Summary Plan Description

Prepared Exclusively for Columbia University

Officers and Support Staff (Non-Union, Local 2110, TWU, SSA, TWU Lamont) and Post Doctoral Clinical and Residency Fellows, Obama Scholars, Post Doctoral Research Fellows

Aetna Columbia Dental Plan -PPO

What Your Plan Covers and How Benefits are Paid

2024

Contents

Introduction

Columbia University in the City of New York ("the University") is pleased to provide you[1] with this Summary Plan Description (SPD) which describes the dental benefits available to you and your covered family members under the Columbia University Group Benefits Plan (the "Plan"). This Summary Plan Description 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 Summary Plan Description 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 Summary Plan supersedes any previous printed or electronic Summary Plan Description for the Plan. You are responsible for using this Summary Plan Description 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 SPD and any summaries provided to you and/or any verbal representations, this SPD will govern in every respect and instance.

How To Use This Summary Plan Description (SPD)

- Please read the entire SPD and share it with your family. Keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.

You can find copies of your SPD and any future amendments at www.hr.columbia.edu 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 Summary Plan Description 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 Summary Plan Description 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 Summary Plan Description 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 SPD.

This Summary Plan Description replaces and supersedes all SPDs describing coverage for the dental benefits plan described in this SPD 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 27 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 27 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 https://humanresources.columbia.edu/content/aetna-dental 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. You may upload claims through contact us function on the Aetna website home page as long as you are a registered on the Aetna member website.

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

Columbia University and Aetna may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services Columbia University that you may find valuable, and as otherwise permitted or required by law. and Aetna may request additional information from you to decide your claim for Benefits. Columbia University and Aetna will keep this information confidential. Columbia University 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 Columbia University and Aetna with all information or copies of records relating to the services provided to you. Columbia University 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 Columbia University and Aetna agree that such information and records will be considered confidential.

Columbia University 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 dental review or quality assessment, or as Columbia University is required to do by law or regulation. During and after the term of the Plan, the Columbia University 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 dental records or billing statements the Columbia University 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 dental 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 Columbia University 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 Columbia University.

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 Officers

You are eligible to enroll in the PPO Dental Plan if you are a regular full-time active Columbia University Officer who is scheduled to work at least 35 hours per week, if you are a regular part-time Officer of Administration who is regularly scheduled to work at least 20 hours per week or if you are a Temporary Full-Time Officer approved for a period of four months or more and with a specific end date.

Eligibility for Support Staff (Non-Union, Local 2110, TWU Lamont, SSA) and Postdoctoral Fellows and Obama Scholars)

You are eligible to enroll in the PPO Dental Plan if you are a full-time or part-time Support Staff employee (Non-Union, Local 2110, and TWU Lamont). If you are a full-time Support Staff SSA or at TWU. If you are a full-time Postdoctoral Clinical or Residency Fellows, Postdoctoral Research Fellows, and Obama Scholar.

When Your Benefits Start

Officers, Postdoctoral Clinical or Residency Fellows, Postdoctoral Research Fellows and Obama Scholars

You are eligible for benefits on your date of hire in order for your benefits to be effective on your date of hire or newly eligibility date, you must log onto CUBES at www.hr.columbia.edu within 31 days of the date you first become eligible for Dental coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit election or if you have a Qualified Life Status Change. Obama Scholars are required to complete an enrollment form.

Each year during annual Open Enrollment, you have the opportunity to review and change your dental election. Any changes you make during Open Enrollment will become effective the following January 1.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other Qualified Life Status Change, you must login on to CUBES at **www.hr.columbia.edu** within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

Support Staff (Non-Union, Local 2110, TWU, TWU Lamont, SSA)

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 or eligibility date. 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 be defaulted to Emblem Health individual coverage for the remainder of the calendar year. You will have to wait until the Benefits Open Enrollment period. 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
- Legally dependent children, including adopted children, foster children and stepchildren of your Spouse, 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 or your spouse are the 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 is required. See How to Continue Coverage for a Disabled Child, below.

