

**Columbia University**

**Aetna Columbia PPO Dental  
Plan**

**Officers and Support Staff  
(Non-Union, Local 2210 and TWU)**

**Effective January 1, 2010  
As of April 2010**

**What Your Plan  
Covers and How  
Benefits are Paid**

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# INTRODUCTION

Columbia University is pleased to provide you with this Summary Plan Description (SPD), which describes the benefits available to you and your covered family members under the Columbia University Dental Plan. It includes summaries of:

Who is eligible

Services that are covered, called Covered Health Services

Services that are not covered, called Exclusions

How benefits are paid

Your rights and responsibilities under the Dental Plan.

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for this Plan – including previously released Benefits in Brief. You are responsible for using this SPD and other resources provided to you to understand your benefits.

The rest of this description provides details about how the coverage works as well as information about who is eligible, processes and events that can affect coverage, administrative information, and your rights as a participant in the Plan. Please note that the words “you” and “your” refer to eligible covered persons enrolled in the Plan.

**If there is a conflict between this SPD and any summaries provided to you and/or any verbal representations, this SPD will govern in every respect and instance.**

## How To Use This SPD

- Please read the entire SPD and share it with your family.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments at [www.hr.columbia.edu](http://www.hr.columbia.edu) or request printed copies by contacting the Columbia University HR Benefits Service Center at 212-851-7000.

## Claim Filing Deadline

This Plan will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for dental expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

You have 12 months to submit a claim for a covered service to your dental plan. While most in-network providers automatically submit claims on behalf of the patient, there are many situations when this does not occur. If you receive services from an out-of-network provider, you are responsible for submitting your claim for a covered service within the 12 months from the date of incurral.

## **Preauthorization (or “Precertification”) Requirements**

Certain procedures, services and/or supplies require you to obtain preauthorization from your dental claim administrator for you to receive the maximum benefits under the plan. You must get authorization for certain procedures and treatments before the procedure is performed or before the treatment starts.

## In-Network Services

When you use a provider who participates in the Aetna or Columbia University network, the plan pays the provider directly. In addition, if the charges exceed the network negotiated rates, you are not responsible for the difference in cost. Participating network providers are not permitted to bill you for any balance.

## Out-of-Network Services

The Aetna Columbia Dental Plan allows you the flexibility to use providers who are not in the network. However, your cost toward your dental expenses is significantly higher because there are no negotiated fees. In addition, the percentage paid by Aetna Dental will be limited to the network-negotiated fees. This means if you use an out-of-network dentist, your reimbursement will be based on the *network* fees for the services provided. ***You are responsible for paying the full amount of any charges that exceed this limit.***

In addition, you must file claim forms with your dental carrier for each service or supply and wait for reimbursement.

# ADMINISTRATIVE AND LEGAL INFORMATION ABOUT THE PLAN

## Your Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all group health plans protect the confidentiality of your health information. The Plan and Columbia University will not use or further disclose information that is protected by HIPAA (referred to as protected health information or “PHI”) except as necessary for treatment, payment, health plan operations, and plan administration, or as permitted or required by law.

When you enroll in the Columbia University Dental Plan, you consent to and authorize the Plan to share your claims data when appropriate.

By law, Columbia University has required all of its business associates to also observe HIPAA’s privacy rules. The Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Columbia University. The Plan reserves the right to modify its practices with respect to dental information.

You have certain rights under HIPAA with respect to your protected health information, including the right to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the United States Department of Health and Human Services. If you have any questions on this issue, you should contact the HIPAA Privacy Office. To exercise your HIPAA rights under Columbia University dental plan, contact:

Privacy Officer  
Columbia University HR Benefits  
Studebaker 4<sup>th</sup> Floor, MC 8705  
615 West 131<sup>st</sup> Street  
New York, NY 10027

Email: [hrprivoff@columbia.edu](mailto:hrprivoff@columbia.edu)

## Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option.

The special enrollment events include:

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan:
  - Employee only;
  - spouse only;
  - Employee and spouse;
  - Dependent child(ren) only; Employee and Dependent child(ren);
  - Employee, spouse and Dependent child(ren).

Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage. Dependent children who were already Dependents of the Employee but not currently enrolled in the Plan are not entitled to special enrollment.

- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
  - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
  - the other plan no longer offers any benefits to a class of similarly situated individuals.
  
- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
  
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases:
  - due to failure of the employer or other responsible entity to remit premiums on a timely basis;
  - when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or
  - when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual.

This does not include termination of an employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

Special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

Individuals who enroll in the Plan due to a special enrollment event will not be denied enrollment. You will not be enrolled in this plan if you do not enroll within 30 days of the date you become eligible, unless you are eligible for special enrollment.

## Your ERISA Rights

As a participant in the medical (including prescription drug), dental, flexible spending accounts, long-term disability and life insurance benefits described in this SPD, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA). You are entitled to receive a yearly summary of each plan's financial report. You may examine all the official documents related to the Plans in the Columbia University HR Benefits department. If you wish, you can obtain your own copies of Plan documents by writing to HR Benefits. You may have to pay a reasonable charge to cover the cost of postage and photocopying.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who administer the plans. These people are called “fiduciaries” and have a duty to act prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person or organization, may terminate you or otherwise discriminate against you in any way in order to prevent you from obtaining your Plan benefits or exercising your rights under ERISA.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case the court may require the Plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator.

If you have a claim for a welfare benefit which is denied in whole or in part, you must receive a written explanation of the reason for the denial. For the medical, dental, life and long-term disability plans, the reason for the denial is explained in the Explanation of Benefits (EOB) or denial letter. (Please see the section Claim Review and Appeals Procedures under each Plan.) For the other plans covered under ERISA, you have the right to have the Plan Administrator review and reconsider the claim by submitting a request for appeal within 60 days of the denial. The request may be made by you or your authorized representative and should include the reason you are requesting a review of the claim, as well as any additional information that supports your claim. A review of your claim will take place no later than 120 days after receipt of your appeal. If your claim is still denied, you may file suit in a state or federal court. If you have any questions about your rights under ERISA, you may contact the nearest office of the U.S. Department of Labor.

### **Obtaining a Certificate of Creditable Coverage**

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will automatically be mailed to each terminating individual at the last address on file. You or your dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, call the toll-free customer service number on the back of your ID card.

### **Statement of the University’s Rights**

This document is not a contract or agreement for employment. Employment with Columbia University is “at-will”—nothing in this document changes your right and the University’s right, to end your employment at any time and for any reason. Employment at Columbia University is not guaranteed for any period of time.

The Plan Administrator has full power and discretion to resolve all issues concerning eligibility, status, entitlement to benefits, and any other interpretations under the Plan. Such interpretations or rulings will be binding on all parties. The Plan Administrator has the right to delegate some of these duties to third party providers, such as the claims administrators for the plans. As the Plan Administrator’s delegates, the claims administrators have the authority to make decisions relating to benefit claims.

The University intends that the terms of the Plan described in this SPD, including those relating to coverage and benefits, are legally enforceable, and that the Plan is maintained for the exclusive benefit of participants, as defined by law.

Although Columbia University expects to continue the Plan, it reserves the right to amend, modify or discontinue all or any part of the Plan or any plan or coverage at any time for any or all employees including active, disabled and former employees participating in the Columbia University Dental Plan. In the event of termination of the Plan, no benefits will be paid for incidents or events occurring after the date of termination.

No oral or written communication will be effective in amending The Plan unless it is by way of a formal amendment. Complete details, terms and conditions relating to each element of the plans are contained in the relevant plan documents; the specific provision and language of these documents will govern in every respect and instance.

