent coverage

Your dependent’s coverage begins on the date we receive a completed enrollment application and you pay any required premium contribution. See the Adding new dependents section for details.

Late enrollment
If we receive your enrollment application and premium contribution more than 31 days after the date you become eligible, coverage will only become effective if, and when:

- We agree to enroll you
Medical necessity requirements

The starting point for covered benefits under your plan is whether the services and supplies are eligible dental services. See the Eligible dental services and Exceptions sections plus the schedule of benefits.

Your plan pays for its share of the expense for eligible dental services only if the eligible dental service is medically necessary.

This section addresses the medical necessity requirements.

Medically necessary/ medical necessity
As we said in the Let's get started! section, medical necessity is a requirement for you to receive a covered benefit under this plan.

The medical necessity requirements are in the Glossary section, where we define "medically necessary, medical necessity."
What are your eligible dental services?

The information in this section is the first step to understanding your plan’s eligible dental services. If you have questions about this section, see the How to contact us for help section.

Your plan covers many kinds of dental care services and supplies. Your eligible dental services are listed in the schedule of benefits. There you will find the detailed list of eligible dental services. But sometimes those services are not covered at all or are covered only up to a limit.

You can find out about exclusions in the Exceptions and the What rules and limits apply to dental care sections, and about the limitations in the schedule of benefits.

Dental emergency

Eligible dental services include dental services provided for a dental emergency. The care provided must be a covered benefit.

If you have a dental emergency, you should consider calling your dental in-network provider who may be more familiar with your dental needs. However, you can get treatment from any dentist including one that is an out-of-network provider. If you need help in finding a dentist, call Member Services at the toll-free number on the back of your ID card.

If you get treatment from an out-of-network provider for a dental emergency, the plan pays a benefit at the in-network cost-sharing level of coverage up to the dental emergency services maximum. Any charges above the dental emergency services maximum will be paid at the out-of-network cost-sharing level.

For follow-up care to treat the dental emergency, you should consider using your in-network dental provider so that you can get the maximum level of benefits. Follow-up care will be paid at the cost-sharing level that applies to the type of provider that gives you the care.
What rules and limits apply to dental care?

Several rules apply to the dental benefits. Following these rules will help you use your plan to your advantage by avoiding expenses that are not covered by your plan.

Alternate treatment rule
Sometimes there are several ways to treat a dental problem, all of which provide acceptable results.

If a charge is made for a non-eligible dental service or supply and an eligible dental service that would provide an acceptable result, then your plan will pay a benefit for the eligible dental service or supply.

If a charge is made for an eligible dental service but another eligible dental service that would provide an acceptable result is less expensive, the benefit will be for the least expensive eligible dental service.

The benefit will be based on the in-network provider’s negotiated charge for the eligible dental service or, in the case of an out-of-network provider, on the recognized charge.

You should review the differences in the cost of alternate treatment with your dental provider. Of course, you and your dental provider can still choose the more costly treatment method. You are responsible for any charges in excess of what your plan will cover.

Coverage for dental work begun before you are covered by the plan
Your plan does not cover dental work that began before you were 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 you were covered by the plan
- A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before you were covered by the plan
- Root canal therapy, if the pulp chamber for it was opened before you were covered by the plan

Reimbursement policies
We have the right to apply Aetna reimbursement policies. Those policies may reduce the negotiated charge or recognized charge. These policies take into account factors such as:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided and
- The educational level, licensure or length of training of the provider

Aetna reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services’ (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of dental practice and
- The views of providers and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.
Replacement rule
Some eligible dental services are subject to your plan’s replacement rule. The replacement rule applies to replacements of, or additions to existing:

- Crowns
- Inlays
- Onlays
- Implants
- Veneers
- Complete dentures
- Removable partial dentures
- Fixed partial dentures (bridges)
- Other prosthetic services

These eligible dental services are covered only when you give us proof that:
- While you were covered by the plan:
  - You had a tooth (or teeth) extracted after the existing denture, bridge, or other prosthetic item was installed.
  - As a result, you need to replace or add teeth to your denture, bridge, or other prosthetic item.
  - The tooth that was removed was not an abutment to a removable or fixed partial denture, bridge, or other prosthetic item installed during the prior 8 years.
- The present item cannot be made serviceable, and is:
  - A crown installed at least 8 years before its replacement.
  - An inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), implant, or other prosthetic item installed at least 8 years before its replacement.
- While you were covered by the plan:
  - You had a tooth (or teeth) extracted.
  - Your 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 items are needed to replace one or more natural teeth that were removed while you were covered by the plan. (The extraction of a third molar tooth does not qualify.)
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 8 years.

Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Congenital defects treatment rule
For newly born children, dental benefits are provided for medically diagnosed congenital defects and birth abnormalities to the same extent as other dental conditions. Any waiting periods will apply.
What your plan doesn’t cover – eligible dental service exceptions and exclusions

We already told you about the many dental care services and supplies that are eligible for coverage under your plan in the What are your eligible dental services section. In that section we also told you that some dental care services and supplies have exceptions and some are not covered at all (exclusions).

In this section we tell you about the exceptions and exclusions that apply to your plan.

And just a reminder, you’ll find benefit and coverage limitations in the schedule of benefits.

