Summary Plan Description

Prepared Exclusively for Columbia University in the City of New York Officers and Support Staff (Non-Union, Local 2110 and TWU)

Aetna Columbia PPO Dental Plan

Effective: January 1, 2016

January 2016
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Introduction

Columbia University in the City of New York (“the University”) is pleased to provide you¹ with this Benefit Summary, which describes the dental benefits available to you and your covered family members under the Columbia University in the City of New York Group Benefits Plan (the “Plan”). This Benefit Summary provides information about:

- Who is eligible
- Services that are covered, called Covered Health Services
- Services that are not covered, called Exclusions
- How benefits are paid

Together, this Benefit Summary and the Wrap Document constitute the official Plan Document and Summary Plan Description for the Plan. Collectively, this Benefit Summary and the Wrap Document are designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). This Benefit Summary supersedes any previous printed or electronic Benefit Summary for the Plan – including previously released Benefits in Brief, and Benefits Highlights. You are responsible for using this Benefit Summary and other resources provided to you to understand your benefits.

The rest of this summary 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.

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

How To Use This Benefit Summary

- Please read the entire Benefit Summary and share it with your family.
- Many of the sections of this Benefit Summary 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 Benefit Summary and any future amendments at www.hr.columbia.edu or request printed copies by contacting the Columbia Benefits Service Center at 212-851-7000.

Overview of the PPO Dental Plan

What the Plan Covers

All plan coverage is subject to conditions, limits and exceptions explained in the sections, “Covered Services” and “Exclusions.” The University and Aetna assume no responsibility for the outcome of any covered services or supplies.

¹ The terms “you” and “your” as used in this Benefit Summary refer to an employee of the University who is otherwise eligible to participate in the Plan and is actually participating in the Plan pursuant to the applicable plan’s terms. Your receipt of this Benefit Summary is not an indication that you are in fact a participant in the Plan.
The PPO Dental Plan described in the following pages of this Benefit Summary is a benefit provided by the University. These benefits are not insured with Aetna, or any of its affiliates but are paid from University funds. Aetna provides certain administrative services under the Plan including claim determination, application of coinsurance and limitations in accordance with the conditions, rights, and privileges as set forth in this Benefit Summary.

This Benefit Summary replaces and supersedes all Benefit Summaries describing coverage for the dental benefits plan described in this Benefit Summary that you may previously have received from the University or Aetna.

**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 service.

**Notice of Provider Directory/Networks**

Notice Regarding Provider Directories and Provider Networks
The PPO Dental Plan provides you with access to Aetna PPO national network of Providers, as well as Columbia University of Dental Medicine faculty and Alumni, called the Columbia Preferred Dental Network.

You may access a list of Providers who participate in the network by visiting [www.aetna.com/docfind/custom/columbia](http://www.aetna.com/docfind/custom/columbia) or by calling the toll-free telephone number 800-773-9326.

**Pre-Existing Conditions**
There are no pre-existing condition limits under the Plan.

**In-Network services**
When you use a provider who participates in the Aetna or Columbia Preferred Dental Network, you do not have to submit claim forms to receive reimbursement for your expenses. 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 - at any time. 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 Relationship with Providers
The relationship between you and any Provider is that of Provider and patient. Your Provider is solely responsible for the quality of the services provided to you. You:

♦ are responsible for choosing your own Provider;
♦ are responsible for paying, directly to your Provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
♦ are responsible for paying, directly to your Provider, the cost of any non-Covered Health Service;
♦ must decide if any Provider treating you is right for you (this includes Network Providers you choose and Providers to whom you have been referred); and
♦ must decide with your Provider what care you should receive.

Information and Records
The Plan Administrator and Aetna may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. The Plan Administrator and Aetna may request additional information from you to decide your claim for Benefits. The Plan Administrator and Aetna will keep this information confidential. The Plan Administrator and Aetna may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish The Plan Administrator and Aetna with all information or copies of records relating to the services provided to you. The Plan Administrator and Aetna have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Employee’s enrollment form. The Plan Administrator and Aetna agree that such information and records will be considered confidential.

