

Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions



Aetna Student Health

Dental Plan Design and Benefits Summary

Preferred Provider Organization (PPO)

Columbia University

Policy Year: 2018 - 2019

Policy Number: 704502

www.aetnastudenthealth.com

(877) 238-6200



This Aetna Dental® Preferred Provider Organization (PPO) insurance plan summary is provided by Aetna Life Insurance Company (Aetna) for some of the more frequently performed dental procedures. Under this plan, you may choose at the time of service either a PPO participating dentist or any nonparticipating dentist. With the PPO plan, savings are possible because the PPO participating dentists have agreed to provide care for covered services at the negotiated fee schedule.

Who Is Covered

You, the Student to whom this Certificate is issued, are covered under this Certificate. Members of Your family may also be covered depending upon the type of coverage You selected.

Types of Coverage

We offer the following types of coverage:

Individual. If You selected individual coverage, then You are covered.

Individual and Spouse/Partner. If You selected individual and Spouse/Partner coverage, then You and Your Spouse/Partner are covered.

Parent and Child/Children. If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.

Family. If You selected family coverage, then You and Your Spouse/Partner and Your Child or Children, as described below, are covered.

Enrollment

You can enroll during an enrollment period established by Your Policyholder. If You, the Student, elect coverage before becoming eligible or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible or on the date determined by Your Policyholder.

If You do not enroll during the enrollment period established by Your Policyholder, You must wait until the next Plan Year enrollment period to enroll.

Children Covered Under this Certificate

If You selected parent and child/children or family coverage, Children covered under this Certificate include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. Coverage lasts until the [end of the [month; year] in which] the Child turns 19 years of age. Any unmarried Child who is a student at an accredited institution of learning is considered a Child until age 23 and coverage will last until the end of the year in which the Child turns 23 years of age.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request

that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this section.

Coverage shall continue for a Child who is a full-time student when the Child takes a medical leave of absence from school due to illness for a period of 12 months from the last day of attendance in school. However, coverage of the Child is not provided beyond the age at which coverage would otherwise terminate. To qualify for such coverage, We may require that the leave be certified as Medically Necessary by the Child's Physician who is licensed to practice in the state of New York.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Student and all other prospective or covered Members in relation to eligibility for coverage under this Certificate at any time.

Enrollment

To enroll the dependent(s) of a covered student, please complete the Enrollment Form by visiting www.aetnastudenthealth.com, selecting the school name, and clicking on the "Plans & Products Offered to You" link on the left hand side of the screen, or by calling customer service at (877) 238-6200 and requesting that an Enrollment Form be sent in the mail. Please refer to the Coverage Periods section of this document for coverage dates and deadline dates. Dependent enrollment applications will not be accepted after the enrollment deadline, unless there is a special significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan.) The completed Enrollment Form and premium must be sent to Aetna Student Health.

Coverage Periods

Students:

Coverage for all insured students enrolled for coverage in the Plan for the following Coverage Periods. Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below, and will terminate at 11:59 PM on the Coverage End Date indicated.

Dependents:

Coverage will become effective on the same date the insured student's coverage is effective. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy.

Coverage for all insured students enrolled for coverage in the Plan for the following Coverage Periods. Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below, and will terminate at 11:59 PM on the Coverage End Date indicated.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment Deadline Date
Annual	08/15/2018	08/14/2019	09/30/2018
Spring	01/01/2018	08/14/2019	02/15/2019

Rates

2018-2019 Dental Plan Rates

	Annual	Spring (new Students)
Student Only	\$392	\$242
Spouse/Partner Only	\$415	\$258
Per Child	\$630	\$391

Who provides the care

Just as the starting point for coverage under your plan is whether the services and supplies are eligible dental services, the foundation for getting covered care is through our network.

This section tells you about in-network and out-of-network providers.

In-network providers

In-network benefits are the highest level of coverage available. In-network benefits apply when Your care is provided by Participating Providers in our Preferred Provider Network. You should always consider receiving dental care services first through the in-network benefits portion of this Certificate.

You may select an in-network provider from the directory or by logging on to our website at www.aetnastudenthealth.com. You can search our online directory, DocFind®, for names and locations of dental providers.

