Schedule of benefits

Comprehensive dental insurance plan

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

Prepared for:

Policyholder:	Columbia University
Policyholder number:	GP-0619362
Schedule of benefits:	2A
Group policy effective date:	January 1, 2022
Plan name:	Dental Maintenance Organization – New Jersey Specialty Care Dentist Services
Plan effective date:	January 1, 2022
Plan issue date:	November 20, 2025
Plan revision effective date:	January 1, 2026

Underwritten by Aetna Life Insurance Company in the state of New Jersey

Schedule of benefits

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

How to read your schedule of benefits

- The **coinsurance** listed in the schedule of benefits below reflects the **coinsurance** amounts under your plan.
- You must pay your part of the **coinsurance**.
- The **coinsurance** listed in the schedule of benefits reflects the plan **coinsurance** percentage. This is the **coinsurance** amount the plan pays. You are responsible for paying any remaining **coinsurance**.
- You must pay the full amount of any dental care services you get that 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 a **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 the number on your ID card

The coverage described in this schedule of benefits will be provided under **Aetna Life Insurance Company's group policy**. This schedule of benefits replaces any schedule of benefits previously in effect under the **group policy**. Keep this schedule of benefits with your booklet-certificate.

General coverage provisions

This section explains the:

- **Coinsurance**
- **Copayment**

Coinsurance

The specific **coinsurance** percentage the plan pays for **eligible dental services**.

Copay, copayments

The specific dollar amount you have to pay for **eligible dental services**.

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 booklet-certificate.

Plan features

Coinsurance

Expenses	Coinsurance
Type B expenses	100% of the **recognized charge**
Type C expenses	60% of the **recognized charge**

Eligible dental services

Type B expenses: Basic restorative care

Endodontics

- 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

Type C expenses: Major restorative care

Endodontics

- Molar root canal therapy and retreatment

General anesthesia and intravenous sedation

- General anesthesia and intravenous sedation are covered when provided as part of a covered surgical procedure
- Evaluation by anesthesiologist for deep sedation or general anesthesia

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 procedure

Prosthodontics

- Implants (limited to 2 per year)

Type: Orthodontics 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**

Additional eligible dental services

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 (limited to 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. The **coinsurance** applied to the additional **eligible dental services** will be 100%. These additional benefits will not be subject to any frequency limits except as shown above.