Exceptions and exclusions
The following are not eligible dental services under your plan except as described in:
• The Eligible dental services under your plan section of this certificate or
• A rider or amendment issued to you for use with this certificate:

Charges for services or supplies
• Provided by in-network providers in excess of the negotiated charge
• Provided by an out-of-network provider in excess of the recognized charge
• Provided for your personal comfort or convenience, or the convenience of any other person, including a dental provider
• Provided in connection with treatment or care that is not covered under the plan
• Cancelled or missed appointment charges or charges to complete claim forms
• Charges for which you have no legal obligation to pay
• Charges that would not be made if you did not have coverage, including:
  – Care in charitable institutions
  – Care for conditions related to current or previous military service
  – Care while in the custody of a governmental authority

Charges in excess of any benefit limits
• Any charges in excess of the benefit, dollar, visit, or frequency limits stated in the schedule of benefits

Cosmetic services and plastic surgery (except to the extent coverage is specifically provided in the Eligible Dental Services section of the schedule of benefits)
• 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 services to protect, clean, whiten, bleach alter the appearance of teeth whether or not for psychological or emotional reasons

Facings on molar crowns and pontics will always be considered cosmetic

Court-ordered services and supplies
• Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding
Dental services and supplies
- Acupuncture, acupressure and acupuncture therapy
- Asynchronous dental treatment
- Crown, inlays and onlays, and veneers unless for one of the following:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge
- 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
- Dentures, crowns, inlays, onlays, bridges, or other prosthetic appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion
- 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 you were not covered
- General anesthesia and intravenous sedation, unless specifically covered and done in connection with another eligible dental service
- Instruction for diet, tobacco counseling and oral hygiene
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered in the Eligible Dental Services section of the schedule of benefits
- Dental services and supplies made with high noble metals (gold or titanium) except as covered in the Eligible Dental Services section of the schedule of benefits
- Services and supplies provided in connection with treatment or care that is not covered under the plan
- 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
- Replacement of teeth beyond the normal complement of 32
- Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth
- Surgical removal of impacted wisdom teeth when removed only for orthodontic reasons
- Temporomandibular joint dysfunction/disorder

Experimental or investigational
- Experimental or investigational drugs, devices, treatments or procedures

Non-medically necessary services
- Services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary (as determined by Aetna) for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.

Non-U.S. citizen
- Services and supplies received by a covered person (who is not a United States citizen) within the covered person’s home country but only if the home country has a socialized medicine program

Other primary payer
- Payment for a portion of the charge that another party is responsible for as the primary payer

Outpatient prescription drugs, and preventive care drugs and supplements
- Prescribed drugs, pre-medication or analgesia
Personal care, comfort or convenience items
- Any service or supply primarily for your convenience and personal comfort or that of a third party

Providers and other health professionals
- 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
  - Cleaning of teeth
  - Topical application of fluoride
- Charges submitted for services by an unlicensed provider or not within the scope of the provider’s license

Services paid under your medical plan
- Your plan will not pay for amounts that were paid for the same services under a medical plan covering you. When a dental service is covered under both plans, we will figure the amount that would be payable under this plan if you did not have other coverage, then subtract what was paid by your medical plan. If there is any difference, this plan will pay it. If the amount paid by your medical plan is equal to or more than the benefit under this plan, this plan will not pay anything for the service.

Services provided by a family member
- Services provided by a spouse, civil union partner, domestic partner, parent, child, step-child, brother, sister, in-law or any household member

Services, supplies and prescription drugs received outside of the United States
- Services, supplies, and prescription drugs received outside of the United States. They are not covered even if they are covered in the United States under this certificate of coverage.

Sports
- Any services or supplies given by providers as a result from play or practice of collegiate or intercollegiate sports, not including intercollegiate club sports and intramurals

Valid and collectible insurance
- Services and supplies covered by any other valid and collectible medical, dental, health, or accident insurance but only to the extent that benefits are payable under other valid and collectible insurance. This applies whether or not a claim is made for such benefits.

Work related illness or injuries
- Coverage available to you under workers’ compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers’ compensation law or similar law.
- If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered “not work related” regardless of cause.
Who provides the care

Just as the starting point for coverage under your plan is whether the services and supplies are eligible dental services, the foundation for getting covered care is through our network. This section tells you about in-network and out-of-network providers.

In-network providers
We have contracted with dental providers to provide eligible dental services to you. These dental providers make up the network for your plan.

For you to receive the in-network level of benefits you must use in-network providers for eligible dental services.

The exceptions are:
- Dental emergency services – Refer to the What are your eligible dental services section
- In-network providers are not available to provide the service or supply that you need

You may select in-network providers from the directory or by logging on to our website at www.aetnastudenthealth.com. You can search our online directory for names and locations of dental providers.

You will not have to submit claims for treatment received from in-network providers. Your in-network provider will take care of that for you. And we will directly pay the in-network provider for what the plan owes.

