BENEFIT PLAN

Prepared Exclusively For
California Institute of Technology

Passive PPO Dental - Pre 65 Retirees

What Your Plan Covers and How Benefits are Paid

Aetna Life Insurance Company
Booklet-Certificate

This Booklet-Certificate is part of the Group Insurance Policy between **Aetna** Life Insurance Company and the Policyholder

Preferred Provider Organization (PPO)
Dental Insurance Plan

Booklet-Certificate

Prepared exclusively for

Policyholder:	California Institute of Technology
Policyholder number:	869105
Booklet-certificate	1
Group policy effective date:	January 1, 2020
Insurance plan effective date:	January 1, 2020
Insurance plan issue date:	December 10, 2019

Underwritten by Aetna Life Insurance Company

TIMELY ACCESS TO CARE

Standards for timely access to dental benefits include:

- Urgent care within 48 hours of the request
- Non-urgent care within 36 business days of the request
- Preventive care within 40 days of the request

We may have exceptions to appointment wait times when the Department of Insurance allows such exceptions. Interpreter services will be made available to you at the time of your appointment.

NOTICE: If you have a complaint, including because you cannot access dental care in a timely manner, you can contact us at the number shown on your ID card. You can also write to us at:

Member Services
Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

If you are not satisfied with our resolution, you can contact the California Department of Insurance with your concerns. You can contact them at:

California Department of Insurance
Consumer Services Division
300 South Spring Street
South Tower
Los Angeles, CA 90013
1-800-927-HELP (4357)
TDD: 1-800-482-4TDD (4833)
www.insurance.ca.gov

Welcome

Thank you for choosing **Aetna**.

This is your booklet-certificate. It is one of three documents that together describe the benefits covered by your **Aetna** plan for in-network and out-of-network coverage.

This booklet-certificate will tell you about your **covered benefits** – what they are and how you get them. If you become covered, this booklet-certificate becomes your certificate of coverage under the **group policy**, and it replaces all certificates describing similar coverage that we sent to you before. The second document is the schedule of benefits. It tells you how we share expenses for **eligible dental services** and tells you about limits – like when your plan covers only a certain number of visits.

The third document is the **group policy** between **Aetna Life Insurance Company** ("**Aetna**") and the policyholder. Ask the policyholder if you have any questions about the **group policy**.

Sometimes, we may send you documents that are amendments, endorsements, attachments, inserts or riders. They change or add to the documents that they're part of. When you receive these, they are considered part of your **Aetna** plan for coverage.

Where to next? Try the *Let's get started!* section. *Let's get started!* gives you a summary of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your **Aetna** plan.

IMPORTANT: If you choose to receive dental services that are not **covered benefits** under this plan, a participating **dental provider** may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a **covered benefit**, the **dentist** should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call Member Services at 1-877-238-6200. To fully understand your coverage, you should carefully review this booklet-certificate.

THE INSURANCE DESCRIBED IN YOUR CERTIFICATE-BOOKLET IS A PREFERRED PROVIDER ORGANIZATION (PPO) PLAN. YOU WILL BE COVERED FOR BOTH IN-NETWORK AND OUT-OF-NETWORK BENEFITS REGARDLESS OF WHERE YOU LIVE.

WE WILL PAY FOR **EMERGENCY SERVICES** AT THE IN-NETWORK LEVEL.

GENERALLY, SERVICES WILL NOT BE PAID AT THE IN-NETWORK LEVEL IF THE THEY ARE RECEIVED FROM AN **OUT-OF-NETWORK PROVIDER**. ANY SERVICES PROVIDED BY AN **OUT-OF-NETWORK PROVIDER**:

- WILL BE PAID AT A LOWER PERCENTAGE
- MAY BE SUBJECT TO HIGHER OUT-OF-POCKET LIMIT AND **DEDUCTIBLE** AMOUNTS

A LISTING OF ALL **IN-NETWORK PROVIDERS** IN YOUR SERVICE AREA MAY BE ACCESSED AT ANY TIME IN OUR DIRECTORY. YOU CAN SEARCH THE DIRECTORY AT WWW.AETNA.COM UNDER THE DOCFIND® LABEL.

Table of Contents

Let's get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details – and this is very important – you need to read this entire booklet-certificate and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

Some notes on how we use words in the booklet-certificate and schedule of benefits

- When we say "you" and "your", we mean both you and any covered dependents.
- When we say "us", "we", and "our", we mean **Aetna**.
- Some words appear in **bold** type and we define them in the *Glossary* section.

Sometimes we use technical dental language that is familiar to **dental providers**.

What your plan does – providing covered benefits

Your plan provides in-network and out-of-network **covered benefits**. These are **eligible dental services** for which your plan has the obligation to pay.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after the eligibility and enrollment process is completed. To learn more see the *Who the plan covers* section.

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons, such as growing up and leaving home. To learn more see the *When coverage ends* section.

Ending coverage under the plan doesn't necessarily mean you lose coverage with us. See the *Special coverage options after your plan coverage ends* section.