Your dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both covered under the Plan, you may each be enrolled as an Employee or be covered as a Dependent of the other person, but not both. In addition, if you and your spouse are both covered under the Plan, only one parent may enroll your child as a dependent. A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order.

Note: The only qualifying Domestic Partnerships will include those whose coverage was effective on or before January 1, 2023 or, in limited circumstances, in instances where an employee can demonstrate that the employee or their domestic partner reside in a country or jurisdiction where their marriage is prohibited and/or persecuted, or can demonstrate an equally compelling reason for an exception to the policy, as determined at the sole discretion of the plan administrator.

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; he/she is no longer living with the employee and no longer eligible as a dependent.

• A dependent who is employed by the University. if the dependent is employed with the university he/she would have his/her own coverage with the university. They cannot be covered under the university's dental plan both as an employee and a dependent.

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 are 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. You may call Aetna at 1 (800) 773-9326 to request the disabled dependent forms.

Your dental 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 part-time Officers
- Part-Time Officers, except for part-time Officers of Administration who work 20 hours or more a week
- Support Staff other than Non-Union Support Staff, Local 2110, TWU, TWU Lamont, SSA as described in their collective bargaining agreements.

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 (Family)

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 Work for the University

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

- One Spouse or makes the dental choice for the entire family, including eligible dependent children, if any. In this case, the other Spouse must select "No Coverage."
- Each Spouse or can make his or her own dental choice. In this case, all eligible dependents must be covered by you.

Enrollment

How to Enroll

Newly Eligible Employee

If you are newly hired or newly eligible, you must enroll for benefits within 31 days of your date of hire or eligibility date. 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.

New Eligible Employee – Support Staff

If you are newly hired or newly eligible, you must enroll for benefits within 31 days of your date of hire or eligibility date. If you do not enroll you will be defaulted to Emblem Health individual coverage for the remainder of the calendar year. You will have to wait until the Annual Benefits Open Enrollment period. The benefit choices you make at that time take effect the following January 1.

You will be notified of your benefits on-line enrollment opportunity via email. Enrollment is through CUBES. 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 during the Annual 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 the 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;
- Birth, adoption or placement for adoption or foster care;
- Death of a dependent (Spouse, 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, please log into CUBES at **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. Please remember that you must provide proper documentation for your change, such as a birth certificate, marriage certificate or divorce decree. These documents may be uploaded on CUBES when you make your changes. 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 or newly eligible and is also provided to you each year during the 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 TWU, TWU Lamont and SSA 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 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 Benefit Coverage – Post Doctoral Fellows

The cost of your coverage at the COBRA rate.

When Coverage Ends

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

- Your employment ends
- 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 Group Benefit plan, 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 dental 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.
- The date Aetna receives written notice from Columbia University to end your coverage, or the date requested in the notice, if later

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

- the date your coverage ends;
- the date you stop making the required contributions.
- the last day of the month your Dependents no longer qualify as Dependents under this Plan.
- The date Aetna receives written notice from Columbia University to end your coverage, or the date requested in the notice, if later

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.

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 below). 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 the university grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Dental Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by the university to continue coverage. If any coverage the university 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 the university 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 the university

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise

terminate. If Dental Benefits terminate because your approved FMLA leave is deemed terminated by the university, 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 the university 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 the university Employer following the date the university 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 the university 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 the university 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 the university 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 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.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if Columbia University is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

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

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

- An Employee.
- An Employee's enrolled Dependent, including with respect to the Employee's children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law.
- An Employee's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

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

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

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

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

[3]From the date of the Employee's death if the Employee dies during the continuation coverage.

Getting Started

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

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

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

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

- During Open Enrollment.
- Following a change in family status,

Notification Requirements

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

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

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

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

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

Notification Requirements for Disability Determination

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

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 16, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

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

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

When COBRA Ends

COBRA coverage will end before the maximum continuation period, on the earliest of the following dates:

- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare.
- The date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days).
- The date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date).
- The date the entire Plan ends.
- The date coverage would otherwise terminate under the Plan as described in the beginning of this section.

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

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 ofemployment.