Out-of-network providers
You also have access to out-of-network providers. This means you can receive eligible dental services from an out-of-network provider. If you use an out-of-network provider to receive eligible dental services, you are subject to a higher out-of-pocket expense and are responsible for:
- Paying your out-of-network deductible
- Your out-of-network coinsurance
- Any charges above the scheduled limit
- Any charges over our recognized charge
- Submitting your own claims
What the plan pays and what you pay

Who pays for your eligible dental services – this plan, both of us, or just you? That depends. This section gives the general rule and explains these key terms:

- Your deductible
- Your coinsurance
- Your copayment
- Your maximums

We also remind you that sometimes you will be responsible for paying the entire bill – for example, if you get care that is not an eligible dental service.

The general rule

When you get eligible dental services:

- You pay your deductible.

And then

- Your plan and you share the expense up to any policy year and lifetime maximum. The schedule of benefits lists how much you pay and how much your plan pays. The copayment and coinsurance percentage may vary by the type of expense. Your share is called copayment and coinsurance percentage.

And then

- You are responsible for any amounts above the maximum

When we say “expense” in this general rule, we mean the negotiated charge for in-network providers, and recognized charge for out-of-network providers. See the Glossary section for what these terms mean.

Important note – when you pay all

You pay the entire expense for an eligible dental service:

- When you get a dental care service or supply that is not medically necessary. See the Medical necessity requirements section.

In this case, the dental provider may require you to pay the entire charge. And any amount you pay will not count towards your deductible or towards your policy year maximum.

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses or costs in excess of the negotiated charge for in-network covered benefits
Where your schedule of benefits fits in
This section explains some of the terms you will find in your schedule of benefits.

How your deductible works
Your deductible is the amount you need to pay for eligible dental services per policy year before your plan begins to pay for eligible dental services. Your schedule of benefits shows the deductible amounts for your plan.

How we count your deductible
When you see in-network providers, we count the negotiated charge toward your in-network deductible. When you see out-of-network providers, we count the recognized charge toward your out-of-network deductible.

How your coinsurance works
Your coinsurance is the amount your plan pays for eligible dental services after you have paid your deductible. Your schedule of benefits shows you which coinsurance your plan will pay for specific eligible dental services.

How your copayment plan works
Using in-network providers
Your copayment is the amount you pay for eligible dental services after you have paid your deductible, then your plan will pay up to negotiated charge when you see in-network providers.

Using out-of-network providers
Your coinsurance is the amount your plan pays for eligible dental services after you have paid your deductible. Your schedule of benefits shows you which coinsurance your plan will pay for specific eligible dental services.

Your schedule of benefits shows you which copayments you need to pay for in-network specific eligible dental services and coinsurance for out-of-network.

How your maximum works
The maximum is the most your plan will pay for eligible dental services per policy year incurred by you or your covered dependent after any applicable deductible and coinsurance. You are responsible for any amounts above the maximum.

Important note:
See the schedule of benefits for any deductibles, coinsurance, maximum and maximum age, visit limits, and other limitations that may apply.
When you disagree – claim decisions and grievance procedures

In the previous section, we explained how you and we share responsibility for paying for your **eligible dental services**.

When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. We also explain what you can do if you think we got it wrong.

**Claim procedures**

You or your **dental provider** are required to send us a claim in writing. You can request a claim form from us. We will review that claim for payment to the **provider** or to you as appropriate.

The table below explains the claim procedures as follows:

<table>
<thead>
<tr>
<th>Notice</th>
<th>Requirement</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit a claim</td>
<td>• You should notify us in writing within 20 days and request a claim form from us</td>
<td>• You must send us notice and proof within 90 days.</td>
</tr>
<tr>
<td></td>
<td>• The claim form will provide instructions on how to complete and where to send the form(s)</td>
<td>• If you are unable to complete a claim form, you may send us:</td>
</tr>
<tr>
<td></td>
<td>• If we do not provide you with a claim form within 15 days, you will have complied with any requirements to submit proofs of loss</td>
<td>− A description of services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Bill of charges</td>
</tr>
<tr>
<td>Proof of loss (claim)</td>
<td>• A completed claim form and any additional information required by us</td>
<td>• You must send us notice and proof within 90 days.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Proof of loss may not be given later than 1 year after the time proof is otherwise required, except if you are legally unable to notify us.</td>
</tr>
<tr>
<td>When you have received a service from an eligible <strong>dental provider</strong>, you will be charged.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The information you receive for that service is your proof of loss.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Benefit (claim) payment
- Written proof must be provided for all claim benefits
- If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss
- Benefits (claims) will be paid immediately or as soon as the necessary proof to support the claim is received

If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if it is filed as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 15 months after the deadline.

### Communicating our claim decisions
The amount of time that we have to tell you about our decision on a claim is shown below.

#### Post-service claim
A post service claim is a claim that involves dental care services you have already received. We will make a decision within 30 days of receiving all necessary information. We will provide written notice of our decision to you within 10 working days of our determination.

<table>
<thead>
<tr>
<th>Type of notice</th>
<th>Post-service claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial decision by us</td>
<td>30 days</td>
</tr>
<tr>
<td>Extensions</td>
<td>15 days</td>
</tr>
<tr>
<td>If we request more information</td>
<td>30 days</td>
</tr>
<tr>
<td>Time you have to send us additional information</td>
<td>45 days</td>
</tr>
</tbody>
</table>

### Timely access to review
A toll-free telephone number is listed on the back of your member ID card, if you or your provider need to contact Aetna’s review staff.