To the extent this SPD provides a general description of the tax results that may be applicable to coverage under the Plan, Columbia University assumes no responsibility for your own personal tax status, or for any tax consequences resulting from any claims made contrary to current tax law. Please consult your tax advisor for further information on the tax treatment of your benefits.

## **Plan Information**

The name of the Plan is:

Columbia University Group Benefits Plan

## **Plan Sponsor and Administrator**

Columbia University is the Plan Sponsor and Plan Administrator of the Columbia University Welfare Benefit Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator – Dental Plan  
Columbia University  
Studebaker Bldg., MC 8703  
615 West 131<sup>st</sup> Street  
New York, NY 10027  
(212) 851-7000

Employer Identification Plan Number (EIN): 135598093 515

The name, address and ZIP code of the person designated as agent for the service of legal process is:

Employer named above

The office designated to consider the appeal of denied claims is:

The Claim Office of your Dental plan (Aetna). The phone number is listed on your member Identification card.

The cost of the Plan is shared by the Employee and Employer.

The Plan year is calendar and ends on 12/31.

## **Plan Trustees**

A list of Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

## **Plan Type**

The plan is a Dental plan.

## **Collective Bargaining Agreements**

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements. A copy is available for examination from the Plan Administrator upon written request.

## **Claim Administrator**

The Plan Administrator delegates to your dental plan (Aetna) the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to your dental plan (Aetna) the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the University. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

**Agent for Service of Legal Process**

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Agent for Legal Process – Dental Plan  
Columbia University  
Studebaker Bldg., MC 8703  
615 West 131<sup>st</sup> Street  
New York, NY 10027  
(212) 851-7000

Legal process may also be served on the Plan Administrator.

**Type of Administration**

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

<b>Plan Name:</b>	Columbia University Welfare Benefit Plan
<b>Plan Number:</b>	501
<b>Employer ID:</b>	13-5598093
<b>Plan Type:</b>	Welfare benefits plan
<b>Plan Year:</b>	Calendar
<b>Plan Administration:</b>	Self-Insured
<b>Source of Plan Contributions:</b>	Employee and University
<b>Source of Benefits:</b>	Assets of the University

# ELIGIBILITY FOR BENEFIT COVERAGE

## **Eligibility:**

If you are a full-time active Columbia University Officer or Support Staff (excluding SSA), you and your family are eligible for dental coverage under the Aetna Columbia Dental Plan.

### **Officers and Support Staff (Non-Union, Local 2110 and TWU)**

If you are a full-time active Columbia University Officer, you and your family are eligible for dental coverage under the Aetna Columbia Dental Plan.

If you are a full-time or part-time (with scheduled hours greater than or equal to 20 hours per week) Support Staff employee (Non-Union, Local 2210 and TWU) you are eligible for the Aetna Columbia Dental Plan.

## **When Your Benefits Start**

### **Officers**

You are eligible for medical benefits on your date of hire. However, your benefits will commence as soon as administratively feasible after your hire date. In most cases, benefits will start 3 to 4 weeks after your date of hire due to administrative processes that must be initiated internally and with external medical insurance administrators.

### **Support Staff (Non-Union, Local 2110 and TWU)**

You are eligible for medical benefits after a wait period as defined by your collective bargaining agreement. Please refer to your agreement for your eligible start date. Your benefits will commence as soon as administratively feasible after your hire date. In most cases, benefits will start 3 to 4 weeks after your eligible date due to administrative processes that must be initiated internally and with external medical insurance administrators.

### **Officers and Support Staff (Non-Union, Local 2110 and TWU)**

In order to receive benefits, you must enroll within 31 days of your date of hire. You must select the coverage you want and whom you want to cover. If you do not enroll within 31 days of your date of hire, you will not have any medical benefit coverage for the remainder of the calendar year. You will have to wait until the Benefits Open Enrollment period held annually in the fall. The benefit choices you make at that time take effect the following January. See the section, How To Enroll.

## **Your Eligible Dependents**

You can also elect to cover your dependents. Your eligible dependents include your:

Legal Spouse

Same-sex domestic partner or civil union partner, provided your partner is:

Is at least 18 years old

Is not related to you by blood

Is not legally married to another person

In the case of a civil union partnership, is entered into a certified civil union under applicable state law that recognizes a relationship between people of the same gender or treats

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– **And** meets two or more of the following requirements:

–

Shares the same principal residence with you full-time and for the past 12 continuous months

Shares financial responsibilities with you, such as co-ownership of property, joint financial accounts, etc.

Has power of attorney for medical purposes

–

Unmarried legally dependent children, including adopted children, foster children and stepchildren of your spouse or same-sex domestic partner, provided that you declare the child(ren) as dependents on your federal income tax return. Dependent children are covered:

Until the end of the calendar year in which they turn 19;

Over the age of 19 as long as they remain full-time students. Note coverage ends at the end of the month in which they cease to be a full-time student (e.g. graduate) or the end of the calendar year in which they turn 26, whichever is earlier

If a court has appointed you legal guardian (for any child from birth to age 19, or to age 26 if a full-time student

At any age if they have a mental or physical disability provided he/she is incapable of self-sustaining employment and who chiefly depends upon you for support. You must either apply for continued coverage when you are initially eligible for benefits or prior to the end of the Plan (calendar) year in which the dependent turns age 19. Approval by Aetna is required. See How to Continue Coverage for a Disabled Child, below.

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Eligible dependent children does not include:

A dependent who lives outside the United States, unless he or she is living with you or attending a college or university full time; or

A dependent who is in the military or similar forces anywhere; or

A dependent who is employed by the University.

### **How to Continue Coverage for a Disabled Child**

Coverage for an unmarried mentally or physically disabled child who is not capable of self-sustaining employment and who depends chiefly upon you for support and maintenance may continue coverage beyond age 19:

If you're an eligible employee when your child meets this definition, you must apply for continued coverage before the end of the calendar year in which he or she turns age 19.

If you're a newly eligible employee and your disabled child is older than age 19 when you are electing coverage, you may apply to cover your child when your coverage begins.

To cover a disabled child who is over age 19, you must complete and submit the required form(s) to Aetna. Forms are available from the HR Benefits Service Center at 212-851-7000.

Aetna may request that you provide proof of your child's incapacity and dependency within 31 days of the date coverage would have otherwise ended. You must supply this proof to Aetna within the requested timeframe or the Plan will no longer pay benefits for that child.

## Who is Not Eligible for the Plan

The term “employee” in this document does not include:

Officers whose appointments are incidental to their educational program at the University

Officers who are classified as non-benefited or casual employees in accordance with University personnel policies and procedures

Officers whose terms of employment are subject to a collective bargaining agreement unless the agreement specifically provides for their participation in the Dental Plan

Any individual who has entered into an oral or written agreement with the University whereby such individual acknowledges his or her status as an independent contractor and that he or she is not entitled to participate in the University’s employee benefit plans, notwithstanding that such person is later determined by a court of competent jurisdiction or the Internal Revenue Service (IRS) to be a common law employee for tax purposes.

Any individual who is performing services for the University under a leasing arrangement entered into between the University and some other person, notwithstanding the fact that he or she is later determined by a court of competent jurisdiction or the IRS to be a common law employee or a leased employee.

An employee who is a non-resident alien who received no earned income from the University that constitutes income from sources within the United States (as defined by the IRS).

Temporary employees.

Part-Time Employees.