You will not have to submit claims for treatment received from in-network providers. Your in-network provider will take care of that for you. And we will directly pay the in-network provider for what the plan owes.

Out-of-network providers

The out-of-network benefits portion of this Certificate provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider's charge.

Description of Benefits

The Plan excludes coverage for certain services (referred to as exceptions and exclusions in the certificate of coverage) and has limitations on the amounts it will pay. While this Plan Design and Benefit Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. To look at the full Plan description, which is contained in the Certificate of Coverage issued to you, go to www.aetnastudenthealth.com. If any discrepancy exists between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

This Plan will pay benefits in accordance with any applicable New York Insurance Law(s).

DENTAL CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost- Sharing	
Deductible <ul style="list-style-type: none"> • Individual • Family 	\$50 \$150	\$50 \$150	
Annual Maximum	\$1,500	\$1,500	
		See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how We calculate the Allowed Amount. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible. You must pay the amount of the Non-Participating Provider's charge that exceeds Our Allowed Amount.	

DENTAL CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost- Sharing	Limits
Type A Expenses	20% Coinsurance not subject to Deductible	20% Coinsurance not subject to Deductible	None
Type B Expenses	20% Coinsurance	20% Coinsurance	None
Type C Expenses	50% Coinsurance	50% Coinsurance	None
Orthodontics	Not Covered	Not Covered	None

Type A Expenses

- Oral exams once every 6 months (This includes prophylaxis, scaling, and cleaning of teeth)
- Topical application of sodium or stannous fluoride for persons under 15 years of age.
- X-rays for diagnosis (Also other X-rays not to exceed one full mouth series in a 36 month period and one set of bitewings in a 6 month period)
- Emergency palliative treatment
- First installation of a space maintainer to replace any baby tooth which is lost prematurely

Type B Expenses

- Oral surgery
- Extractions
- Sealants for permanent bicuspid and molars for persons under age 15, not to exceed one application in any 3 Plan Year period
- Fillings
- General anesthetics given in connection with covered dental services
- Treatment of diseased periodontal structures
- Endodontic treatment (This includes root canal therapy)
- Injection of antibiotic drugs

Type C Expenses

- Inlays, gold fillings, or crowns (this includes precision attachments for dentures)
- First installation of fixed bridgework to replace one or more natural teeth extracted while the person is covered (this includes inlays and crowns as abutments)
- Replacement of an existing removable denture or fixed bridgework by new fixed bridgework, or the adding of teeth to existing fixed bridgework (subject to the Replacement rule)
- Repair or recementing of crowns, inlays, bridgework, or dentures
- Relining of dentures
- First installation of removable dentures to replace one or more natural teeth extracted while the person is covered (This includes adjustments for the 6 month period following the date they were

installed)

- Replacement of an existing removable denture or fixed bridgework by a new denture, or the adding of teeth to a partial removable denture (subject to the Replacement rule)

Type A Expenses: Diagnostic & preventive care

Visits and exams

- Office visit during regular office hours for oral examination, (2 visits per year)
- Prophylaxis (cleaning) or scaling-moderate/severe inflammation–full mouth, (2 treatments per year)
- Topical application of fluoride if You are under age 14 (1 applications per year)
- HbA1c in-office point of service testing (1 tests per year)

Images and pathology

- Bitewing images (1 set per year)
- Entire dental series, including bitewings or panoramic film [(1-8) sets every [1-5 years] [6-60 months]]
- Vertical bitewing images (1 set every 5 years)

Type B Expenses: Basic restorative care

Visits and exams

- Office visit after hours (We will pay either for the office visit charge or for the dental care services performed, whichever is more)
- Emergency palliative treatment, per visit
- Sealants, per tooth (1 application every 5 years for permanent bicuspid and molars only and if You are under age 14)
- Sealant repair - per tooth (for permanent bicuspid and molars only and if You are under age 14)

Images and pathology

- Periapical images
- Intra-oral, occlusal view
- Extra-oral
- Accession of tissue
- Diagnostic casts

Restorative - Excluding inlays, onlays and crowns. Multiple restorations in 1 surface will be considered as a single restoration.

