Aetna Student Health

Dental Plan Design and Benefits Summary

PPO Dental Max - Preferred Provider Organization (PPO)

Columbia University

Policy Year: 2024 - 2025
Policy Number: 696730
www.aetnastudenthealth.com/columbia
(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 60 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.

To enroll as a covered student, please complete the Enrollment Form by visiting www.aetnastudenthealth.com/columbia, selecting the school’s 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.

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, Stepchildren, 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 60 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.

**Dependent Enrollment**

To enroll the dependent(s) of a covered student, please complete the Enrollment Form by visiting [www.aetnastudenthealth.com/columbia](http://www.aetnastudenthealth.com/columbia), selecting the school’s 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.

<table>
<thead>
<tr>
<th>Coverage Period</th>
<th>Coverage Start Date</th>
<th>Coverage End Date</th>
<th>Enrollment Deadline Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual</td>
<td>08/15/2024</td>
<td>08/14/2025</td>
<td>09/30/2024</td>
</tr>
<tr>
<td>Spring</td>
<td>01/01/2025</td>
<td>08/14/2025</td>
<td>02/15/2025</td>
</tr>
</tbody>
</table>
## Rates

### 2024-2025 Dental Plan Rates

<table>
<thead>
<tr>
<th></th>
<th>Annual</th>
<th>Spring/Summer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Student Only</strong></td>
<td>$427.00</td>
<td>$427.00</td>
</tr>
<tr>
<td><strong>Spouse/Partner Only</strong></td>
<td>$453.00</td>
<td>$453.00</td>
</tr>
<tr>
<td><strong>Per Child</strong></td>
<td>$686.00</td>
<td>$686.00</td>
</tr>
</tbody>
</table>

### 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](http://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](http://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).

<table>
<thead>
<tr>
<th>DENTAL CARE</th>
<th>Participating Provider</th>
<th>Non-Participating Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>Member Responsibility for Cost-Sharing</td>
<td>Member Responsibility for Cost-Sharing</td>
</tr>
<tr>
<td>Individual</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Family</td>
<td>$150</td>
<td>$150</td>
</tr>
<tr>
<td><strong>Annual Maximum</strong></td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>DENTAL CARE</th>
<th>Participating Provider</th>
<th>Non-Participating Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type A expenses</strong></td>
<td>10% Coinsurance not subject to Deductible</td>
<td>10% Coinsurance not subject to Deductible</td>
</tr>
<tr>
<td><strong>Type B expenses</strong></td>
<td>20% Coinsurance after Deductible</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td><strong>Type C expenses</strong></td>
<td>50% Coinsurance after Deductible</td>
<td>50% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
Type A expenses: Diagnostic & preventive care

Visits and exams
- Office visit during regular office hours for oral examination (2 routine visits and 2 problem focused 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 16, (1 applications per year)
- Sealant repair - per tooth (for permanent molars only and if you are under age 16)
- Sealants, per tooth (1 application every 3 years for permanent molars only and if you are under age 16)

Images and pathology
- Bitewing images (1 set per year)
- Entire dental series, including bitewings or panoramic film (1 set every 3 years)
- Vertical bitewing images (1 sets every 3 years)
- Periapical images

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

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 eligible dental services performed, whichever is more)
- Emergency palliative treatment, per visit

Images and pathology
- Intra-oral, occlusal view
- Extra-oral
- Accession of tissue

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
- Recementation
- Prefabricated crowns, primary teeth only (excluding temporary crowns)
Periodontics
- Periodontal maintenance (following active therapy, 2 per year)
- Occlusal adjustment, (other than with an appliance or by restoration)
- 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, (1 separate quadrants 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 site every 3 years)
- Gingival flap procedure, 4 or more teeth per quadrant, (1 per quadrant every 3 years)
- Apically positioned flap
- Unscheduled dressing change (by someone other than treating dentist or their staff)

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

Oral surgery
- Extractions – coronal remnants – deciduous tooth
- Extractions erupted tooth or exposed root
- Surgical removal of erupted tooth
- Surgical removal of residual tooth roots
- 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
• Alveoloplasty
• 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
• Removal of impacted tooth-Soft tissue
• Sialolithotomy
• Closure of salivary fistula