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.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.
If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.
You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.
Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

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.).

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.

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 Summary Plan Description 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 Summary Plan Description 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 Summary Plan Description in a safe place for future reference.

Common Terms

Many terms throughout this Summary Plan Description 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 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 Preferred in-network provider or an Aetna in-network provider. You have the freedom to choose a dental provider who is not in the dental network. You will pay more

if you choose an Aetna out-of-network provider.

The *Schedule of Benefits* shows you how the plan's level of coverage for the Columbia Preferred in-network services and supplies, the Aetna in-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 Networ*k Dentist:*

- You will receive the plan's higher level of coverage when your care is provided by a Columbia Preferred in-network provider or an Aetna in-network provider.
- The plan begins to pay benefits after you satisfy an Aetna network deductible.
- The plan pays up to the Annual Maximum Benefit
- The plan begins to pay benefits with no deductible to satisfy on the Columbia Preferred in-network.
- You share the cost of covered services and supplies by paying a portion of certain expenses (your payment percentage). Columbia Preferred in-network and Aetna in-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 fora 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 Preferred in-network and Aetnain- network providers. Your in-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 Preferred in-network or Aetna in-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. Please contact Aetna at 1(800) 773-9326 for assistance,

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 in**surance** level.

What The Plan Covers

PPO Dental Plan

Schedule of Benefits for the 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 (eligible dental services) and provided by a dental provider
- 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 Provider services

- Dentist's office
- Tele dentistry

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

Additional eligible dental services if you have at least one of the following conditions:

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

Dental Medical Integration (DMI) dental services:

- Scaling and root planning (4 or more teeth). Per quadrant,
- Scaling and root planning (limited to 1-3 teeth) per quadrant,
- 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
- Pulp Vitality test & Diagnostic Casts

X-Ray and Pathology

- Periapical x-rays (single films)
- Intra-oral, occlusal view, maxillary or mandibular
- Upper or lower jaw, extra-oral

Oral Surgery

- Removal Erupted tooth or exposed root
- Coronal remnants

Periodontics

- Root planning 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
- Recementation
    - Inlay
    - Crown
    - Bridge

Repairs –

- inlay
- onlay,
- veneer,
- bridges

- Adjustment to denture more than 6 months after installation
- Dentures and Partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)
    - Rebase, per denture
    - Office reline
    - Laboratory reline
- Full and partial denture repairs
    - Broken dentures, no teeth involved
    - Repair cast framework
    - Replacing missing or broken teeth, each tooth
    - Adding teeth to existing partial denture
        - Each tooth
        - Each clasp

Space Maintainers

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

- Removable (unilateral or bilateral)
- Unscheduled dressing Change

Type C Expenses: Major Restorative Care

Oral Surgery

- Surgical removal of impacted teeth
    - Removal of tooth (partially bony)

- Removal of tooth (completely bony)
- Biopsy and histopathologic examination of oral tissue

- 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
  - Surgical revision procedure

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
  - Anterior
  - Bicuspid
  - Molar
- Pulp capping
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Pulpal regeneration
- Hemisection
- Retrograde filling
- Root amputation

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,
- prefabricated crowns (primary teeth only, excludes temporary crowns)
- Pins
- Pin retention - per tooth, in addition to amalgam or resin restoration
- Coping
- Precision attachments,
- Protective restoration

Prosthodontics

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

- Bridge Abutments (See Inlays and Crowns)
- Pontics
    - Base metal (full cast)
    - Noble metal (full cast)
    - Porcelain with noble metal
    - Porcelain with base metal
    - Resin with noble metal
    - Resin with base metal
- Removable unilateral Partial Denture
- 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 (stay plate), anterior only
    - Special tissue conditioning, per denture
- 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 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 except to the extent coverage is specifically provided in the *What the Plan Covers* section)

- 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;
- Facings on molar crowns and pontics will always be considered **cosmetic**.

Crown (excludes temporary crowns) inlays and onlays, and veneers, labial veneers, unless: Multiple restorations in 1 surface will be considered as a single restoration.

- It is treatment for decay or traumatic **injury** and only when 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 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 contract holder.