The Plan Administrator and Aetna have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as the Plan Administrator is required to do by law or regulation. During and after the term of the Plan, the Plan Administrator and Aetna and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements the Plan Administrator recommends that you contact your health care Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from Aetna, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.
In some cases, the Plan Administrator and Aetna will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as does the Plan Administrator.

**Worker's Compensation Not Affected**
Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers’ compensation insurance.

**Eligibility for Benefit Coverage**

**Eligibility for Full-Time Officers**
If you are a full-time active Officer, you and your family are eligible for dental coverage under the PPO Dental Plan.

**Eligibility for Support Staff (Non-Union, Local 2110 and TWU)**
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 2110 and TWU) you are eligible for the PPO Dental Plan.

**When Your Benefits Start**

**Officers**
You are eligible for benefits on your date of hire. In order for your benefits to be effective on your date of hire, 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 Dental 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.

**Support Staff (Non-Union, Local 2110 and TWU)**
You are eligible for dental benefits as defined by your collective bargaining agreement. Please refer to your agreement for your eligible start date.

In order to receive dental 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 Dental 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:

- Spouse
- Same-sex Domestic Partner, provided your Domestic Partner is:
  - At least 18 years old
  - Not related to you by blood
  - 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 a relationship between people of the same gender as marriage

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

- 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 month in which they turn 26;
  - If a court has appointed you legal guardian (for any child from birth to 26); and
  - At any age if they have a mental or physical disability provided they are incapable of self-sustaining employment and chiefly depend 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 month in which the dependent turns age 26. Approval by your medical insurance carrier (Aetna) is required. See How to Continue Coverage for a Disabled Child, below.

- Eligible dependent children do 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.

Aetna may require certain documentation in order to verify an individual’s status as a Dependent.

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

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 26, as follows:

- If you’re an eligible employee whose child is already covered under the Plan, you must apply for continued coverage before the end of the month in which he or she turns age 26.
- If you’re a newly eligible employee and your disabled child is older than age 26 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 26, you must complete and submit the required form(s) to Aetna. Forms are available from the Columbia Benefits Service Center at 212-851-7000.

Your medical carrier 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 Officers.
- 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 PPO 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 PPO Dental 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 on behalf of your ineligible dependent. 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 report any changes in the status of your dependents within 31 days of the change. Examples of changes include, but are not limited to, divorce, child reaching the limiting age under the Plan, etc. Go to the CU Benefits Enrollment System at www.hr.columbia.edu/benefits and update any changes in the status of your dependents online. If you need assistance, call the Columbia Benefits Service Center at 212-851-7000.

Proof of Eligibility

The Plan Administrator 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 certificate, 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 and one dependent
- Yourself and two or more dependents

Payment of Benefits
Any payment of benefits in reimbursement for covered expenses paid by the child, or the child’s custodial parent or legal guardian, shall be made to the child, the child’s custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

If You and Your Spouse or Same-Sex Domestic Partner Work for the University
If you and your Spouse or same-sex domestic partner work for the University and are eligible for medical coverage, you may choose your coverage in either of the following ways:

- One Spouse or same-sex domestic partner makes the medical choice for the entire family, including eligible dependent children, if any. In this case, the other Spouse or same-sex domestic partner must select “No Coverage.”
- Each Spouse or same-sex domestic partner can make his or her own medical choice. In this case, all eligible dependents must be covered by you or your Spouse or same-sex domestic partner.

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 under the Plan 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 3 weeks of your date of hire, please contact the Columbia 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.

**Limited Changes During the Year - Qualified Life Status Changes**

The IRS restricts when you can add coverage for a dependent or make changes to your healthcare benefits during the year.

After your initial enrollment when you are hired, or after annual Benefits Open Enrollment, you will only be able to change most benefits for the remainder of the calendar year if you experience a Qualified Life Status Change.

Examples of a Qualified Life Status Change include:

- Marriage, divorce or the beginning or end of a same-sex domestic partnership;
- Birth, adoption or placement for adoption or foster care;
- Death of a dependent (Spouse, same-sex domestic partner, child);
- A dependent losing eligibility for coverage, such as a child reaching maximum age;
- Losing coverage under another plan, such as a Spouse/partner losing coverage from his or her employer;
- A Spouse or eligible dependent being called to military duty in the U.S. Armed Forces;
- Job promotions and/or transfers that change the benefit offerings.