Support Staff other than Non-Union, Local 2110 and TWU

## You Are Responsible for Covering Only Eligible Dependents

You are responsible for ensuring that only your eligible dependents are enrolled in the Dental Plan. An employee who covers an individual whom he or she knows does not meet the definition of an eligible dependent will be subject to disciplinary action up to and including dismissal and may be liable for other punishment under the law. If the University learns that you have enrolled an ineligible dependent (such as a *former* spouse or a child over the age limit), the dependent will not be covered by the Plan for any dental expenses incurred while he or she was ineligible.

You will be required to repay all costs to the University of providing coverage and any benefits paid to you. Also, if you don’t notify the University when a dependent has become ineligible, the dependent could lose his or her ability to continue coverage under COBRA health care continuation rules.

### Report Changes in Dependent Eligibility

When a dependent is no longer eligible, it is your responsibility to notify the Columbia University HR Benefits department *within 31 days of the change*. Examples of changes include, but are not limited to, divorce, child no longer a student, etc. Contact the Columbia University HR Benefits Service Center at 212-851-7000 to report any changes in the status of your dependents within 31 days.

### Verify Student Status to Avoid Loss of Coverage

A full-time student is a student who is taking 12 or more credit hours at an accredited educational institution, or as defined as full-time by the institution. You must provide proof of your child’s student status.

Each year, your selected health plan will request verification, which may include the following forms of proof of student status:

A signed letter from the Registrar or Dean of Students

A copy of your dependent child’s current semester official class schedule

A copy of the current term tuition bill

School name

Student name

Term

Credit Hours: 12 or more (9 or more if graduate students) or indication of full-time status.

In addition, you may be asked to provide the following information:

Dental plan member ID (located on your ID card)

Dental plan account number (located on your ID card)

If you do not provide all the requested information in the timeframe designated by Aetna, **your child's coverage will automatically be terminated.**

### **Proof of Eligibility**

Columbia University has a responsibility to ensure that only eligible expenses are paid from the benefit Plans. This is a requirement of the Internal Revenue Service (IRS) regulations that govern qualified benefit plans.

You must be prepared to provide satisfactory proof that your enrolled dependents meet the eligibility requirements. Audits are conducted periodically each year to ensure that all dependents continue to meet the eligibility requirements of the benefit plans. If you are selected for an audit, you will receive a letter detailing the audit process. Examples of proof of dependent eligibility include, but are not limited to, birth certificates for each covered child, a marriage license, etc. **If you cannot provide proof that your dependent is eligible for coverage, his or her coverage will be terminated.**

### **You Choose Who to Cover Under Your Benefits**

You must select from one of the following coverage options to ensure your dependents have dental benefits:

Yourself only

Yourself and your legal spouse or yourself and your same-sex domestic partner

Yourself and a child or children

Family

### **If You and Your Spouse or Same-Sex Domestic Partner Work for the University**

If you and your spouse work for the University and are eligible for dental coverage, you may choose your coverage in either of the following ways:

One spouse makes the dental choice for the entire family, including eligible dependent children, if any. In this case, the other spouse must select "No Coverage."

Each spouse can make his or her own dental choice. In this case, all eligible dependent children must be covered by one spouse or the other.

# ENROLLMENT

## How to Enroll

### Newly Eligible Employee

*If you are newly hired, you must enroll for benefits within 31 days of your date of hire.* If you do not make your benefit elections during your first 31 days of employment, you and any eligible dependents will not receive Dental coverage from Columbia University for the remainder of the calendar year.

You will be notified of your benefits on-line enrollment opportunity via email. If you do not receive this notice within 2 weeks of your date of hire, please contact the HR Benefits Service Center at 212-851-7000.

### Annual Enrollment Opportunities

After your initial enrollment, you have the opportunity to make changes each fall during the Benefits Open Enrollment period. You will receive notification from the University about this opportunity to change your health plan and the eligible dependents that you want to cover. The selections you make during annual Benefits Open Enrollment are effective the following January 1.

### Making Changes to Your Benefits During the Year

After your initial enrollment, or after annual Benefits Open Enrollment, you will be able to change your benefits for the remainder of the calendar year only if you experience a “qualified life status change.” Columbia University healthcare benefits are governed by The Internal Revenue Service (Section 125), which limits when you can make changes to your benefit elections as well as the type of changes you are permitted to make.

Examples of a qualified life status change include:

Marriage, divorce

Beginning or end of a same-sex domestic partnership

Birth, adoption, or placement for adoption

Death of a dependent

Dependent loses eligibility for coverage (child reaches maximum age, spouse/domestic partner loses non-University coverage from their employer)

Spouse or eligible dependent called to military duty in the United States armed forces.

Job promotions and/or transfers that change the benefit offerings within job grade and/or bargained benefits.

If you experience a qualified life status change, *you must contact the Columbia University HR Benefits Service Center at 212-851-7000 within 31 days of the event.* You may be required to provide proof (e.g., marriage certificate, birth certificate) in order to make changes to your benefit selections. Your benefit changes must be consistent with the nature of your qualified life status change.

## **Your Cost**

### **Your Cost for Benefit Coverage**

You and Columbia University share the cost of your coverage. Each year, the University determines its level of support for benefit coverage for you and your eligible dependents.

Information about your share of the cost is provided with your enrollment materials when you are newly hired and is also provided to you each year during the fall annual Benefits Open Enrollment period.

Your contributions toward the cost of coverage are regularly deducted from your University paycheck on a pre-tax basis as allowed under Internal Revenue Service Section 125. Your pre-tax “premium” for dental coverage is based on the coverage level you select (individual vs. family, etc.)

### **Your Cost for Same-Sex Domestic Partner/Civil Union Partner**

Federal income tax rules require that your contributions toward the coverage of a same-sex domestic partner or civil union partner be deducted from your pay on an after-tax basis. In addition, University contributions toward premiums for covering your domestic or civil union partner are taxable to you.

# WHEN COVERAGE ENDS

This section summarizes what happens to your dental coverage when certain events occur including:

- Your employment ends
- You become disabled
- You take a leave of absence
- You or a covered family member dies.

Generally, in situations when Columbia University-provided coverage ends, you and your eligible dependents will be provided with the opportunity to continue coverage for a period of time under COBRA continuation rules. See the section, COBRA Continuation Rights.

## **When Your Employment Ends**

If your employment with the Columbia University ends, your Columbia University-sponsored dental coverage for you and your dependents ends after 21 days or the end of the month – whichever is greater.

Your entitlement to Benefits automatically ends on the date that coverage ends

When your coverage ends, Columbia University will still pay claims for Covered Dental Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for dental services that you receive after coverage ended, even if the underlying condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- 21 days after your employment ends or the end of the month – whichever is greater.
- the date the Plan ends;
- the last day of the month you stop making the required “premium” contributions;
- the last day of the month you are no longer eligible;

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the last day of the month you stop making the required “premium” contributions;
- the last day of the month your Dependents no longer qualify as Dependents under this Plan.

However, you may continue the dental coverage in effect for you and your eligible dependents for up to 18 months under COBRA provisions. Under COBRA, the same plans are available as under the Columbia University Medical and Dental Plan and the same rules apply for eligible dependents and qualifying changes in status. See the section, COBRA Continuation Rights.

### **If You Become Disabled**

If you become disabled, your dental coverage can continue based on the type of disability and the length of your disability.

- If you receive salary continuance: Any “premium” contributions you make for Columbia University benefits will continue on a before-tax basis. Your coverage continues without change under the dental plan in effect when your disability began.
- If you receive temporary disability benefits: Any contributions you make for Columbia University benefits will be on an after-tax basis. Coverage continues under the dental plan in effect when your disability began.
- If you receive Long Term Disability benefits: Any “premium” contributions you make for Columbia University will be on an after-tax basis.