- Amalgam restorations
- Resin-based composite restorations, (other than for molars)
- Protective restoration
- Reattachment of tooth fragment, incisal edge or cusp
- Interim therapeutic restoration – primary dentition
- Pin retention, per tooth, in addition to restoration

Type C Expenses: Major restorative care

Restorative – Inlays, onlays, labial veneers and crowns (excludes temporary 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. Coverage is limited to 1 per tooth every 10 years. (See the *Replacement rule*.)

- Inlays
- Onlays
- Labial veneers
- Crowns
- Prefabricated crowns (excluding temporary crowns)
- Post and core
- Core build-up
- Recementation
- Repairs - inlay, onlay, veneer, crown

Endodontics

- Pulp cap
- Pulpal debridement
- Pulpal therapy
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root canal therapy and retreatment once per lifetime
 - Anterior
 - Bicuspid
 - Molar
- Pulpal regeneration
- Periradicular surgery without apicoectomy
- Hemisection
- Retrograde filling
- Root amputation
- Treatment of root canal obstruction
- Incomplete endodontic surgery
- Internal root repair of defect

Periodontics

- Periodontal maintenance (following active therapy, 1 per year)
- Occlusal adjustment, (other than with an appliance or by restoration)
- Osseous surgery, (including flap and closure), 1 to 3 teeth per quadrant (1 per site every 5 years)
- Osseous surgery, (including flap and closure), 4 or more per teeth per quadrant (1 per quadrant every 5 years)
- Soft tissue graft procedures
- Clinical crown lengthening - hard tissue

- Full mouth debridement (1 per lifetime)
- Bone grafts, first site in quadrant (1 per lifetime)
- Bone grafts, each additional site in quadrant (1 per lifetime)
- Root planing and scaling, 1 to 3 teeth per quadrant, (1 per site every 2 years)
- Root planing and scaling, 4 or more teeth per quadrant, (4 separate quadrants every 2 years)
- Scaling and debridement – (implant 1 tooth/teeth every 2 years)
- Surgical revision procedure, per tooth
- Gingivectomy/gingivoplasty, 1 to 3 teeth per quadrant, (1 per site every 3 years)
- Gingivectomy/gingivoplasty, 4 or more teeth per quadrant, (1 per quadrant every 3 years)
- Gingival flap procedure, 1 to 3 teeth per quadrant, (1 per quadrant every 3 years)
- Gingival flap procedure, 4 or more teeth per quadrant, (1 per site every 3 years)
- Apically positioned flap
- Unscheduled dressing change (by someone other than treating dentist or their staff)

Prosthodontics - The 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 less than 10 years old. (See the *Tooth missing but not replaced rule*.) Replacement of existing bridges, implants, or dentures is limited to 1 every 10 years. (See the *Replacement rule*.)

- Bridge abutments
- Pontics
- Implants
- Implant maintenance and repair
- 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 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
- Adjustment to denture more than 6 months after installation
- Repairs, full and partial denture
- Adding teeth and clasps to existing partial denture
- Repairs, bridges
- Occlusal guard for bruxism (1 every 5 years)
- Adjustments, repair or reline of occlusal guard
- Cleaning and inspection of a removable appliance

Oral surgery

- Extractions – coronal remnants – deciduous tooth
- Extractions erupted tooth or exposed root
- Surgical removal of impacted tooth (bony, including wisdom teeth)
- Surgical removal of erupted tooth
- Removal of impacted tooth
 - Soft tissue
 - Partially bony
 - Completely bony
- Surgical removal of residual tooth roots
- Coronectomy
- Primary closure of a sinus perforation
- Oroantral fistula closure
- Tooth transplantation
- Surgical access of unerupted tooth
- Mobilization of erupted or malpositioned tooth to aid eruption
- Placement of device to facilitate eruption of impacted tooth
- Biopsy of oral tissue
- Exfoliative cytological sample collection
- Alveoplasty
- Removal of odontogenic cysts or tumors
- Removal of exostosis
- Removal of torus
- Surgical reduction of osseous tuberosity
- Incision and drainage of abscess
- Removal of foreign body
- Sequestrectomy
- Suture of wounds
- Frenectomy/frenuloplasty
- Excision of hyperplastic tissue per arch
- Excision of pericoronal gingiva
- Surgical reduction of fibrous tuberosity
- Sialolithotomy
- Closure of salivary fistula
- Treatment of complications (post-surgical)