If you experience a Qualified Life Status Change, you must go to [www.hr.columbia.edu/benefits](http://www.hr.columbia.edu/benefits) and make your changes within 31 days of the event. If you need assistance, please contact the Columbia Benefits Service Center at 212-851-7000 and a specialist will help you with your changes. Please remember that you must provide proper documentation for your change, such as a birth certificate, marriage certificate or divorce decree. Your benefit changes must be consistent with the nature of your Qualified Life Status Change. If you have Qualified Life Status Changes after mid-November, you may not be able to make changes to certain benefits for the remainder of the current calendar year.

**Your Cost**

**Your Cost for Benefit Coverage - Officers**

You and the 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 Code Section 125. Your pre-tax “premium” for dental coverage is based on the coverage level you select (individual vs. one or more dependents).
Your Cost for Benefit Coverage – Support Staff

You and the University share the cost of your coverage. For Non Union Support Staff, the University determines its level of support for benefit coverage for you and your eligible dependents. Costs vary depending on the plan you choose, and the number of eligible Dependents that you cover.

You and the University share the cost of your coverage. The costs for 2110 and TWU are negotiated as part of your Collective Bargaining Agreement. Costs vary depending on the plan you choose, and the number of eligible Dependents that you cover.

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 Code Section 125. Your pre-tax “premium” for healthcare coverage is based on the coverage level you select (individual vs. one or more dependents).

Your Cost for Same-Sex Domestic Partner or Same-Sex Spouse

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

Officers who are legally married to their same-sex Spouse are eligible to have their payroll contributions made to the Columbia medical plan, deducted on a pre-tax basis and not subject to imputed income on the employer-sponsored portion of the costs of medical plan coverage. You must contact the Columbia Benefits Service Center at 212-851-7000 to provide a marriage certificate or to request recognition of your same-sex domestic partner as a federal tax dependent for group health plan purposes.

When Coverage Ends

This section summarizes what happens to your medical 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 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 University ends, your Columbia University in the City of New York-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, the 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 medical 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; or
- 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; or
- 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 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 as described below:

- If you receive salary continuance: Any “premium” contributions you make for 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 are placed on unpaid leave, you may continue your dental coverage on direct billing. Any contributions you make for University benefits will be on an after-tax basis.

- If you receive Long Term Disability benefits, any “premium” contributions you make for Columbia University in the City of New York 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 in the City of New York 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 Benefits 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 Columbia Benefits Service Center to discuss these rules.

Please note that for certain types of coverage to remain in effect during your leave of absence, you must pay the monthly premium costs associated with the coverage. You will be billed separately for the coverage by Employee Benefit Plan Administrators (EBPA), an outside vendor. The Columbia Benefits Service Center will notify EBPA of your leave of absence status and calculate the monthly costs for those types of coverage that will require payment during your leave. You will be charged your regular monthly contribution rate for 6 months. After 6 months of leave, you will be charged the full premium rate, that is, your regular contribution plus the Columbia portion of the premium.

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.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by the Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. If any coverage your Employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate. If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If this Plan provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be an eligible dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.
If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under this Plan will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under this Plan only if and when this Plan gives its written consent. If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.

If You Die
If you die, your surviving dependents who are covered under the PPO Dental Plan at the time of your death will be offered COBRA dental as of the date of your death.

If Your Eligible Dependent Dies
If an eligible dependent dies, you can change your 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
The Plan will provide written notice to you that your coverage will end on the date identified in the notice if:

- You commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person’s eligibility or status as a Dependent; or
- You commit an act of physical or verbal use that imposes a threat to the University’s staff, the staff of your selected healthcare plan, or a provider.

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**
The date of your divorce, or commencement of other dental coverage (through Spouse’s employer, etc.).

**Same-Sex Domestic Partner**
The date of the dissolution of the partnership or commencement of other dental coverage (through partner’s employer).