Coverage continues for the remainder of the calendar year under the dental plan in effect when your long term disability began. For the next two calendar years, coverage will continue under the Columbia University program. Medicare health insurance coverage generally becomes available if you have been entitled to Social Security benefits for two years. You must enroll for Medicare when available. For additional information about the need to apply for Medicare, please contact the Columbia University Retiree Service Center at 212-851-7000 For Medicare information, please contact 1-800-Medicare (1-800-633-4227).

### **If You Take a Leave of Absence**

In general, during an approved leave of absence, the coverage in effect before the leave will continue provided that you make the necessary monthly premium payments. However, additional rules apply to military leaves or you may qualify for a protected leave under the Family and Medical Leave Act (see the next page). Please contact the HR Benefits Service Center to discuss these rules.

Please note that for certain coverages to remain in effect during your leave of absence, you must pay the monthly premium costs associated with them. You will be billed separately for these coverages by Employee Benefit Plan Administrators (EBPA), an outside vendor. The HR Benefits Service Center will notify EBPA of your leave of absence status and calculate the monthly costs for those coverages that will require payment during your leave.

EBPA will bill you for these monthly costs using a payment coupon. Payment must be remitted to EBPA at the address shown on the payment coupon. Failure to make the required premium payments will result in termination of coverage retroactive to the date for which the last contribution was received.

### **Coverage While on a Leave Under the Family and Medical Leave Act of 1993 (FMLA)**

You're entitled by Federal law to up to 12 weeks of unpaid leave under the FMLA for specified family medical purposes, such as the birth or adoption of a child, or to care for a spouse, child, or parent who is seriously ill or for your own illness. You are entitled to continue your group health coverage under Columbia University Medical Plans during your FMLA leave period at the same rate as if you were still at work, as long as you continue to make payments. If you don't timely return to covered employment after your leave ends, you are entitled to COBRA continuation coverage.

### **Coverage While on Military Duty in the United States Armed Forces**

If you enter the United States armed forces, you'll be offered the opportunity to continue medical coverage for yourself and your covered dependents based on the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). You may elect to either stop or continue your medical coverage during the period of your military absence. If you elect to continue your medical coverage:

- During the first six months of your military absence, you will continue to pay your portion of the cost for the medical coverage you have in effect at the time your military absence began.
- During the seventh through the 24th month of your military absence, you will be directly billed for the cost of the medical coverage you have in effect at the time your military absence began, or, in the following calendar year, based on the coverage and cost in effect under COBRA rules. No further medical coverage will

be provided beyond the twenty-fourth month of a military absence.

If you choose not to continue coverage during the period of military service, you're entitled to have your coverage reinstated provided you timely return to employment with the Company. No additional exclusion or waiting period will be imposed, except in the case of certain service-connected disabilities. These rights granted by USERRA are dependent on uniformed service that ends honorably.

### **If Your Eligible Dependent Dies**

If an eligible dependent dies, you can change your dental plan and coverage tier. Any change must be made within 31 days of your dependent's death; otherwise, you'll have to wait until the next fall annual Benefits Open Enrollment period.

### **Other Events Ending Your Coverage**

Your coverage may also end when any of the following happen. If your coverage is terminated for any of the reasons below, you will be provided written notice that coverage has ended on the date the Plan Administrator identifies in the notice.

- **Fraud, Misrepresentation or False Information** - occurs when there has been fraud or misrepresentation, or the Employee knowingly gave their dental plan plan or Columbia University false material information. Examples include false information relating to another person's eligibility or status as a Dependent. Columbia University reserves the right to demand that you pay back any reimbursement paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.
- **Material Violation** – occurs when there was a material violation of the terms of the Plan.
- **Threatening Behavior** – occurs when you have committed acts of physical or verbal abuse that pose a threat to Columbia University's staff or the staff of your dental plan staff.

### **Uniformed Services Employment and Reemployment Rights Act**

An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and the Employee's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Employee's absence from work; or
- the day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee's health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been

incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

## **When Coverage Ends for Your Dependents**

When you drop coverage for one or more of your covered dependents either during Benefits Open Enrollment or through a Qualified Change in Status, coverage will end as follows:

### **Spouse**

End of the month or 21 days (whichever is greater) following the date of your divorce, or commencement of other dental coverage (through spouse's employer, etc.).

### **Same-Sex Domestic Partner**

End of the month or 21 days (whichever is greater) following the dissolution of the partnership or commencement of other dental coverage (through partner's employer).

### **Child**

The coverage end date varies based upon the following situations:

Reaches Age 19: Coverage ends December 31<sup>st</sup> of the calendar year in which your child turned 19.

Full-time student over age 19 graduates: End of the month or 21 days whichever is greater following the date of graduation or the date your child is no longer a student.

Full-time student reaches age 26 (and has not yet graduated): Coverage stops the end of the month in which the child reached age 26

### **Coverage of Students on Medically Necessary Leave of Absence**

If your Dependent child is covered by this plan as a student, as defined in the Definition of Dependent, coverage will remain active for that child if the child is on a medically necessary leave of absence from a postsecondary educational institution (such as a college, university or trade school.)

Coverage will terminate on the earlier of:

- a) The date that is one year after the first day of the medically necessary leave of absence; or
- b) The date on which coverage would otherwise terminate under the terms of the plan.

The child must be a Dependent under the terms of the plan and must have been enrolled in the plan on the basis of being a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence.

The plan must receive written certification from the treating physician that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

A “medically necessary leave of absence” is a leave of absence from a postsecondary educational institution, or any other change in enrollment of the child at the institution that: (1) starts while the child is suffering from a serious illness or condition; (2) is medically necessary; and (3) causes the child to lose student status under the terms of the plan.

### **Obtaining a Certificate of Creditable Coverage**

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You or your dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, contact the Plan Administrator or call the toll-free customer service number on the back of your ID card.

# COBRA Continuation Rights

## **Continuing Coverage Through COBRA**

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if Columbia University is subject to the provisions of COBRA.

## **Continuation Coverage under Federal Law (COBRA)**

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- an Employee;
- an Employee's enrolled Dependent, including with respect to the Employee's children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law; or
- an Employee's former Spouse.
- Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage <sup>1</sup>	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
Columbia University files for bankruptcy under Title 11, United States Code. <sup>2</sup>	36 months	36 months <sup>3</sup>	36 months <sup>3</sup>

<sup>1</sup>Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

<sup>2</sup>This is a qualifying event for any Retired Employee and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

<sup>3</sup>From the date of the Employee's death if the Employee dies during the continuation coverage.

\* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

### **Getting Started**

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Employee and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to

elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a Provider, inform that Provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2, *Introduction*.

### **Notification Requirements**

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

### **Notification Requirements for Disability Determination**

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide the Benefits Service Center with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 15, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

### **Trade Act of 2002**

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If an Employee qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan

Administrator for additional information. The Employee must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Employee will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

### **When COBRA Ends**

COBRA coverage will end before the maximum continuation period shown above if:

- you or your covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Dependent becomes eligible for, and enrolls in, Medicare after electing COBRA;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
- coverage would otherwise terminate under the Plan as described in the beginning of this section.

**Note:** If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

# How Your Aetna Dental Plan Works

Common Terms

What the Plan Covers

Rules that Apply to the Plan

What the Plan Does Not Cover

## Understanding Your Aetna Dental Plan

It is important that you have the information and useful resources to help you get the most out of your **Aetna** dental plan. This Booklet explains:

- Definitions you need to know;
- How to access care, including procedures you need to follow;
- What services and supplies are covered and what limits may apply;
- What services and supplies are not covered by the plan;
- How you share the cost of your covered services and supplies; and
- Other important information such as eligibility, **complaints** and **appeals**, termination, continuation of coverage and general administration of the plan.