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 (includes all adjustments within 6 months)

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 the university 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 the universities, 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, 2024

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

PLAN FEATURES	COLUMBIA PREFERRED DENTAL NETWORK	AETNA DENTAL NETWORK	AETNA OUT-OF-NETWORK
Calendar Year Deductible	Individual $0	Individual $25	Individual $25
The calendar year deductible applies to all covered expenses except for 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 expenses.			
PLAN PAYMENT PERCENTAGE	**COLUMBIA PREFERRED NETWORK PAYMENT PERCENTAGE**	**AETNA NETWORK PAYMENT PERCENTAGE**	**AETNA OUT-OF-NETWORK PAYMENT PERCENTAGE**
Type A Expenses	100%	100%	100%
Type B Expenses	100%	80%	80%
Type C Expenses	60%	50%	50%
Orthodontic Treatment	50%	50%	50%
CALENDAR YEAR **MAXIMUM BENEFIT**	**COLUMBIA PREFERRED DENTAL NETWORK BENEFIT**	**AETNA NETWORK BENEFIT**	**AETNA OUT-OF-NETWORK PAYMENT BENEFIT**
	$1,750	$1,500	$1,500
The most the plan will pay for covered expenses incurred by any covered person in a Calendar Year is called the Calendar Year Maximum Benefit The Calendar Year Maximum benefit applies to in-network and out-of-network covered dental expenses combined.			
ORTHODONTIC **LIFETIME MAXIMUM BENEFIT**	**COLUMBIA PREFERRED DENTAL NETWORK BENEFIT**	**AETNA NETWORK BENEFIT**	**AETNA OUT-OF-NETWORK PAYMENT BENEFIT**
	$1,750	$1,500	$1,500

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 In-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 in-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 Summary Plan Description and should be kept with your Summary Plan Description

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 Summary Plan Description

Coordination of Benefits

What Happens When There is More Than One Health Plan Other Plans Not Including Medicare

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

Key terms

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

Allowable expense means:

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

In this section we talk about other "plans" which are those plans where you may have other coverage for dental care expenses, such as:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- An automobile insurance policy
- Governmental benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

Here's how COB works

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

Determining who pays

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

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

If you are:	Primary plan	Secondary plan
Covered under the plan as an employee, retired employee or dependent	The plan covering you as an employee or retired employee	The plan covering you as a dependent You cannot be covered as an employee and dependent
COB rules for dependent children		
Child of: • Parents who are married or living together	The "birthday rule" applies The plan of the parent whose birthday* (month and day only) falls earlier in the **Calendar Year** *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)* *Same birthdays--the plan that has covered a parent longer is primary
Child of: • Parents separated or divorced or not living together • With court-order	The plan of the parent whom the court said is responsible for dental coverage But if that parent has no coverage then their spouse's plan is primary	The plan of the other parent But if that parent has no coverage, then their spouse's plan is primary
Child of: • Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody	Primary and secondary coverage is based on the birthday rule	
Child of: • Parents separated or divorced or not living together and there is no court-order	The order of benefit payments is: • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parents pays next • The plan of the spouse of the noncustodial parent (if any) pays last	

• Child covered by: Individual who is not a parent (i.e. stepparent or grandparent)	Treat the person the same as a parent when making the order of benefits determination: See *Child of* content above	
Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee)	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee)

COBRA or state continuation	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally	

How are benefits paid?	
Primary plan	The primary plan pays your claims as if there is no other dental plan involved
Secondary plan	The secondary plan calculates payment as if the primary plan did not exist, and then applies that amount to any allowable expenses under the secondary plan that were not covered by the primary plan. The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense
Benefit reserve each family member has a separate benefit reserve for each **Calendar Year**	The benefit reserve: • Is made up of the amount that the secondary plan saved due to COB • Is used to cover any unpaid allowable expenses • Balance is erased at the end of each year

Other dental coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

Right to receive and release needed information

We have the right to release or obtain any information we need for COB purposes. That

includes information we need to recover any payments from your other dental plans.