**Child**
Coverage ends at the end of the calendar month in which your child turns age 26.

**Disabled Child**
Coverage for your disabled child may be continued past the maximum age for a dependent child, see the section Eligible Dependents. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

In addition, coverage will cease on the first to occur of:

- Cessation of the disability.
- Failure to give proof that the disability continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

**How Your Aetna Dental Plan Works**

- Common Terms
• What the Plan Covers
• Rules that Apply to the Plan
• What the Plan Does Not Cover

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

• Definitions you need to know;
• How to access care, including procedures you need to follow;
• What expenses for services and supplies are covered and what limits may apply;
• What expenses for 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 Benefit Summary 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 Benefit Summary in a safe place for future reference.

**Common Terms**

Many terms throughout this Benefit Summary 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:

By using Columbia Preferred Dental Network and Aetna PPO Network of Dentist
• 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 in 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

In the 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.

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 visits 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-rays, 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 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.)
  ♦ 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 overage 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 Partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)
  - Complete upper denture
  - Complete lower denture
  - Partial upper or lower, resin base (including any conventional clasps, rests and teeth)
  - Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
  - Stress breakers
  - Interim partial denture (stayplate), anterior only
  - 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. Generally, the plan does not cover dental services that are given after your coverage terminates. However, 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.

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.

**Additional Items Not Covered By A Health Plan**

Not every health 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 medically necessary and included in the What the Plan Covers section. Charges made for the following are not covered except to the extent listed under the What The Plan Covers section or by amendment attached to this Booklet.

Acupuncture, acupressure and acupuncture therapy, except as provided in the What the Plan Covers section.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet.

Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider’s license.

Charges submitted for services that are not rendered, or not rendered to a person not eligible for coverage under the plan.

Court ordered services, including those required as a condition of parole or release.

Examinations:

- Any dental examinations:
  - required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - required by any law of a government, securing insurance or school admissions, or professional or other licenses;
  - required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
  - any special medical reports not directly related to treatment except when provided as part of a covered service.

**Experimental or investigational** drugs, devices, treatments or procedures, except as described in the What the Plan Covers section.

Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

Miscellaneous charges for services or supplies including:
• Cancelled or missed appointment charges or charges to complete claim forms;
• Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  ◦ Care in charitable institutions;
  ◦ Care for conditions related to current or previous military service; or
  ◦ Care while in the custody of a governmental authority.

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

Routine dental exams and other preventive services and supplies, except as specifically provided in the What the Plan Covers section.

Services rendered before the effective date or after the termination of coverage, unless coverage is continued under the Continuation of Coverage section of this Booklet.

Work related: Any illness or injury related to employment or self-employment including any injuries that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers’ compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers’ compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered “non-occupational” regardless of cause.

Schedule of Benefits

Employer: Columbia University in the City of New York
ASA: 619362
Effective Date: January 1, 2016

For: Three Tier PPO Dental Benefits

This is an ERISA plan, and you have certain rights under this plan. Please see the ERISA Rights section for additional information.

Comprehensive Dental Plan (PPO)

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>COLUMBIA PREFERRED DENTAL NETWORK</th>
<th>AETNA DENTAL NETWORK</th>
<th>AETNA OUT-OF-NETWORK</th>
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</thead>
<tbody>
<tr>
<td>Calendar Year</td>
<td>Individual $0</td>
<td>Individual $25</td>
<td>Individual $25</td>
</tr>
</tbody>
</table>
The calendar year deductible applies to all covered 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.

<table>
<thead>
<tr>
<th>PLAN PAYMENT PERCENTAGE</th>
<th>COLUMBIA UNIVERSITY NETWORK PAYMENT PERCENTAGE</th>
<th>AETNA NETWORK PAYMENT PERCENTAGE</th>
<th>AETNA OUT-OF-NETWORK PAYMENT PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type A Expenses</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Type B Expenses</td>
<td>100%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Type C Expenses</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontic Treatment</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

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.
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 section of this Schedule of Benefits.

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 the Aetna out-of-network deductible.