### Adverse benefit determinations
We pay many claims at the full rate negotiated charge with in-network providers and the recognized charge with out-of-network providers, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we don’t pay at all. Any time we don’t pay even part of the claim that is an “adverse benefit determination” or “adverse decision.”

If we make an adverse benefit determination, we will tell you in writing. This will include the main reason(s) for the determination. It will also include instructions for submitting a grievance or reconsideration of the determination, and for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination.

### The difference between a complaint and an appeal
A complaint
You may not be happy about a dental provider or an operational issue, and you may want to complain. You can call or write Member Services. Your complaint should include a description of the issue. Member Services will review all the facts of your complaint as quickly and as courteously as possible. Complaints are resolved on an informal basis.
A grievance
A grievance is a written complaint when you are unhappy about:
- Getting an appointment with a provider
- The quality of the service you received
- An adverse determination or adverse decision
- Getting a claim paid or reimbursement for a payment you made
- Operational issues between you and us

You can write to member services if you are dissatisfied about:
- Getting an appointment with a provider
- The quality of the service you received or
- Operational issues between you and us

Your grievance should include a description of the issue. You should include copies of any records or documents that you think are important. We will let you know in writing with 10 working days that we received your grievance.

Grievances of adverse benefit determinations
First-level grievance
You can ask in writing us to re-review an adverse determination. This is a grievance of an adverse determination. We will assign your grievance to someone who was not involved in making the original decision. You must file a grievance no later than 180 calendar days from the time you receive the notice of an adverse determination.

You can send your written grievance to the address on the notice of adverse determination, or by contacting us. You need to include:
- Your name
- The policyholder’s name
- A copy of the adverse determination
- Your reasons for your grievance
- Any other information you would like us to consider

We will let you know in writing within 10 working days that we received your grievance.

We will conduct a complete investigation of the grievance within 15 working days after we receive a pre-service grievance and 20 working days after we receive a post-service grievance, unless the investigation cannot be completed within this time. If more time or information is needed to make the determination, we will notify you in writing on or before the 20th working day and the investigation will be completed within 30 working days thereafter. The notice will include specific reasons why additional time is needed for the investigation.

If your adverse determination was based on a medical judgment, we will consult with a health professional who is knowledgeable about your medical condition and who was not involved in making the original decision. The health professional will be a clinical peer of the same or similar specialty in the field of medicine involved in the medical judgment. This individual will be someone who was not involved in the initial decision and who is not the subordinate of the person who make the initial decision.

Within five (5) working days after the investigation is complete, the individual not involved in the circumstances that lead to your grievance or its investigation will decide upon the appropriate resolution and notify you in writing of our decision and your right to file a grievance for a second review. The notice will explain this decision and your right to file a grievance in terms that are clear and specific. You will be notified of the decision within 15 working days after the investigation is completed.
**Second-level grievance**
You can submit a second grievance of an adverse determination under this plan. You must present your second grievance no later than 180 calendar days from the date you receive the notice of the first-level grievance decision.

A grievance committee will review your second-level grievance. The grievance committee will consist of other plan members, and some of Aetna’s employees who were not involved with your first-level grievance.

Where the grievance involves an adverse determination, and the grievance advisory panel makes an initial decision that the determination would be upheld, we shall submit the grievance for review to two independent clinical peers in the same or similar specialty as would typically manage the case being reviewed who were not involved in the circumstances that lead to the grievance or in any subsequent investigation or determination of the grievance. In the event that both independent reviews agree with the grievance advisory panel’s initial decision, the panel’s decision shall stand. If both independent reviewers disagree with the grievance advisory panel’s initial decision, the initial adverse determination shall be overturned. If one of the two independent reviewers disagree with the grievance advisory panel’s initial decision, the panel shall reconvene and make a final decision in its discretion.

The review of your second-level grievance will follow the time frames required for a first-level grievance. We will tell you in writing of the grievance committee’s final decision in terms that are clear and specific. You may request access to and copies of documents, records and information relevant to the grievance. This includes the actual benefit provision, guideline, protocol, or other similar criteria on which the grievance decision was based. We will provide you with that information free of charge.

If you are unhappy with our decision, you may at any time contact the Missouri Department of Commerce and Insurance (DCI) at:

Missouri DCI  
Division of Consumer Affairs  
P.O. Box 690  
Jefferson City, Missouri 65102-0690  
Consumer Hotline: 800-726-7390  
TDD: 573-526-4536

**Expedited grievance review**
You may request the grievance process be expedited if the time frames of the standard grievance procedures would seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of your dental provider, would cause you severe pain which cannot be managed without the requested services. A request for an expedited grievance review may be submitted orally or in writing.

We will notify you orally within 72 hours after receiving the expedited review request. We will send written confirmation to you within 3 working days.

**External review**
External review is a review done by people in an organization outside of Aetna. This is called an independent review organization (IRO).