Right to pay another carrier

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

Right of recovery

If we pay more than we should have under the COB rules, we may recover the excess from:

- Any person we paid or for whom we paid
- Any other plan that is responsible under these COB rules

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 *Summary* Plan Description 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 Summary Plan Description 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 morethan 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 Columbia University your employer or **Aetna**.

- Columbia University 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.

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**.

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.

Important Administrative Information: ERISA

What this section includes:

- Plan administrative information, including your rights under *ERISA*.

This section includes information on the administration of the dental Plan, as well as information required of all Summary Plan Descriptions by *ERISA*.While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator

Columbia University is the Plan Sponsor and Plan Administrator of the Columbia University in the City of New York Group Benefits Plan and has the discretionary authority to interpret the Plan.
You may contact the Plan Administrator at:

Plan Administrator – Dental Plan
Trustees of the Columbia University in the City of New York
615 West 131st Street
4th Floor
New York, NY 10027
(212) 851-7000

Claims Administrator

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

You may contact the Claims Administrator by phone or in writing at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 6156
Telephone number:1 (800) 773-9326

Agent for Service of Legal Process

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

Agent for Legal Process – Dental Plan
The Trustees of Columbia University In the City of New York
615 West 131st Street
4th Floor
New York, NY 10027
(212) 851-7000
Legal process may also be served on the Plan Administrator.

Other Administrative Information

This section of your SPD contains information about how the Plan is administered as required by ERISA.

Type of Administration

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

Plan Name:	Columbia University in the City of New York Group Benefits Plan
Plan Number:	515
Employer ID:	13-5598093
Plan Type:	Dental benefits plan
Plan Year:	January 1 - December 31
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee and University
Source of Benefits:	Assets of the University

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- Receive information about Plan Benefits.
- Examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents — including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies. Requests for available plan documents should be sent to the address provided under *How to Appeal a Denied Claim*, *Claims Procedures*.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, *ERISA* imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under *ERISA*.
If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. *Claims Procedures*, for details.

Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document from the Plan, and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.
If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the

administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a federal court.
The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.
If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration*, *U.S. Department of Labor*, listed in your telephone directory, or write to the *Division of Technical Assistance and Inquiries*, *Employee Benefits Security Administration*, *U.S. Department of Labor*, 200 Constitution Avenue NW Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publications hotline of the *Employee Benefits Security Administration* at
1-866-444-3272.

The Plan's Benefits are administered by Columbia University, the Plan Administrator. Aetna is the Claims Administrator and processes claims for the Plan and provides appeal services; however, Aetna and Columbia University are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by an In-Network or Out-of-Network provider Aetna and Columbia University are neither liable nor responsible for the treatment, services or supplies provided by In-Network or Out-of-Network providers.HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's In-Network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at *1 (800) 773-9326*

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's In-Network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at
1 (800) 773-9326

LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your issuer.

NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator", it is a reference to Aetna Life Insurance, on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member at *1 (800) 773-9326,* **or the Plan Sponsor.**

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

Glossary

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

A

Accident

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

Aetna

Aetna Life Insurance Company

C

Copay or Copayment

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

Cosmetic

Services or supplies that alter, improve or enhance appearance.

Covered expenses

Medical, dental, vision or hearing services and supplies shown as covered under this Summary Plan Description.

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. **Network provider** information is also available through **Aetna's** online provider **directory**,Aetna.com.

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 Summary Plan Description.

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 drug**s 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.

N

Negotiated charge

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

Network provider

A dental 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.

O

Occupational injury or Occupational illness

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

- Arises out of (or in the course of) any activity in connection with employment or self-employment

whether or not on a full time basis; or

- Results in any way from an **injury** or **illness** that does.

Occurrence

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

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

Orthodontic Treatment

This is any:

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

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

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

whether or not for the purpose of relieving pain.

Out-of-network service(s) and Supply(ies)

Health care service or supply that is furnished by an out-of **network provider**.

Out-of-network provider

A dental 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**.

P

Payment percentage

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

- 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 **dentist**s 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.

S

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

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

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