Covered expenses that are subject to the deductible include dental expenses under the PPO 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 expense 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 amount 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 Benefit Summary and should be kept with your Benefit Summary.

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 Benefit Summary.

Coordination of Benefits
What Happens When There is More Than One Health Plan
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:
   a. secondary to the plan covering the person as a dependent; and
   b. 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:
   c. covers the person as other than a dependent; and
   d. 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:
      d. 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.
      e. 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:
   a. 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;
   b. 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.
   c. 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;
   d. 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.

   e. 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;
   f. then the above paragraph will not apply.
The general rule is that the benefits otherwise payable under this Plan for all expenses processed during a single "processed claim transaction" will be reduced by the total benefits payable under all "other plans" for the same expenses. An exception to this rule is that when the coordination of benefits rules of this Plan and any "other plan" both agree that this Plan is primary, the benefits of the other plan will be ignored in applying this rule. As used in this paragraph, a "processed claim transaction" is a group of actual or prospective charges submitted to Aetna for consideration, that have been grouped together for administrative purposes as a "claim transaction" in accordance with Aetna's then current rules. If the contract includes both medical and dental coverage, those coverages will be considered separate plans. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy plans. In turn, the dental coverage will be coordinated with other dental plans.

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.
**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 Benefit Summary, 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 Benefit Summary 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. If you have any questions about the terms of the Aetna dental benefits 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 and your rights under this plan may not be assigned. A direction to pay a provider is not an assignment of any right under this plan or of any legal or equitable right to institute any court proceeding.

**Misstatements**

If any fact as to the Contract holder 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 Contract holder 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 Contract holder 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 after it has been in force for 2 years from its effective date.
- No statement made by the Contract holder 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.

Subrogation and Right of Recovery Provision

Definitions
As used throughout this provision, the term “Responsible Party” means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person’s injury, illness, or condition. The term “Responsible Party” includes the liability insurer of such party or any insurance coverage.

For purposes of this provision, the term “Insurance Coverage” refers to any coverage providing dental expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, dental payments coverage, workers compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

For purposes of this provision, a “Covered Person” includes anyone on whose behalf the plan pays or provides any benefit including, but not limited to, the minor child or dependent of any plan member or person entitled to receive any benefits from the plan.

Subrogation
Immediately upon paying or providing any benefit under this plan, the plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person’s injury, illness, or condition to the full extent of benefits provided or to be provided by the plan.

Reimbursement
In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury, illness, or condition, the plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this plan has paid and will pay as a result of that injury, illness, or condition, from such payment, up to and including the full amount the Covered Person receives from any Responsible Party.
Constructive Trust
By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an injury, illness, or condition, he or she will serve as a constructive trustee over the funds that constitutes such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person’s fiduciary duty to the plan.

Lien Rights
Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury, or condition for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise, including from any Insurance Coverage, related to treatment for any illness, injury, or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan, including, but not limited to, the Covered Person, the Covered Person’s representative or agent; Responsible Party; Responsible Party’s insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the plan.

First-Priority Claim
By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person acknowledges that this plan’s recovery rights are a first priority claim against all Responsible Parties and are to be paid to the plan before any other claim for the Covered Person’s damages. This plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party’s payments, even if such payment to the plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person’s damage claim.

Applicability to All Settlements and Judgments
The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the dental benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than dental expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation
The Covered Person shall fully cooperate with the plan’s efforts to recover its benefits paid. It is the duty of the Covered Person to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person’s intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or condition sustained by the Covered Person. The Covered Person and his or her agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.
The Covered Person shall do nothing to prejudice the plan’s subrogation or recovery interest or to prejudice the plan’s ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

The Covered Person acknowledges that the plan has the right to conduct an investigation regarding the injury, illness, or condition to identify any Responsible Party. The plan reserves the right to notify responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

**Interpretation**

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

**Jurisdiction**

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

**Worker’s Compensation**

If benefits are paid by Aetna and Aetna determines you received Worker’s Compensation benefits for the same incident, Aetna has the right to recover as described under the Subrogation and Right of Reimbursement provision. Aetna will exercise its right to recover against you.