### Important Notes:

Unless otherwise indicated, "you" refers to you and your covered dependents. You can refer to the *Eligibility* section for a complete definition of "you".

This Booklet applies to coverage only and does not restrict your ability to receive covered expenses that are not or might not be **covered expenses** under this dental plan.

Store this Booklet in a safe place for future reference.

## Getting Started: Common Terms

Many terms throughout this Booklet are defined in the *Glossary* Section at the back of this document. Defined terms appear in bolded print. Understanding these terms will also help you understand how your plan works and provide you with useful information regarding your coverage.

## About the PPO Dental Plan

The plan is a Preferred **Provider** Organization (PPO) that covers a wide range of dental services and supplies. You can visit the **dental provider** of your choice when you need dental care.

You can choose a **dental provider** who is in the dental network. You may pay less out of your own pocket when you choose a Columbia University **network provider** or an Aetna **network provider**.

You have the freedom to choose a **dental provider** who is not in the dental network. You may pay more if you choose an Aetna **out-of-network provider**.

The *Schedule of Benefits* shows you how the plan's level of coverage is different for Columbia University **network services and supplies**, Aetna **network services and supplies** and Aetna **out-of-network services and supplies**.

## The Choice is Yours

You have a choice each time you need dental care:

### Using Columbia University Network Providers and Aetna Network Providers

- You will receive the plan's higher level of coverage when your care is provided by a Columbia University **network provider** or an Aetna **network provider**.
- The plan begins to pay benefits after you satisfy an Aetna network **deductible**.
- The plan begins to pay benefits with no **deductible** to satisfy on the Columbia University network.
- You share the cost of covered services and supplies by paying a portion of certain expenses (your **payment percentage**). Columbia University and Aetna **Network providers** have agreed to provide covered services and supplies at a **negotiated charge**. Your **payment percentage** is based on the **negotiated charge**. In no event will you have to pay any amounts above the **negotiated charge** for a covered service or supply. You have no further out-of-pocket expenses when the plan covers in network services at 100%.
- You will not have to submit dental claims for treatment received from Columbia University and Aetna **network providers**. Your **network provider** will take care of claim submission. You will be responsible for **deductibles, payment percentage** and **copayments**, if any.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **deductible, copayment, payment percentage** or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

### Availability of Providers

**Aetna** cannot guarantee the availability or continued participation of a particular **provider**. Either **Aetna** or any Aetna **network provider** may terminate the provider contract or limit the number of patients accepted in a practice.

### Using Aetna Out-of-Network Providers

You can obtain dental care from **dental providers** who are not in the network. The plan covers Aetna **out-of-network services and supplies**, but your expenses will generally be higher.

You must satisfy a **deductible** before the plan begins to pay benefits.

You share the cost of covered services and supplies by paying a portion of certain expenses (your **payment percentage**). The benefit payable for charges made by an Aetna **out-of-network provider** is an amount equal to the amount which results from applying the Aetna out-of-network **payment percentage** to the **negotiated charge** that would have applied for the service or supply if it had been provided by a Columbia University or Aetna **network provider**. Any charge excess of the **negotiated charge** will not be a **covered expense** under this plan.

You must file a claim to receive reimbursement from the plan.

#### Important Reminder

Refer to the *Schedule of Benefits* for details about any **deductibles, copays, payment percentage** and maximums that apply. There is a separate maximum that applies to **orthodontic treatment**.

## Getting an Advance Claim Review

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

#### Important Note

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

## When to Get an Advance Claim Review

An advance claim review is recommended whenever a course of dental treatment is likely to cost more than \$350. Ask your **dentist** to write down a full description of the treatment you need, using either an **Aetna** claim form or an ADA approved claim form. Then, before actually treating you, your **dentist** should send the form to **Aetna**. **Aetna** may request supporting x-rays and other diagnostic records. Once all of the information has been gathered, **Aetna** will review the proposed treatment plan and provide you and your **dentist** with a statement outlining the benefits payable by the plan. You and your **dentist** can then decide how to proceed.

The advance claim review is voluntary. It is a service that provides you with information that you and your **dentist** can consider when deciding on a course of treatment. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

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

## What is a Course of Dental Treatment?

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

## In Case of a Dental Emergency

The plan pays a benefit at the Aetna network level of coverage even if the services and supplies were not provided by a Columbia University or Aetna **network provider**. The care provided must be a covered service or supply. You must submit a claim to **Aetna** describing the care given. Additional dental care to treat your **dental emergency** will be covered at the appropriate **coinsurance** level.

## What The Plan Covers

### PPO Dental Plan

#### Schedule of Benefits for the PPO Dental Plan

PPO Dental is merely a name of the benefits in this section. The plan does not pay a benefit for all dental care expenses you incur.

#### Important Reminder

Your dental services and supplies must meet the following rules to be covered by the plan:

- The services and supplies must be **medically necessary**.
- The services and supplies must be covered by the plan.
- You must be covered by the plan when you incur the expense.

**Covered expenses** include charges made by a **dentist** for the services and supplies that are listed in the dental care schedule.

The next sentence applies if:

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

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

## Dental Care Schedule

The dental care schedule is a list of dental expenses that are covered by the plan. There are several categories of **covered expenses**:

- Preventive
- Diagnostic
- Restorative
- Oral surgery
- Endodontics
- Periodontics
- Orthodontics

These covered services and supplies are grouped as Type A, Type B or Type C.

Coverage is also provided for a **dental emergency**. Services provided for a **dental emergency** will be covered at the Aetna **network** level of benefits even if services and supplies are not provided by a Columbia University or Aetna **network provider**. There is a maximum benefit payable. For additional information, please refer to *In Case of a Dental Emergency section*.

## PPO Dental Expense Insurance Plan

The following additional dental expenses will be considered **covered expenses** for you and your covered dependent if you have medical coverage:

- Pregnancy;
- Coronary artery disease/cardiovascular disease;
- Cerebrovascular disease; or
- Diabetes

## Additional Covered Dental Expenses

- One additional prophylaxis (cleaning) per year.
- Scaling and root planing
- Full mouth debridement;
- Periodontal maintenance; and
- Localized delivery of antimicrobial agents. (Not covered for pregnancy)

## Payment of Benefits

The additional prophylaxis, the benefit will be payable the same as other prophylaxis under the plan.

The **plan coinsurance** applied to the other covered dental expenses above will be 100% for Columbia University and Aetna **network** expenses and 80% for Aetna **out-of-network** expenses. These additional benefits will not be subject to any frequency limits except as shown above or any Calendar Year maximum.

**Aetna** will reimburse the provider directly, or you may pay the provider directly and then submit a claim for reimbursement for **covered expenses**.

## Important Reminder

The **deductible, payment percentage** and maximums that apply to each type of dental care are shown in the *Schedule of Benefits*.

You may receive services and supplies from Columbia University **network**, Aetna **network** and Aetna **out-of-network providers**. Services and supplies given by a Columbia University **network provider** are covered at the Columbia University **network** level of benefits shown in the *Schedule of Benefits*. Services and supplies given by an Aetna **network provider** are covered at the Aetna **network** level of benefits shown in the *Schedule of Benefits*. Services and supplies given by an Aetna **out-of-network provider** are covered at the Aetna **out-of-network** level of benefits shown in the *Schedule of Benefits*.

Refer to *About the PPO Dental Coverage* for more information about covered services and supplies.

