Schedule of benefits

Health Maintenance Organization

Managed dental plan

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

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:

Contract holder:	Columbia University
Contract holder number:	GP-0619362-NC
Schedule of benefits:	1A
Group agreement effective date:	January 1, 2021
Plan name:	Dental Maintenance Organization - North Carolina
Plan effective date:	January 1, 2021
Plan issue date:	November 20, 2025
Plan revision effective date:	January 1, 2026

This is a legal contract

READ YOUR SCHEDULE OF BENEFITS CAREFULLY

Important cancellation information

Please read entire *When coverage ends* in the Booklet-Certificate section on page 28.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the company

Underwritten by Aetna Dental Inc. in the state of North Carolina

Schedule of benefits

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 **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 Dental 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

This section explains the:

- **Temporomandibular joint dysfunction/disorder (TMJ) lifetime maximum**

Temporomandibular joint dysfunction/disorder (TMJ) lifetime maximum

This maximum is the most the plan will pay for **eligible dental services** that you incur during your lifetime for the treatment of **TMJ**. You are responsible for any amounts above this maximum.

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

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 **orthodontic treatment** of adolescent and adult dentition	$2,400

Maximums	Amounts
Temporomandibular joint dysfunction/disorder (TMJ) lifetime maximum	$3,500

Eligible dental services

In-network coverage

This dental care schedule applies to **eligible dental services** provided by **primary care dentists** (**PCDs**) and other **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 (4 visits per year)
- Oral hygiene instruction
- Consultation - second opinion
- Prophylaxis (cleaning) or scaling - moderate/severe inflammation - full mouth (2 treatments per year)
- Topical application of fluoride or fluoride varnish if you are under age 16 (1 treatment per year)
- Sealants, per tooth, if you are under age 16 (1 application every 3 years for permanent molars)
- 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 (frequency combined with oral evaluations)

Images and pathology

- Bitewing Images (1 set per year)
- Entire dental series, including bitewings, or panoramic film (1 set every 3 years)
- Vertical bitewing X-rays (1 set every 3 years)
- 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

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:

Expense	**In-network coverage**
Additional **eligible dental services**	0%