The Recovery Rights will be applied even though:

- The Worker’s Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that bodily injury or illness was sustained in the course of or resulted from your employment;
- The amount of Worker’s Compensation due to medical or health care is not agreed upon or defined by you or the Worker’s Compensation carrier; or
- The medical or health care benefits are specifically excluded from the Worker’s Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this contract, you will notify Aetna of any Worker’s Compensation claim you make, and that you agree to reimburse Aetna as described above.

If benefits are paid under this Contract and you or your covered dependent recover from a responsible party by settlement, judgment or otherwise, Aetna has a right to recover from you or your covered dependent an amount equal to the amount Aetna paid.
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 and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.
**Appeals Procedure**

**Definitions**

**Adverse Benefit Determination:** A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage;
- The results of any Utilization Review activities;
- A determination that the service or supply is **experimental or investigational**; or
- A determination that the service or supply is not **medically necessary**.

**Appeal:** A written request to **Aetna** to reconsider an **adverse benefit determination**.

**Complaint:** Any written expression of dissatisfaction about quality of care or the operation of the Plan.

**Concurrent Care Claim Extension:** A request to extend a previously approved course of treatment.

**Concurrent Care Claim Reduction or Termination:** A decision to reduce or terminate a previously approved course of treatment.

**Pre-Service Claim:** Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

**Post-Service Claim:** Any claim that is not a “Pre-Service Claim.”

**Urgent Care Claim:** Any claim for medical care or treatment in which a delay in treatment could:

- jeopardize your life;
- jeopardize your ability to regain maximum function;
- cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

**Claim Determinations**

**Urgent Care Claims**

**Aetna** will make notification of an **urgent care claim** determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, **Aetna** will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify the claimant within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the **physician** to provide **Aetna** with the information.
If the claimant fails to follow plan procedures for filing a claim, Aetna will notify the claimant within 24 hours following the failure to comply.

Pre-Service Claims
Aetna will make notification of a claim determination as soon as possible but not later than 15 calendar days after the pre-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 15 calendar days claim determination period is required. Such an extension, of not more than 15 additional calendar days, will be allowed if Aetna notifies you within the first 15 calendar days period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Post-Service Claims
Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not more than 15 additional calendar days, will be allowed if Aetna notifies you within the first 30 calendar day period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Concurrent Care Claim Extension
Following a request for a concurrent care claim extension, Aetna will make notification of a claim determination for emergency or urgent care as soon as possible but not later than 24 hours, with respect to emergency or urgent care provided the request is received at least 24 hours prior to the expiration of the approved course of treatment, and 15 calendar days with respect to all other care, following a request for a concurrent care claim extension.

Concurrent Care Claim Reduction or Termination
Aetna will make notification of a claim determination to reduce or terminate a previously approved course of treatment with enough time for you to file an appeal.

Complaints
If you are dissatisfied with the service you receive from the Plan or want to complain about a provider you must write Aetna Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the complaint, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations
You may submit an appeal if Aetna gives notice of an adverse benefit determination. This Plan provides for one level of appeal. It will also provide an option to request an external review of the adverse benefit determination.

You have 180 calendar days following the receipt of notice of an adverse benefit determination to request your level one appeal. Your appeal may be submitted verbally or in writing and should include:
- Your name;
- Your employer’s name;
- A copy of Aetna’s notice of an adverse benefit determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

The notice of an adverse benefit determination will include the address where the appeal can be sent. If your appeal is of an urgent nature, you may call Aetna’s Customer Service Unit at the toll-free phone number on your ID card.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing verbal or written consent to Aetna.

**Level One Appeal - Group Health Claims**

A level one appeal of an adverse benefit determination shall be provided by Aetna personnel not involved in making the adverse benefit determination.

**Urgent Care Claims** (May include concurrent care claim reduction or termination)

Aetna shall issue a decision within 36 hours of receipt of the request for an appeal.

**Pre-Service Claims** (May include concurrent care claim reduction or termination)

Aetna shall issue a decision within 15 calendar days of receipt of the request for an appeal.

**Post-Service Claims**

Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim.