## **Type A Expenses: Diagnostic and Preventive Care**

### **Visits and X-Rays**

Office visit during regular office hours, for oral examination

    Routine comprehensive or recall examination

    Problem-focused examination

Prophylaxis (cleaning)

    Adult

    Child

Topical application of fluoride

Sealants

Bitewing X-rays

Complete X-ray series, including bitewings if necessary, or panoramic film

Vertical bitewing X-rays

**Space Maintainers** Only when needed to preserve space resulting from premature loss of primary teeth. (Includes all adjustments within 6 months after installation.)

Fixed (unilateral or bilateral)

## **Type B Expenses: Basic Restorative Care**

### **Visits and X-Rays**

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

Study models

Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician

### **X-Ray and Pathology**

Periapical x-rays (single films up to 13)

Intra-oral, occlusal view, maxillary or mandibular

Upper or lower jaw, extra-oral

Biopsy and histopathologic examination of oral tissue

### **Oral Surgery**

Extractions

    Erupted tooth or exposed root

    Coronal remnants

### **Periodontics**

Root planing and scaling

Periodontal maintenance procedures following active therapy

Debridement

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

Amalgam restorations

Resin-based composite restorations (other than for molars)

Recementation

Inlay

Crown

Bridge

Repairs: crowns

Adjustment to denture more than 6 months after installation

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.)

Rebase, per denture

Office reline

Laboratory reline

Full and partial denture repairs

Broken dentures, no teeth involved

Repair cast framework

Replacing missing or broken teeth, each tooth

Adding teeth to existing partial denture

Each tooth

Each clasp

**Space Maintainers** Only when needed to preserve space resulting from premature loss of primary teeth. (Includes all adjustments within 6 months after installation.)

Removable (unilateral or bilateral)

## **Type C Expenses: Major Restorative Care**

### **Oral Surgery**

Surgical removal of impacted teeth

Removal of tooth (partially bony)

Removal of tooth (completely bony)

Extractions

Surgical removal of erupted tooth/root tip

Impacted Teeth

Removal of tooth (soft tissue)

Cysts and Neoplasms

Incision and drainage of abscess

Removal of odontogenic cyst or tumor

Other Surgical Procedures

Alveoplasty, in conjunction with extractions - per quadrant

Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant

Alveoplasty, not in conjunction with extraction - per quadrant

Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant

Sialolithotomy: removal of salivary calculus

Closure of salivary fistula

Excision of hyperplastic tissue

Removal of exostosis

Transplantation of tooth or tooth bud

Closure of oral fistula of maxillary sinus

Sequestrectomy

Crown exposure to aid eruption

Removal of foreign body from soft tissue

Frenectomy

## Suture of soft tissue injury

### **Periodontics**

- Osseous surgery (including flap and closure)
- Soft tissue graft procedures
- Clinical crown lengthening, hard tissue
- Occlusal adjustment (other than with an appliance or by restoration)
- Gingivectomy
- Gingival flap procedure
- Localized delivery of antimicrobial agents
- Splinting
- Distal wedge procedure
- Bone replacement graft
- Guided tissue regeneration

### **Endodontics**

- Root canal therapy Including necessary X-rays
- Molar
- Pulp capping
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root canal therapy including necessary X-rays
  - Anterior
  - Bicuspid

**Restorative.** Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge.

Inlays/Onlays

Labial Veneers

- Laminate-chairside
- Resin laminate – laboratory
- Porcelain laminate – laboratory

Crowns

- Resin
- Resin with noble metal
- Resin with base metal
- Porcelain/ceramic substrate
- Porcelain with noble metal
- Porcelain with base metal
- Base metal (full cast)
- Noble metal (full cast)
- 3/4 cast metallic or porcelain/ceramic

Crowns (when tooth cannot be restored with a filling material)

- Prefabricated stainless steel
- Prefabricated resin crown (excluding temporary crowns)

Post and core

Core build up, including any pins

Pins

Pin retention - per tooth, in addition to amalgam or resin restoration

Coping

Precision attachments

**Prosthodontics**- First installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge.

Bridge Abutments (See Inlays and Crowns)

Pontics

- Base metal (full cast)
- Noble metal (full cast)
- Porcelain with noble metal
- Porcelain with base metal
- Resin with noble metal
- Resin with base metal

Removable Bridge (unilateral)

One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics

Dentures and Partial (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)

Complete upper denture

Complete lower denture

Partial upper or lower, resin base (including any conventional clasps, rests and teeth)

Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)

Stress breakers

Interim partial denture (stayplate), anterior only

Special tissue conditioning, per denture

Repairs: bridges

Occlusal guard (for bruxism only)

Implants

**General Anesthesia and Intravenous Sedation** (only when **medically necessary** and only when provided in conjunction with a covered surgical procedure)

Local anesthesia

### **Visit and Exam**

Emergency palliative treatment, per visit

Therapeutic parental drug administration

### **Orthodontics**

Interceptive orthodontic treatment

Limited orthodontic treatment

Comprehensive orthodontic treatment of adolescent dentition

Comprehensive orthodontic treatment of adult dentition

Post treatment stabilization

Removable appliance therapy to control harmful habits

Fixed appliance therapy to control harmful habits

## **Rules and Limits That Apply to the Dental Plan**

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

### **Orthodontic Treatment Rule**

The plan does not cover the following orthodontic services and supplies:

- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an **accident**;
- Maxillofacial surgery;
- Myofunctional therapy;
- Treatment of cleft palate;

- Treatment of micrognathia;
- Treatment of macroglossia;
- Lingually placed direct bonded appliances and arch wires (i.e. "invisible braces"); or
- Removable acrylic aligners (i.e. "invisible aligners").

## Coverage for Dental Work Completed After Termination of Coverage

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

- Crowns;
- Removable bridges;
- Dentures;
- Fixed partial dentures (bridges); and
- Root canals.

"Ordered" means:

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

## What The PPO Dental Plan Does Not Cover

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

These dental exclusions are in addition to the exclusions listed under your medical coverage.

Any instruction for diet, plaque control and oral hygiene.

**Cosmetic** services and supplies including plastic surgery, reconstructive surgery, **cosmetic** surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *What the Plan Covers* section. Facings on molar crowns and pontics will always be considered **cosmetic**.

Crown, inlays and onlays, and veneers unless:

- It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material; or
- The tooth is an abutment to a covered partial denture or fixed bridge.
- Braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.

Dental services and supplies that are covered in whole or in part:

- Under any other part of this plan; or
- Under any other plan of group benefits provided by the contractholder.

Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion.

Except as covered in the *What the Plan Covers* section, treatment of any **jaw joint disorder** and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply.

**Orthodontic treatment** except as covered in the *What the Plan Covers* section.

Prescribed drugs; pre-medication; or analgesia.

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.

Services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

Surgical removal of impacted wisdom teeth only for orthodontic reasons.

Treatment by other than a **dentist**. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a **dentist**. These are:

- Scaling of teeth; and
- Cleaning of teeth.

## **Conversion from a Group to an Individual Plan**

You may be eligible to apply for an individual health plan without providing proof of good health:

- At the termination of employment.
- When loss of coverage under the group plan occurs.
- When loss of dependent status occurs.
- At the end of the maximum health coverage continuation period.

The individual policy will not provide the same coverage as the former group plan offered by your employer. Certain benefits may not be available. You will be required to pay the associated contribution costs for the coverage. For additional conversion information, contact your employer or call the toll-free number on your member ID card.

# Coordination of Benefits - What Happens When There is More Than One Health Plan

## Other Plans Not Including Medicare

### Other Plans Not Including Medicare

Some persons have health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this Plan, have a "coordination of benefits" provision.

Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by "other plans".