You may request an external review if:
- Our claim decision involved medical judgment
- We decided the service or supply is not medically necessary or not appropriate
- We decided the service or supply is experimental or investigational
- You have received an adverse determination
You do not have to exhaust our internal grievance process before you can request an external review. If you wish to pursue an external review, you may write to the Missouri Department of Commerce and Insurance (DCI) at:

Missouri DCI
Division of Consumer Affairs
P.O. Box 690
Jefferson City, Missouri 65102-0690

Include any information or documentation to support your request. If you have any questions or concerns during the external review process, you can call the DCI’s Consumer Affairs Hotline at 800-726-7390.

You will pay for any information that you send and want reviewed by the ERO. We will pay for information we send to the IRO plus the cost of the review.

The Consumer Affairs Division ("Division") will review your grievance as any other consumer complaint. The Division will contact us and request our decision in writing and all supporting documentation. The Division will first review the matter to determine if they can resolve the issue instead of referring to the IRO. For instance, if the grievance involves a matter of insurance law or a policy provision. However, if the grievance remains unresolved after exhausting the Division’s consumer complaint process, then the Director may contact a state qualified IRO to perform an independent review of you claim. Unresolved grievances include a difference in opinion between the treating dental professional and us concerning:

- Appropriateness
- Effectiveness of the dental service
- Health care settings
- Level of care
- Medical necessity

If the claim is eligible for external review, the Division will notify you and us. You and we will have 15 working days to provide any additional medical information that you and we wish to have reviewed and considered. All additional information must be received by the Division in writing.

The IRO will:

- Assign the grievance to one or more independent clinical reviewers that have the proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Notify the Director of its opinion within 20 calendar days of receiving your grievance

The IRO may request additional time for its review, but not more than 5 calendar days.

**How long will it take to get an IRO decision?**

After the Director receives the IRO’s opinion, the Director will issue a decision which shall be binding on you and us, with limited exceptions for judicial review. The Director’s decision will be in writing and provided to you and us within 25 calendar days of receiving the IRO’s opinion. At no time will the IRO decision be longer than 45 calendar days of the date the IRO receives your request for an external review and all the information to be considered to the date you and we are notified of the Director’s decision.

Sometimes you can get a faster IRO decision. You must call us or the Division as soon as possible.
You may be able to get a faster external review for an adverse determination if a delay in receiving dental services would:

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (in the case of experimental or investigational treatment)

If your situation qualifies for this faster review, you will receive a decision from the Director within 72 hours of the IRO getting your request. The Director will send you the decision in writing within 48 hours after verbal notification.

**Recordkeeping**
We will keep the records of all complaints and grievances for at least 10 years.

**Fees and expenses**
We do not pay any fees or expenses incurred by you when you submit a complaint or grievance.
Coordination of benefits

Some people have dental coverage under more than one plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB).

Key terms
Here are some key terms we use in this section. These terms will help you understand this COB section.

Allowable expense means:
- A dental care expense that any of your dental plans cover to any degree. If the dental care service is not covered by any of the plans, it is not an allowable expense. For example, cosmetic surgery generally is not an allowable expense under this plan.

In this section we talk about other “plans” which are those plans where you may have other coverage for dental care expenses, such as:
- Group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, policyholder organization plans, or employee benefit organization plans
- An automobile insurance policy
- Medicare or other governmental benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

Here’s how COB works
- The primary plan pays first. When this is the primary plan, we will pay your claims first as if the other plan does not exist.
- The secondary plan pays after the primary plan. When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid.
- We will never pay an amount that, when combined with payments from your other coverage, add up to more than 100% of the allowable expenses.

Determining who pays
Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.

A plan that does not contain a COB provision is always the primary plan.

<table>
<thead>
<tr>
<th>If you are:</th>
<th>Primary plan</th>
<th>Secondary plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered under the plan as a subscriber or dependent</td>
<td>The plan covering you as a subscriber</td>
<td>The plan covering you as a dependent</td>
</tr>
<tr>
<td>COB rules for dependent children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Child of:</strong></td>
<td><strong>The “birthday rule” applies.</strong> The plan of the parent whose birthday* (month and day only) falls earlier in the calendar year. *Same birthdays--the plan that has covered a parent longer is primary.</td>
<td><strong>The plan of the parent born later in the year (month and day only)</strong>*</td>
</tr>
<tr>
<td>Parents who are married or living together</td>
<td></td>
<td>*Same birthdays--the plan that has covered a parent longer is primary.</td>
</tr>
<tr>
<td><strong>Child of:</strong></td>
<td><strong>The plan of the parent whom the court said is responsible for dental coverage</strong></td>
<td><strong>The plan of the other parent.</strong> But if that parent has no coverage, then his/her spouse’s plan is primary.</td>
</tr>
<tr>
<td>Parents separated or divorced or not living together</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With court-order</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Child of:</strong></td>
<td><strong>Primary and secondary coverage is based on the birthday rule</strong></td>
<td></td>
</tr>
<tr>
<td>Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Child of:**                      | **The order of benefit payments is:**  
* The plan of the custodial parent pays first  
* The plan of the spouse of the custodial parent (if any) pays second  
* The plan of the noncustodial parent pays next  
* The plan of the spouse of the noncustodial parent (if any) pays last | |
| Parents separated or divorced or not living together and there is no court-order | | |
| **Child covered by:** Individual who is not a parent (i.e. stepparent or grandparent) | **Treat the person the same as a parent when making the order of benefits determination:** See *Child of* content above | |

**COBRA or state continuation**

The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage, COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree.