**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 8 years. (See the Replacement rule.)

• Inlays
• Onlays
• Labial veneers
• Crowns
• Post and core
• Repairs - inlay, onlay, veneer, crown

**Periodontics**

• Osseous surgery, (including flap and closure), 1 to 3 teeth per quadrant (1 per site every 3 years)
• Osseous surgery, (including flap and closure), 4 or more per teeth per quadrant (1 per quadrant every 3 years)
• Soft tissue graft procedures
• Full mouth debridement (1 per lifetime)

**Endodontics**

• Root canal therapy and retreatment once per lifetime
  - Molar
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 8 years old. (See the Tooth missing but not replaced rule.) Replacement of existing bridges, implants, or dentures is limited to 1 every 8 years. (See the Replacement rule.)

- Bridge abutments
- 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 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 3 years)
- Adjustments, repair or reline of occlusal guard
- Cleaning and inspection of a removable appliance

Oral surgery
- Surgical removal of impacted tooth (bony, including wisdom teeth)
- Coronectomy
- Removal of impacted tooth
  - Partially bony
  - Completely bony

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
Emergency Dental Care
Eligible dental services include dental services provided for a dental emergency. The care provided must be a covered benefit. If you have a dental emergency, you should consider calling your dental in-network provider who may be more familiar with your dental needs. However, you can get treatment from any dentist including one that is an out-of-network provider. If you need help in finding a dentist, call Member Services at the toll-free number on the back of your ID card.

If you get treatment from an out-of-network provider for a dental emergency, the plan pays a benefit at the in-network cost-sharing level of coverage. For follow-up care to treat the dental emergency, you should consider using your in-network dental provider so that you can get the maximum level of benefits. Follow-up care will be paid at the cost-sharing level that applies to the type of provider that gives you the care.

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 dental 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, mother, father, sister, or brother of You or Your Spouse.
**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.

**Vision Services.**
We do not Cover the examination or fitting of eyeglasses or contact lenses.

**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.
**Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-480-4161.

**Smartphone or Tablet**

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

**Non-Discrimination**

Aetna is committed to being an inclusive health care company. Aetna does not discriminate on the basis of ancestry, race, ethnicity, color, religion, sex/gender (including pregnancy), national origin, sexual orientation, gender identity or expression, physical or mental disability, medical condition, age, veteran status, military status, marital status, genetic information, citizenship status, unemployment status, political affiliation, or on any other basis or characteristic prohibited by applicable federal, state or local law.

Aetna provides free aids and services to people with disabilities and free language services to people whose primary language is not English.

These aids and services include:

- Qualified language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Qualified interpreters
- Information written in other languages

If you need these services, contact the number on your ID card. Not an Aetna member? Call us at 1-877-480-4161.

If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-877-480-4161.

*Please note, Aetna covers health services in compliance with applicable federal and state laws. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations, and conditions of coverage.*

**Language accessibility statement**

*Interpreter services are available for free.*

Attention: If you speak English, language assistance service, free of charge, are available to you. Call **1-877-480-4161** (TTY: **711**).

**Español/Spanish**

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-480-4161** (TTY: **711**).
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العربية/Arabic

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجاني. اتصل برقم 1-877-480-4161 (رقم الهاتف النصي: 711).

ہیڈژھر یۆسو/ussion

Bàsòò Wùqù/Bassa


中文/Chinese

注意：如果您说中文，我们可为您提供免费的语言协助服务。请致电 1-877-480-4161 (TTY: 711)。

فارسی/Farsi

توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارائه می‌گردد، با شماره 1-877-480-4161 (TTY: 711) تماس بگیرید.

Français/French

Attention : Si vous parlez français, vous pouvez disposer d'une assistance gratuite dans votre langue en composant le 1-877-480-4161 (TTY: 711).

ગુજરાતી/Gujarati


Kreyòl Ayisyen/Haitian Creole


Igbo


한국어/Korean

Português/Portuguese


Русский/Russian


Tagalog


اردو/Urdu


Tiếng Việt/Vietnamese


Yorùbá/Yoruba


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).