When this and another health expenses coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:
  - secondary to the plan covering the person as a dependent; and
  - primary to the plan covering the person as other than a dependent;

The benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

- covers the person as other than a dependent; and
  - is secondary to Medicare.
3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:
  - a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.
  - b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.
  - c. If there is not such a court decree:

If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the person on whose expenses claim is based as a:

- laid-off or retired employee; or
- the dependent of such person;

Shall be determined after the benefits of any other plan which covers such person as:

- an employee who is not laid-off or retired; or
- a dependent of such person.

If the other plan does not have a provision:

- regarding laid-off or retired employees; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

- regarding right of continuation pursuant to federal or state law; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses incurred in a calendar year will be reduced by all "other plan" benefits payable for those expenses. When the coordination of benefits rules of this Plan and an "other plan" both agree that this Plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved.

In order to administer this provision, Aetna can release or obtain data. Aetna can also make or recover payments.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

### **Other Plan**

This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

# General Provisions

## Type of Coverage

Coverage under the plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational illnesses** are covered. The plan covers charges made for services and supplies only while the person is covered under the plan.

## Physical Examinations

**Aetna** will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you.

## Legal Action

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

**Aetna** will not try to reduce or deny a benefit payment on the grounds that a condition existed before your coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

## Confidentiality

Information contained in your medical records and information received from any provider incident to the provider patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **Aetna** when necessary for your care or treatment, the operation of the plan and administration of this Booklet, or other activities, as permitted by applicable law. You can obtain a copy of **Aetna's** Notice of Information Practices by calling **Aetna's** toll-free Member Service telephone.

## Additional Provisions

The following additional provisions apply to your coverage:

- This Booklet applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under the plan because you are connected with more than one employer.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the plan. Additional provisions are described elsewhere in the *group contract*. If you have any questions about the terms of the plan or about the proper payment of benefits, contact your employer or **Aetna**.
- Your employer hopes to continue the plan indefinitely but, as with all group plans, the plan may be changed or discontinued with respect to your coverage.

## Assignments

Coverage may be assigned only with the written consent of **Aetna**. To the extent allowed by law, **Aetna** will not accept an assignment to an Aetna out-of-network provider, provider or facility including but not limited to, an assignment of:

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

## Misstatements

If any fact as to the Contractholder or you is found to have been misstated, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

All statements made by the Contractholder or you shall be deemed representations and not warranties. No written statement made by you shall be used by **Aetna** in a contest unless a copy of the statement is or has been furnished to you or your beneficiary, or the person making the claim.

**Aetna's** failure to implement or insist upon compliance with any provision of this contract at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

## Incontestability

As to **Accident** and Health Benefits:

Except as to a fraudulent misstatement, or issues concerning Premiums due:

- No statement made by the Contractholder or you or your dependent shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
- No statement made by the Contractholder shall be the basis for voiding this Contract after it has been in force for 2 years from its effective date.
- No statement made by you, an eligible employee or your dependent shall be used in defense of a claim for loss incurred or starting after coverage as to which claim is made has been in effect for 2 years.

## Recovery of Overpayments

### Health Coverage

If a benefit payment is made by **Aetna**, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, **Aetna** has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery **Aetna** may have with respect to such overpayment.

## Reporting of Claims

A claim must be submitted to **Aetna** in writing. It must give proof of the nature and extent of the loss. Your employer has claim forms.

All other claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the loss.

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

## Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

All covered health benefits are payable to you. However, **Aetna** has the right to pay any health benefits to the service provider. This will be done unless you have told **Aetna** otherwise by the time you file the claim.

**Aetna** will notify you in writing, at the time it receives a claim, when an assignment of benefits to a health care provider or facility will not be accepted.

The Plan may pay up to \$1,000 of any other benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

## Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

- Names of **dentists** who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

## Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna's** Home Office at:

Aetna Life Insurance Company  
151 Farmington Avenue  
Hartford, CT 06156

You may also use **Aetna's** toll free Member Services phone number on your ID card or visit **Aetna's** web site at [www.aetna.com](http://www.aetna.com).

## Effect of Benefits Under Other Plans

### Effect of An Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an eligible class and have chosen dental coverage under an HMO Plan offered by your employer, you will be excluded from dental expense coverage on the date of your coverage under such HMO Plan.

If you are in an eligible class and are covered under an HMO Plan providing dental coverage, you can choose to change to coverage for yourself and your covered dependents under this plan. If you:

- Live in an HMO Plan enrollment area and choose to change dental coverage during an open enrollment period, coverage will take effect on the group policy anniversary date after the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change dental coverage when there is not an open enrollment period, coverage will take effect only if and when **Aetna** gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change dental coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when **Aetna** gives its written consent.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

## Effect of Prior Coverage - Transferred Business

If your coverage under any part of this plan replaces any prior coverage for you, the rules below apply to that part.

"Prior coverage" is any plan of group coverage that has been replaced by coverage under part or all of this plan; it must have been sponsored by your employer (e.g., transferred business). The replacement can be complete or in part for the eligible class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan.

Coverage under any other section of this plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this plan.

## Discount Programs

### Discount Arrangements

From time to time, we may offer, provide, or arrange for discount arrangements or special rates from certain service providers such as pharmacies, optometrists, **dentists**, alternative medicine, wellness and health living providers to you under this plan. Some of these arrangements may be made available through third parties who may make payments to **Aetna** in exchange for making these services available.

The third party service providers are independent contractors and are solely responsible to you for the provision of any such goods and/or services. We reserve the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance. There are no benefits payable to you nor do we compensate providers for services they may render through discount arrangements.

## Incentives

In order to encourage you to access certain medical services when deemed appropriate by you in consultation with your **physician** or other service providers, we may, from time to time, offer to waive or reduce a member's **copayment, coinsurance, and/or a deductible** otherwise required under the plan or offer coupons or other financial incentives. We have the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the covered persons to whom these arrangements are available.

# Glossary

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet.

## A

### Accident

This means a sudden; unexpected; and unforeseen; identifiable **occurrence** or event producing, at the time, objective symptoms of a bodily **injury**. The **accident** must occur while the person is covered under this Contract. The **occurrence** or event must be definite as to time and place. It must not be due to, or contributed by, an **illness** or disease of any kind.

### Aetna

Aetna Life Insurance Company

## C

### Copay or Copayment

The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various **copayments**, and these **copayment** amounts or percentages are specified in the *Schedule of Benefits*.

### Cosmetic

Services or supplies that alter, improve or enhance appearance.

### Covered Expenses

Medical, dental, vision or hearing services and supplies shown as covered under this Booklet.

## D

### Deductible

The part of your **covered expenses** you pay before the plan starts to pay benefits. Additional information regarding **deductibles** and **deductible** amounts can be found in the *Schedule of Benefits*.

### 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 Provider

This is:

- Any **dentist**;
- Group;
- Organization;
- Dental facility; or
- Other institution or person.

legally qualified to furnish dental services or supplies.

## Dentist

A legally qualified **dentist**, or a **physician** licensed to do the dental work he or she performs.

## Directory

A listing of all **network providers** serving the class of employees to which you belong. The contractholder will give you a copy of this **directory**. **Network provider** information is also available through **Aetna's** online provider **directory**, DocFind®.

## E

### Experimental or Investigational

A drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved; or
- Approval required by the FDA has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational**, or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of “phases” indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is **experimental or investigational**, or for research purposes.

## H

### Hospital

An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

***In no event*** does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility,

intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

## I

### Illness

A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

### Injury

An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.
- An act or event must be definite as to time and place.

## J

### Jaw Joint Disorder

This is:

- A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint; or
- A Myofascial Pain Dysfunction (MPD); or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

## L

### Late Enrollee

This is an employee in an Eligible Class who requests enrollment under this Plan after the Initial Enrollment Period. In addition, this is an eligible dependent for whom the employee did not elect coverage within the Initial Enrollment Period, but for whom coverage is elected at a later time.

