

## Schedule of benefits

### Managed dental plan

For all full-time, salaried, employees of Columbia University, located in Arizona.

If this is an ERISA plan, you have certain rights under this plan. If the **contract holder** is a church group or a government group this may not apply. Please contact the **contract holder** for additional information.

#### Prepared for:

|  |   |
|--|---|
| <b>Contract holder:</b>                | Columbia University                       |
| <b>Contract holder</b> number:         | GP-0619362-AZ                             |
| Schedule of benefits:                  | 1A  |
| <b>Group agreement</b> effective date: | January 1, 2023                           |
| Plan name:                             | Dental Maintenance Organization - Arizona |
| Plan effective date:                   | January 1, 2023                           |
| Plan issue date:                       | November 20, 2025                         |
| Plan revision effective date:          | January 1, 2026                           |

Underwritten by Aetna Health Inc. in the state of Arizona



## Schedule of benefits

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This schedule of benefits lists the **eligible dental services**, office visit **copayments**, **coinsurance**, maximums, and any limits that apply to the services you get under this plan.

### How to read your schedule of benefits

- When we say “in-network coverage” we mean that you get care from **in-network providers**.
- You must pay any office visit **copayment** and your part of the **coinsurance**.
- The **coinsurance** listed in the schedule of benefits reflects your **coinsurance** percentage. Your **coinsurance** percentage is the amount that you pay. We are responsible for paying any remaining **coinsurance**.
- You must pay the full amount of any dental care services you get that is not a **covered benefit**.
- This plan also has limits for some **covered benefits**. For example, these could be visit limits. See later in this schedule of benefits for more information about limits.

#### Important note:

All **covered benefits** are subject to an office visit **copayment** and **coinsurance** unless otherwise noted in the schedule of benefits below.

### How to contact us for help

We are here to answer your questions:

- Register and log onto our self-service website available 24/7 at <https://www.aetna.com/>
- Call us at 1-877-238-6200

**Aetna Health Inc.’s group agreement** provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your certificate of coverage.

## General coverage provisions

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This section explains the:

### **Your financial responsibility and determination of benefits provisions**

Your financial responsibility for the cost of services is based on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment that occurs in more than one **Calendar Year**. Determinations regarding when benefits are covered are subject to the terms and conditions of the certificate of coverage.

# Plan features

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## In-network plan features

| Expense      | Copayment     |
|--------------|---------------|
| Office visit | \$0 per visit |

| Expenses        | Coinsurance           |                         |
|-----------------|-----------------------|-------------------------|
|                 | Primary care services | Specialty care services |
| Type A expenses | 0%                    | Not applicable          |
| Type B expenses | 0%                    | 0%                      |
| Type C expenses | 40%                   | 40%                     |

| Expense  | Copayment |
|--|-----------|
| Comprehensive <b>orthodontic treatment</b> of adolescent and adult dentition | \$2,400   |

## Eligible dental services

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### In-network coverage

This dental care schedule applies to **eligible dental services** provided by **primary care dentists (PCDs)** and other **in-network providers** upon **referral** from your **PCD**. The plan covers only the **eligible dental services** listed below.

#### Primary care services Type A expenses

##### Visits and exams

- Oral evaluation
- Oral hygiene instruction
- Consultation - second opinion
- Prophylaxis (cleaning) or scaling - moderate/severe inflammation - full mouth
- Topical application of fluoride or fluoride varnish if you are under age 16
- Sealants, per tooth (for permanent molars if you are under age 16)
- Sealant repair (for permanent molars if you are under age 16)
- Resin infiltration of incipient smooth surface lesions for permanent teeth only, if you are under age 16 (1 application every 3 years)
- Preventive resin restoration if you are under age 16 (1 application every 3 years for permanent molars)
- Diagnostic casts
- Emergency palliative treatment
- Application of hydroxyapatite regeneration medicament - per tooth (1 application every 3 years)
- Testing for cracked tooth

##### Images and pathology

- Bitewing Images
- Entire dental series, including bitewings, or panoramic film
- Vertical bitewing X-rays
- Periapical X-rays
- Intra-oral radiographic image
- Extra-oral radiographic image
- Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report
- Accession of tissue

**Space maintainers** - Only when needed to preserve space resulting from premature loss of deciduous teeth. Includes all adjustments within 6 months after installation.

- Fixed
- Removable

**Primary care services  
Type B expenses**

**Endodontics**

- Pulp cap
- Pulpotomy
- Pulpal debridement
- Pulpal therapy
- Pulpal regeneration
- Treatment of root canal obstruction
- Internal root repair
- Incomplete endodontic surgery
- Root canal therapy and retreatment, anterior & bicuspid
- Surgical procedure for isolation of tooth with rubber dam

**Restorative**

- Amalgam restoration
- Resin-based composite restoration
- Retention pins
- Placement of interim direct restoration
- Crowns - prefabricated and stainless steel (excluding temporary crowns)
- Re-cement
- Reattachment of tooth fragment
- Excavation of a tooth resulting in the determination of non-restorability

**Periodontics**

- Scaling and root planing, 1-3 teeth (1 per site every 2 years)
- Scaling and root planing, 4 or more teeth (4 separate quadrants, every 2 years)
- Periodontal maintenance procedures following active therapy (limited to 2 per year)
- Unscheduled dressing change

**Oral surgery** - Includes local anesthetics and routine post-operative care

- Extractions - coronal remnants - deciduous tooth
- Extractions erupted tooth or exposed root
- Surgical removal of erupted tooth
- Surgical removal of impacted tooth (soft tissue)
- Incision and drainage of abscess
- Excision of hyperplastic tissue
- Excision of pericoronal gingiva
- Removal of foreign body from soft tissue
- Surgical access of an unerupted tooth
- Suture

**Space maintainers** - Only when needed to preserve space resulting from premature loss of deciduous teeth. Includes all adjustments within 6 months after installation.