**Longer or shorter length of coverage**

If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.

**Other rules do not apply**

If none of the above rules apply, the plans share expenses equally.
<table>
<thead>
<tr>
<th><strong>How are benefits paid?</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary plan</td>
<td>The primary plan pays your claims as if there is no other dental plan involved.</td>
</tr>
<tr>
<td>Secondary plan</td>
<td>The secondary plan calculates payment as if the primary plan did not exist, and then applies that amount to any allowable expenses under the secondary plan that were not covered by the primary plan.</td>
</tr>
<tr>
<td></td>
<td>The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense</td>
</tr>
</tbody>
</table>

**Other coverage updates – contact information**
You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly. See the How to contact us for help section for details.

**Right to receive and release needed information**
We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other dental plans.

**Right to pay another carrier**
Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

**Right of recovery**
If we pay more than we should have under the COB rules, we may recover the excess from:
- Any person we paid or for whom we paid

Any other plan that is responsible under these COB rules

We will not request a refund or offset against a claim more than 12 months after paying the claim, except in cases of fraud or misrepresentation by the provider.
When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends.

When will your coverage end?
Coverage under this plan will end if:

- This plan is discontinued
- The student policy ends
- You are no longer eligible for coverage, including when you are no longer in an eligible class
- The last day for which any required premium contribution has been paid
- We end your coverage
- You become covered under another dental plan offered by your policyholder
- The date you withdraw from the school because of entering the armed forces of any country

If you withdraw from school because you have entered the armed forces, premiums will be refunded, on a pro-rata basis, when we receive your request within 90 days from the date of the withdrawal.

When will coverage end for any dependents?
Coverage for your dependent will end if:

- Your dependent child reaches age 26. Coverage will end on the first premium due date following the child's birthday.
- Your dependent is no longer eligible for coverage, including the date dependents are no longer in an eligible class.
- The student policy ends.
- You do not make the required premium contribution toward the cost of dependents’ coverage.
- Your coverage ends for any of the reasons listed above.

Why would we end your coverage?
We will give you 31 days advance written notice before we end your coverage because you commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the General provisions – other things you should know section for more information on loss of coverage.

On the date your coverage ends, we will refund to the policyholder any prepayments for periods after the date your coverage ended.

Coverage will end for you and any dependents on the earlier of the date the student policy terminates or immediately on the next premium contribution due date at the end of the second-eleventh month at the end of the quarter at the end of the policy year at the end of the next policy year following the date on which you no longer meet the eligibility requirements at the end of the period defined by the policyholder following the date on which you no longer meet the eligibility requirements.
General provisions – other things you should know

Administrative provisions

How you and we will interpret this certificate
We prepared this certificate according to federal and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this certificate when we administer your coverage, so long as we use reasonable authority.

Any provision of this plan which is in conflict with state or federal law is hereby automatically amended to conform with the minimum requirements of such laws.

If there is any conflict between the provisions of the student policy and this certificate, we will resolve those in your favor.

How we administer this plan
We apply policies and procedures we’ve developed to administer this plan.

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan including enrollment and benefit determinations.

Who’s responsible to you
We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your providers. They are not our employees or agents.

Coverage and services

Your coverage can change
Your coverage is defined by the student policy. This document may have amendments or riders too. Under certain circumstances, we or the policyholder or the law may change your plan according to the requirements of the student policy. Only Aetna may waive a requirement of your plan. No other person – including the policyholder or provider – can do this.

If your student status changes the amount of your coverage or benefit levels, the change will take effect on the date of the status change and the amount of coverage or benefit level will be changed to the new amount.

A retroactive change in your student status will not cause a retroactive change in your coverage.

If your dependent status changes the amount of your dependent coverage or benefit levels, the change will take effect on the date of the status change and the amount of coverage or benefit level will be changed to the new amount.

Financial sanctions exclusions:
If payment for any claim under this certificate violates or will violate any economic or trade sanctions, the claim will not be paid. Your coverage will continue under this plan, however you will be financially responsible for the entire claim. For example, we cannot pay for eligible dental services if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Assets Control (OFAC). You can find out more by visiting http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.
Legal action
We encourage you to complete the grievance process before you take any legal action against us for any expense or bill. You cannot take any action until 60 days after we receive written submission of claim. See the When you disagree – claim decisions and grievance procedures section.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Physical examinations and evaluations
At our expense, we have the right to have a provider of our choice examine you. This will be done at all reasonable times while a claim for benefits is pending or under review.

Records of expenses
You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:
- Names of dental providers, dentists and other providers who provide services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception
Honest mistakes
You or the policyholder may make an honest mistake when you share facts with us. Except for fraud, all statements made by you are considered representations and not warranties. No statement will void this student policy or reduce the benefits after the coverage has been in force for 2 years from its effective date, unless the statement was in a written application or enrollment form signed by you, and you received a copy of the application or enrollment form.