However, an eligible employee or dependent may not be considered a **Late Enrollee** under certain circumstances. See the *Special Enrollment Periods* section of the Booklet.

### Lifetime Maximum

This is the most the plan will pay for **covered expenses** incurred by any one covered person during their lifetime.

## M

### Medically Necessary or Medical Necessity

Health care or dental services, and supplies or **prescription drugs** that a **physician**, other health care provider or **dental provider**, exercising prudent 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 provision of the service, supply or **prescription drug** is:

- a) In accordance with generally accepted standards of medical or dental practice;
- b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease; and

- c) Not primarily for the convenience of the patient, **physician**, other health care or **dental provider**; and
- d) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury**, or disease.

For these purposes “generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with **physician** or dental specialty society recommendations and the views of **physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

## N

### Negotiated Charge

The maximum charge a **network provider** has agreed to make as to any service or supply for the purpose of the benefits under this plan.

### Network Provider

A **dental provider** who has contracted to furnish services or supplies for a **negotiated charge**; but only if the provider is, with **Aetna's** consent, included in the **directory** as a **network provider** for:

- The service or supply involved; and
- The class of employees to which you belong.

### Network Service(s) or Supply(ies)

Health care service or supply that is:

- Furnished by a **network provider**

### Non-Occupational Illness

A **non-occupational illness** is an **illness** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **illness** that does.

An **illness** will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that **illness** under such law.

### Non-Occupational Injury

A **non-occupational injury** is an accidental bodily **injury** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **injury** which does.

## O

### Occupational Injury or Occupational Illness

An **injury** or **illness** that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an **injury** or **illness** that does.

## Occurrence

This means a period of disease or **injury**. An **occurrence** ends when 60 consecutive days have passed during which the covered person:

- Receives no medical treatment; services; or supplies; for a disease or **injury**; and
- Neither takes any medication, nor has any medication prescribed, for a disease or **injury**.

## Orthodontic Treatment

This is any:

- Medical service or supply; or
- Dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- Of the teeth; or
- Of the bite; or
- Of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

## Out-of-Network Service(s) and Supply(ies)

Health care service or supply that is:

- Furnished by an **out-of network provider**.

## Out-of-Network Provider

A **dental provider** who has not contracted with **Aetna** to furnish services or supplies at a **negotiated charge**.

## P

### Payment Percentage

**Payment percentage** is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the “plan **payment percentage**,” and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **payment percentage** amounts.

## Physician

A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;

- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- A physician is not you or related to you.

## Prescriber

Any **physician** or **dentist**, acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

## Prescription

An order for the dispensing of a **prescription drug** by a **prescriber**. If it is an oral order, it must be promptly put in writing by the pharmacy.

## Prescription Drug

A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

# R

## Recognized Charge

Only that part of a charge which is less than or equal to the **recognized charge** is a **covered benefit**. The **recognized charge** for a service or supply is the lowest of:

- The provider's usual charge for furnishing it;
- The charge **Aetna** determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded; or the provider charge data from the Ingenix Incorporated Prevailing HealthCare Charges System (PHCS) at the 80th percentile of PHCS data. This PHCS data is generally updated at least every six months.
- The charge **Aetna** determines to be the usual charge level made for it in the geographic area where it is furnished.

In determining the **recognized charge** for a service or supply that is:

- Unusual; or
- Not often provided in the geographic area; or
- Provided by only a small number of **providers** in the geographic area;

**Aetna** may take into account factors, such as:

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

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

As used above, the term “geographic area” means a Prevailing HealthCare Charges System (PHCS) expense area grouping. Expense areas are defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, PHCS never crosses state lines. This data is produced semi-annually. Current procedure codes that have been developed by the American Medical Association, the American Dental Association, and the Centers for Medicare and Medicaid Services are utilized.

## S

### **Specialist**

A **physician** who practices in any generally accepted medical or surgical sub-specialty.

### **Specialist Dentist**

Any **dentist** who, by virtue of advanced training is board eligible or certified by a Specialty Board as being qualified to practice in a special field of dentistry.

### **Specialty Care**

Health care services or supplies that require the services of a **specialist**.



# Schedule of Benefits

**Employer:** Columbia University

**ASA:** 619362

**Issue Date:** December 17, 2007

**Effective Date:** January 1, 2008

**Schedule:** 2A

**Booklet Base:** 2

For: Three Tier PPO Dental Benefits

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

## Comprehensive Dental Plan (PPO)

### Schedule of Comprehensive Dental Benefits

PLAN FEATURES	COLUMBIA UNIVERSITY NETWORK	AETNA NETWORK	AETNA OUT-OF-NETWORK
Calendar Year Deductible	Individual \$0	Individual \$25	Individual \$25

The calendar year **deductible** applies to all covered expenses except Type A Expenses.

Please refer to the listing of **covered expenses** and the percentage payable appearing below. The percentage the plan will pay varies by the type of expense.

PLAN PAYMENT PERCENTAGE	COLUMBIA UNIVERSITY NETWORK PAYMENT PERCENTAGE	AETNA NETWORK PAYMENT PERCENTAGE	AETNA OUT-OF-NETWORK PAYMENT PERCENTAGE
Type A Expenses	100%	100%	100%
Type B Expenses	100%	80%	80%
Type C Expenses	60%	50%	50%
Orthodontic Treatment	50%	50%	50%

### **Calendar Year Maximum Benefit**

Calendar Year Maximum for Columbia University	
Network Benefits:	\$1,500
Calendar Year Maximum for Aetna Network	
Benefits:	\$1,250
Calendar Year Maximum for Aetna	
Out-of-Network Benefits:	\$1,250

The most the plan will pay for **covered expenses** incurred by any one covered person in a Calendar Year is called the Calendar Year Maximum Benefit.

The Calendar Year maximum benefit applies to **network** and **out-of-network covered** dental expenses combined.

### **Orthodontic Lifetime Maximum Benefit**

Orthodontic Lifetime Maximum for Columbia	
University Network Benefits:	\$1,500
Orthodontic Lifetime Maximum for Aetna	
Network Benefits:	\$1,250
Orthodontic Lifetime Maximum for Aetna	
Out-of-Network Benefits:	\$1,250

## **Expense Provisions**

### **The following provisions apply to your health expense plan.**

This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

### **KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.**

## **Deductible Provisions**

### **Aetna Network Calendar Year Deductible**

This is an amount of Aetna **network covered expenses** incurred each Calendar Year for which no benefits will be paid. The Aetna **network** Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the Aetna **network** Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

### **Aetna Out-of-Network Calendar Year Deductible**

This is an amount of Aetna **out-of-network covered expenses** incurred each Calendar Year for which no benefits will be paid. The Aetna **out-of-network** Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the Aetna **out-of-network** Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

**Covered expenses** applied to the **Aetna out-of-network deductible** will be applied to satisfy the Aetna **network deductible** and **covered expenses** applied to the Aetna **network deductible** will be applied to satisfy the Aetna **out-of-network deductible**.

**Covered expenses** that are subject to the **deductible** include dental expenses provided under the Dental Plan, as applicable.

## Payment Provisions

### Payment Percentage

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the “Plan Payment Percentage”. Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

## General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.

# Amendment to Plan of Benefits

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**For Employees of:** Columbia University  
**Administrative Services Agreement No.:** 619362

Effective August 1, 2008, the following changes have been made to your Summary of Benefits.

Benefits for orthodontic diagnostics are separately eligible and are considered at 100% for Columbia providers only.