- Removal of fixed space maintainer

## Primary care services

### Type C expenses

**Restorations** - Multiple restorations in 1 surface will be considered as a single restoration

- Inlays
- Onlays
- Crowns (including build-ups)
- Crown repair
- Connector bar
- Labial veneers
- Post and core
- Core build up
- Pontics
- Removal of an indirect restoration on a natural tooth

**Prosthodontics** - Replacement of existing bridges or dentures is limited to 1 every 5 years. (See the *Replacement rule*.)

- Bridge abutments
- Pontics
- Dentures and partials - fees for dentures and partial dentures include relines, rebases and adjustments with 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.
  - Complete upper and lower denture
  - Partial upper and lower (including any conventional clasps, rests and teeth)
  - Removable unilateral partial denture
- Stress breakers
- Interim partial denture (stayplate), anterior only
- Reline (partial or complete)
- Rebase, per denture
- Special tissue conditioning, per denture
- Repairs: full and partial denture
- Replace missing or broken teeth, complete denture - per tooth
- Adding teeth and clasps to existing partial denture
- Procedures to construct new crown under existing partial denture framework
- Repairs: bridges
- Occlusal guard for bruxism (limited to 1 every 3 years)
- Adjustments, repairs or reline of occlusal guard (adjustments are not eligible within 6 months of the placement of the appliance)
- Cleaning and inspection of a removable appliance
- Accessing and retorquing loose implant screw - per screw

### Periodontics

- Full mouth debridement (limited to 1 per lifetime)

## Specialty care services

### Type B expenses

#### Endodontics - Includes local anesthetics

- Apexification/recalcification
- Apicoectomy
- Surgical repair of root resorption
- Retrograde filling
- Root amputation
- Hemisection

#### Oral surgery - Includes local anesthetics and post-operative care

- Surgical removal of residual tooth roots
- Closure of sinus perforation
- Oroantral fistula closure
- Transplantation of tooth
- Mobilization of erupted or malpositioned tooth to aid eruption
- Placement of device to facilitate eruption of impacted tooth
- Incisional biopsy of oral tissue
- Exfoliative cytological sample collection
- Alveoloplasty
- Removal of odontogenic cysts or tumors
- Removal of exostosis
- Removal of torus
- Surgical reduction of osseous tuberosity
- Removal of foreign body from bone
- Partial ostectomy/sequestrectomy
- Frenectomy/frenuloplasty
- Surgical reduction of fibrous tuberosity
- Sialolithotomy
- Closure of salivary fistula
- Excisional biopsy of minor salivary glands

#### Periodontics

- Gingivectomy/gingivoplasty, 1-3 teeth per quadrant (limited to 1 per quadrant every 3 years)
- Gingivectomy/gingivoplasty, 4 or more teeth per quadrant (limited to 1 per site every 3 years)
- Gingivectomy or gingivoplasty to allow access for restorative, per tooth procedure
- Gingival flap procedure, 1-3 teeth per quadrant (1 per quadrant every 3 years)
- Gingival flap procedure, 4 or more teeth per quadrant (limited to 1 per quadrant every 3 years)
- Apically positioned flap (limited to 1 per quadrant every 5 years)
- Occlusal adjustment

### Specialty care services

#### Type C expenses

**Endodontics** - Includes local anesthetics

- Molar root canal therapy and retreatment

**Intravenous sedation and general anesthesia sedation** - Only when provided in conjunction with a covered surgical procedure

- Evaluation by anesthesiologist for deep sedation or general anesthesia

**Oral surgery** - Includes local anesthetics and post-operative care

- Removal of impacted teeth, partially or completely bony
- Coronectomy

**Periodontics**

- Osseous surgery (including flap entry and closure), per quadrant (1 per site every 3 years)
- Soft tissue graft procedure
- Surgical revision procedure
- Clinical crown lengthening - hard tissue

**Infiltration of a sustained release therapeutic when provided as part of an eligible dental service** - Only for impacted wisdom teeth

**Prosthodontics**

- Implants (limited to 2 per year)

### Specialty care services

#### Type Orthodontic treatment expenses

- Orthodontic screening exam
- Orthodontic diagnostic records
- Orthodontic retention
- Comprehensive **orthodontic treatment** of adolescent dentition
- Post treatment stabilization
- Fixed or removable appliance therapy to correct harmful habits
- Re-cement, re-bond, or repair of fixed retainer limited **orthodontic treatment**

#### Important note:

The following apply:

- There is an extra charge for **eligible dental services** that use high noble metals (ex. gold or titanium).
- General anesthesia and sedation are **covered benefits** when part of a covered surgical procedure.

## Additional eligible dental services

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We will provide additional **eligible dental services** if you have at least one of the following conditions:

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

The additional **eligible dental services** are:

- Prophylaxis (cleaning) (one additional per **Calendar Year**)
- Scaling and root planing, (4 or more teeth), per quadrant
- Scaling and root planing, (1 to 3 teeth), per quadrant
- Full mouth debridement
- Periodontal maintenance

### Payment of benefits

We will waive the **coinsurance** for the additional **eligible dental services** above.

Your **coinsurance** applied to the additional **eligible dental services** will be:

| <b>Expense</b>                             | <b>In-network coverage</b> |
|--|----------------------------|
| Additional <b>eligible dental services</b> | 0%                         |