A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

**External Review Procedure**

The external review program offers members the opportunity to have certain coverage denials reviewed by independent dental reviewers. Once the applicable plan appeal process has been exhausted, eligible members may request external review if the coverage denial for which the member would be financially responsible involves more than $500 and is based on lack of medical necessity or on the experimental or investigational nature of the service or supply at issue.

If, upon the final level of review, Aetna upholds the coverage denial and it is determined that the member may be eligible for external review, he or she will be informed in writing of the steps necessary to request an external review, and a Request for External Review form will be included with the letter.
If coverage has been denied and the coverage denial letter indicates that the member is not eligible to request external review of the coverage denial, he or she should review the information below to determine if the coverage denial meets eligibility criteria to participate in this program.

The cost of the service or supply at issue for which the member would be financially responsible exceeds $500.

The applicable plan appeal process has been exhausted.

If the above eligibility criteria have been met and the applicable state external review process does not require otherwise, the member should print the Request for External Review form, follow the instructions provided on the form, and submit all information to Aetna’s External Review Unit at the address listed on the form for processing.

A second form, Request for Expedited External Review form, is for use by the treating dentist, if he or she certifies that a delay in service would jeopardize the member’s health.

The Aetna External Review Unit will refer the request to an independent review organization (IRO) contracted with Aetna, and the IRO will choose an appropriate independent dental reviewer (or reviewers, if necessary or required by applicable law) to examine the case. The IRO is responsible for choosing a physician who is board certified in the area of medical specialty at issue in the case. The dental reviewer must take an evidence-based approach to reviewing the coverage determination, and must follow the plan sponsor’s plan documents and applicable criteria governing the member’s benefits.

After all necessary information is submitted, external reviews generally will be decided within 30 calendar days of the request. Expedited reviews are available when a member’s dentist certifies that a delay in service would jeopardize the member’s health. Once the review is complete, the decision of the independent external reviewer will be binding on Aetna, the plan sponsor and the health plan. Members are not charged a professional fee for the review.

**Exhaustion of Process**

You must exhaust the applicable Level one and Level two processes of the Appeal Procedure before you establish any:

- litigation;
- arbitration; or
- administrative proceeding;

regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

**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 A 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.

**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 though discount arrangements.

**Glossary**

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

Creditable coverage

A person’s prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Such coverage includes:

- Health coverage issued on a group or individual basis;
- Medicare;
- Medicaid;
- Health care for members of the uniformed services;
- A program of the Indian Health Service;
- A state health benefits risk pool;
- The Federal Employees’ Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children’s Health Insurance Program (S-CHIP).

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 Myofacial 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 Benefit Summary.

**Lifetime maximum**

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

**L.P.N.**

A licensed practical or vocational nurse.

**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:

- In accordance with generally accepted standards of medical or dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician, other health care or dental provider; and
- 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.
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 care 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.

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 care provider who has not contracted with Aetna, an affiliate, or a third party vendor, to furnish services or supplies for this plan at a negotiated charge.

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.

- Expenses that are not paid or precertification benefit reductions that are made because a required precertification for the service(s) or supply was not obtained from Aetna.

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 use disorder 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

The covered expense is only that part of a charge which is the recognized charge.

As to medical, vision and hearing expenses, the recognized charge for each service or supply is the lesser of:

• What the provider bills or submits for that service or supply; and
• For professional services and other services or supplies not mentioned below:

If Aetna has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply, then the recognized charge is the rate established in such agreement.

Aetna may also reduce the recognized charge by applying Aetna Reimbursement Policies. Aetna Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:
• the duration and complexity of a service;
• whether multiple procedures are billed at the same time, but no additional overhead is required;
• whether an assistant surgeon is involved and necessary for the service;
• if follow up care is included;
• whether there are any other characteristics that may modify or make a particular service unique; and
• when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

Aetna Reimbursement Policies are based on Aetna's review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with physician or dental specialty society recommendations; and the views of physicians and dentists practicing in the relevant clinical areas. Aetna uses a commercial software package to administer some of these policies.

Important Note
Aetna's website Aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools, or contact our Customer Service Department for assistance.

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.