If you or the policyholder makes a misstatement about your age, we may make a fair change in premium contribution when we learn of the mistake. If we do, we will tell you what the mistake was. We will also change the premium to be equal to the amount that the premium would have been if purchased at the actual age or under the actual condition when this policy was issued.

Intentional deception
If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:
- Loss of coverage, starting at some time in the past. If we paid claims for your past coverage, we will want the money back.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.
Some other money issues

Assignment of benefits
When you see in-network providers they will usually bill us directly. When you see out-of-network providers, we may choose to pay you or to pay the provider directly. Unless we have agreed to do so in writing and to the extent allowed by law, we will not accept an assignment to an out-of-network provider under this student policy. This may include:

- The benefits due
- The right to receive payments or
- Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this student policy

To request assignment you must complete an assignment form. The assignment form is available from the policyholder. The completed form must be sent to us for consent.

Recovery of overpayments
We sometimes pay too much for eligible dental services or pay for something that this plan doesn’t cover. If we do, we can require the person we paid – you or your provider – to return what we paid. If we don’t do that we have the right to reduce any future benefit payments by the amount we paid by mistake. We will not request a refund or offset against a claim more than 12 months after paying the claim, except in cases of fraud or intentional misrepresentation by the provider.

Grace period
You will be allowed a grace period of 31 days after the due date for the payment of each contribution due after the first contribution payment. If contributions are not paid by the end of the grace period, your coverage will automatically terminate at the end of the grace period.

Your dental information
We will protect your dental information. We will use it and share it with others to help us process your providers’ claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just call Member Services at the toll-free number on the back of your ID card. When you accept coverage under this plan, you agree to let your providers share your information with us. We will need information about your physical and mental condition and care.
Glossary

Aetna
Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with Aetna.

Coinsurance
The specific percentage we have to pay for eligible dental services.

Copay, copayment
The specific dollar amount you have to pay for eligible dental services. Copayments may be changed by Aetna upon 30 days written notice to the policyholder.

Cosmetic
Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits
Eligible dental services that meet the requirements for coverage under the terms of this plan.

Deductible
The amount you pay for eligible dental services per policy year before your plan starts to pay.

Dental emergency
Any dental condition that:
- Occurs unexpectedly
- Requires immediate diagnosis and treatment in order to stabilize the condition, and
- Is characterized by symptoms such as severe pain and bleeding

Dental emergency services
Services and supplies given by a dental provider to treat a dental emergency.

Dental provider
Any individual legally qualified to provide dental services or supplies.

Dentist
A legally qualified dentist licensed to do the dental work he or she performs.

Directory
The list of in-network providers for your plan. The most up-to-date directory for your plan appears at www.aetnastudenthealth.com. When searching for in-network providers, you need to make sure that you are searching for providers that participate in your specific plan. In-network providers may only be considered in-network providers for certain Aetna plans.

Effective date of coverage
The date your and your dependent's coverage begins under this certificate as noted in our records.
Eligible dental services
The dental care services and supplies listed in the schedule of benefits and not listed or limited in the What rules and limits apply to dental care and Exceptions sections of this certificate of coverage or in the schedule of benefits.

Experimental or investigational
A drug, device, procedure, or treatment that we find is experimental or investigational because:
• There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the illness or injury involved.
• The needed approval by the FDA has not been given for marketing.
• A national medical or dental society or regulatory agency has stated in writing that it is experimental or investigational or suitable mainly for research purposes.
• It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.
• Written protocols or a written consent form used by a facility provider state that it is experimental or investigational.
• It is provided or performed in a special setting for research purposes.

Health professional
A person who is licensed, certified or otherwise authorized by law to provide dental care services to the public. For example, providers and dental assistants.

Illness
Poor health resulting from disease of the teeth or gums.

Injury or injuries
Physical damage done to the teeth or gums.

In-network provider
A provider listed in the directory for your plan.

Medically necessary/medical necessity
Dental care services that we determine a provider using sensible clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that we determine are:
• In accordance with generally accepted standards of dental practice
• Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease
• Not primarily for the convenience of the patient, dentist, or other health care provider
• Not more costly than an alternative service or sequence of services at least as likely to produce the same benefit or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease

Generally accepted standards of dental practice means standards based on credible scientific evidence published in peer-reviewed dental literature and is:
• Generally recognized by the relevant dental community
• Consistent with the standards set forth in policy issues involving clinical judgment
**Medicare**
As used in this plan, Medicare means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

**Negotiated charge**
This is either:
- The amount in-network providers have agreed to accept
- The amount we agree to pay directly to in-network providers or third party vendors (including any administrative fee in the amount paid)

for providing eligible dental services to covered persons in the plan.

**Out-of-network provider**
A provider who is not an in-network provider and does not appear in the directory for your plan.

**Physician**
A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

**Policy year**
A period of 12 months beginning on January 1st and ending on December 31st.

**Policy year maximum**
This is the most this plan will pay for eligible dental services incurred by you during the policy year.

**Premium**
The amount you or the policyholder are required to pay to Aetna to continue coverage.

**Provider**
A dentist, or other entity or person licensed, or certified under applicable state and federal law to provide dental care services to you.

**Recognized charge**
The amount of an out-of-network provider’s charge that is eligible for coverage. You are responsible for all amounts above the recognized charge. The recognized charge may be less than the provider’s full charge.