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

Nutritional counseling - Limited to nutritional counseling for the control of dental disease

Tobacco counseling - Limited to tobacco counseling for the control and prevention of oral disease

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

- Fixed or removable (unilateral or bilateral)
- Recementation or removal
- Appliance therapy to control harmful habits

Emergency Dental Care

Dental services include services and supplies provided for a dental emergency. Emergency Dental Care will be covered even if services and supplies are provided by a Non-Participating Provider.

If You have a dental emergency, You may get treatment from any dentist. You should consider calling Participating Providers who may be more familiar with Your dental needs. If You can't reach your Participating Providers or are away from home, You may get treatment from any dentist. You may also call Member Services for help in finding a dentist.

The care provided must be a covered service or supply. If you get treatment from a Non-Participating provider, the plan pays a benefit at the network level of coverage up to the dental emergency maximum. For follow-up care to treat the dental emergency, services will be paid at the appropriate Coinsurance level. To get the maximum level of benefits, services should be provided by Participating Providers.

Exclusions and Limitations

No coverage is available for the following:

Aviation.

We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

Convalescent and Custodial Care.

We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

Cosmetic Services.

We do not Cover cosmetic services or surgery unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

Coverage Outside of the United States, Canada or Mexico.

We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico.

Experimental or Investigational Treatment.

We do not Cover any health care service, procedure, treatment, or device that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

Felony Participation.

We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection.

Government Facility.

We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

Medical Services.

We do not Cover medical services or dental services that are medical in nature, including any Hospital charges or prescription drug charges.

Medically Necessary.

In general, We will not Cover any dental service, procedure, treatment, test or device that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test or device for which coverage has been denied, to the extent that such service, procedure, treatment, test or device is otherwise Covered under the terms of this Certificate.

Medicare or Other Governmental Program.

We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

Military Service.

We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

No-Fault Automobile Insurance.

We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

Services Not Listed.

We do not Cover services that are not listed in this Certificate as being Covered.

Services Provided by a Family Member.

We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse/partner, mother, father, sister, or brother of You or Your Spouse/Partner.

Services Separately Billed by Hospital Employees.

We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

Services with No Charge.

We do not Cover services for which no charge is normally made.

War.

We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

Workers' Compensation.

We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

The Columbia University Dental® Preferred Provider Organization (PPO) Student Dental Plan is underwritten and administered by Aetna Life Insurance Company (ALIC). Aetna Student HealthSM is the brand name for products and services provided by these companies and their applicable affiliated companies.

IMPORTANT NOTICES:

Notice of Non-Discrimination:

Aetna Life Insurance Company does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan including enrollment and benefit determinations.

Sanctioned Countries:

If coverage provided under this student policy violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for eligible health services if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting <http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

To access language services at no cost to you, call (877) 238-6200.

Para acceder a los servicios de idiomas sin costo, llame al (877) 238-6200. (Spanish)

如欲使用免費語言服務，請致電 (877) 238-6200。 (Chinese)

Afin d'accéder aux services langagiers sans frais, composez le (877) 238-6200. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa (877) 238-6200. (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie (877) 238-6200 an. (German)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم (877) 238-6200. (Arabic)

Pou jwenn sèvis lang gratis, rele (877) 238-6200. (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero (877) 238-6200.
(Italian)

言語サービスを無料でご利用いただくには、(877) 238-6200 までお電話ください。
(Japanese)

무료 언어 서비스를 이용하려면 (877) 238-6200 번으로 전화해 주십시오. (Korean)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-800-###-#### تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć (877) 238-6200.
(Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para (877) 238-6200.
(Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону (877) 238-6200. (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số (877) 238-6200.
(Vietnamese)