Your plan’s recognized charge applies to all out-of-network eligible dental services except out-of-network dental emergency services. In all cases, the recognized charge is based on the geographic area where you receive the service or supply.

Except as otherwise specified below, the recognized charge for each service or supply is the lesser of what the provider bills and:
- 80% of the Aetna out-of-network rate (AONR)

Special terms used:
Aetna out-of-network rates (AONR)
Our standard rates used to begin contract negotiations with in-network providers in a specific geographic area.
Geographic area
The geographic area made up of the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.

Prevailing charge rate:
The 80th percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, we have the right to substitute an alternative database that we believe is comparable.

Additional information:
Get the most value out of your benefits. We have online tools to help you decide the type of care to get and where. Our secure website offers tools to help you determine the cost of eligible dental services, evaluate in-network providers and schedule office visits with them. See the How to contact us for help section for this website.

Student policy
The student policy consists of several documents taken together. These documents are:
- The policyholder’s application
- Your enrollment form, if the policyholder requires one
- The student policy
- The certificate(s) of coverage
- The schedule of benefits
- Any riders, endorsement, inserts, attachments, and amendments to the student policy, the certificate of coverage, and the schedule of benefits

Temporomandibular joint dysfunction/disorder
This is:
- A temporomandibular joint (TMJ) dysfunction/disorder or any similar disorder of the jaw joint
- A myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves
**Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-480-4161.

**Smartphone or Tablet**

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

**Non-Discrimination**

Aetna is committed to being an inclusive health care company. Aetna does not discriminate on the basis of ancestry, race, ethnicity, color, religion, sex/gender (including pregnancy), national origin, sexual orientation, gender identity or expression, physical or mental disability, medical condition, age, veteran status, military status, marital status, genetic information, citizenship status, unemployment status, political affiliation, or on any other basis or characteristic prohibited by applicable federal, state or local law.

Aetna provides free aids and services to people with disabilities and free language services to people whose primary language is not English.

These aids and services include:

- Qualified language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Qualified interpreters
- Information written in other languages

If you need these services, contact the number on your ID card. Not an Aetna member? Call us at 1-877-480-4161.

If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-877-480-4161.

*Please note, Aetna covers health services in compliance with applicable federal and state laws. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations, and conditions of coverage.*

**Language accessibility statement**

*Interpreter services are available for free.*

Attention: If you speak English, language assistance service, free of charge, are available to you. Call **1-877-480-4161** (TTY: 711).

**Español/Spanish**

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-480-4161** (TTY: 711).
 álaba yebelu: እማርኛ ቡንቋ የሚገሩ ከሆነ የትርጉም የሚከተለው የሆኑን የክፍያ ከራይ የስጪ የድርጅቶቹ፣ የላል የክፍያ ከራይ ይክታል። የሚከተለው የቁጥር ፈላይ ያደውሉ 1-877-480-4161 (መስማት ለተሳናቸው: 711).

melhouette: یافتن زبان عربية، في حالة خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-480-4161 (رقمه الهاتف النصي: 711).

Bàssò Wùqù/Bassa

中文/Chinese
注意：如果您说中文，我们可为您提供免费的语言协助服务。请致电 1-877-480-4161 (TTY: 711)。

فارسی/Farsi
توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه می‌گردد، با شماره 1-877-480-4161 (TTY: 711) تماس بگیرید.

Français/French
Attention: Si vous parlez français, vous pouvez disposer d’une assistance gratuite dans votre langue en composant le 1-877-480-4161 (TTY: 711).

ગુજરાતી/Gujarati
ध્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાય સેવા તમને નથી ઉપલબ્ધ છે. શુલ્ક ઉપલબ્ધ 1-877-480-4161 (TTY: 711).

Kreyòl Ayisyen/Haitian Creole

Igbo

한국어/Korean

Português/Portuguese
Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).
Missouri Notice of Protection Provided by Missouri Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Missouri Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Missouri law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Missouri law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms “insurance company” and “insurer” include health maintenance organizations (HMOs).)

The basic protections provided by the Association are as follows:

- **Life Insurance**
  - $300,000 in death benefits but not more than $100,000 in net cash surrender and net cash withdrawal values

- **Health Insurance**
  - $500,000 for health plans
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits

- **Annuities**
  - $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is as follows:

- $300,000 in aggregate for all types of coverage listed above, with the exception of health benefit plans
- $500,000 in aggregate for health benefit plans
- $5,000,000 to one policy owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons “Health benefit plan” is defined in section 376.718, RSMo.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Missouri law.

Benefits provided by a long term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the basic life insurance policy or annuity contract to which it relates.
To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at [www.mo-iga.org](http://www.mo-iga.org), or contact:

Missouri Life and Health  
Insurance Guaranty Association
2210 Missouri Boulevard  
Jefferson City, Missouri 65109
Ph.: 573-634-8455  
Ph.: 573-522-6115

Missouri Department of Insurance, Financial 
301 West High Street, Room 530 
Jefferson City, Missouri 65101 
Fax: 573-634-8488 
Ph.: 573-522-6115

Insurance companies and agents are not allowed by Missouri law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Missouri law, then Missouri law will control.