How your plan works while you are covered in-network

Your in-network coverage helps you:

- Get and pay for a lot of – but not all – dental care services. These are called **eligible dental services**
- Pay less cost share when you use a **in-network provider**

Important note:
See the schedule of benefits for any **deductibles**, **coinsurance**, and maximum age or visit limits that may apply.

Eligible dental services

Eligible dental services meet these requirements:

- They are listed in the *Eligible dental services* section in the schedule of benefits.
- They are not carved out in the *What your plan doesn't cover – some eligible dental service exceptions and exclusions* section. (We refer to this section as the "Exceptions" section.)
- They are not beyond any limits in the schedule of benefits.

Aetna's network of dental providers

Aetna's network of **dental providers** is there to give you the care you need. You can find **in-network providers** and see important information about them most easily on our online **provider directory**. Just log into your secure member website at www.aetna.com.

You can choose any **dental provider** who is in the dental network.

Your plan often will pay a bigger share for **eligible dental services** that you get through **in-network providers**, so choose **in-network providers** as soon as you can.

For more information about the **provider directory** and the role of your **dental provider**, see the *Who provides the care* section.

Paying for eligible dental services– the general requirements
There are general requirements for the plan to pay any part of the expense for an **eligible dental service**. They are:

- The **eligible dental service** is **medically necessary**.
- You get the **eligible dental services** from **in-network** or **out-of-network providers**.

You will find details on **medical necessity** requirements in the *Medical necessity* section.

Paying for eligible dental services– sharing the expense
Generally your plan and you will share the expense of your **eligible dental services** when you meet the general requirements for paying.

But sometimes your plan will pay the entire expense; and sometimes you will. For more information see the *What the plan pays and what you pay* section, and see the schedule of benefits.

How your plan works while you are covered out-of-network

The section above told you how your plan works while you are covered in-network. You also have coverage when you want to get your care from **providers** who are not part of the **Aetna** network. It's called out-of-network coverage.

Your out-of-network coverage:

- Means you can get care from **dental providers** who are not part of the **Aetna** network.
- Means you may have to pay for services at the time that they are provided. You may be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of **eligible dental services** that you paid directly to a **dental provider.**
- Means you will pay a higher cost share when you use an **out-of-network provider**.

You will find details on:

- **Out-of-network providers** and any exceptions in the *Who provides the care* section. Cost sharing in the *What the plan pays and what you pay* section, and your schedule of benefits.
- Claim information in the *When you disagree - claim decisions and appeals procedures* section.

How to contact us for help

We are here to answer your questions. You can contact us by:

- Logging onto your secure member website at www.aetna.com
- Registering for our secure Internet access to reliable dental information, tools and resources

Online tools will make it easier for you to make informed decisions about your dental care, view claims, research care and treatment options, and access information.

You can also contact us by:

- Calling **Aetna** Member Services at 1-877-238-6200
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156

Your ID card

You don't need to show an ID card. When visiting a **dentist**, just provide your name, date of birth and either your ID or social security number. The dental office can use that information to verify your eligibility and benefits. Your ID is located on the front of your digital ID card which you can view or print by going to the secure member website at www.aetna.com. If you don't have internet access, call us at 1-877-238-6200. You can also access your ID card when you're on the go. To learn more, visit us at www.aetna.com/mobile.

Who the plan covers

You will find information in this section about:

- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible

The policyholder decides and tells us who is eligible for dental care coverage.

When you can join the plan

As an employee you can enroll yourself and your dependents:

- At any time
- Once each **Calendar Year** during the annual enrollment period
- At other special times during the year (see the *Special times you and your dependents can join the plan* section below)

If you do not enroll yourself and your dependents when you first qualify for dental benefits, you may have to wait until the next annual enrollment period to join.

Who can be on your plan (who can be your dependent)

If your plan includes coverage for dependents, you can enroll the following family members on your plan. (They are referred to in this booklet-certificate as your "dependents".)

- Your legal spouse
- Your civil union partner
- Your registered domestic partner who meets the requirements under state law
- Your dependent children – your own or those of your spouse or registered domestic partner
    - Under age 26
    - They include:
        - Biological children
        - Stepchildren
        - Legally adopted children, including any children placed with you for adoption
        - Foster children
        - Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)
        - Grandchildren in your court-ordered custody

You may continue coverage for a disabled child past the age limit shown above. See the *Continuation of coverage for other reasons* in the *Special coverage options after your plan coverage ends* section for more information.

Adding new dependents

You can add the following new dependents any time during the year:

- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask the policyholder when benefits for your spouse will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information
    - Within 31 days of the date of your marriage.
- A civil union partner - If you enter a civil union, you can put your civil union partner on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your civil union.
  - Ask the policyholder when benefits for your civil union partner will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information
    - Within 31 days of the date of your civil union.
- A registered domestic partner - If you enter a domestic partnership, you can enroll your registered domestic partner on your dental plan.
  - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership.
  - Ask the policyholder when benefits for your domestic partner will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information
    - Within 31 days of the date of your Domestic Partnership.
- A newborn child - Your newborn child is covered on your dental plan for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information within 31 days of birth.
  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have dental benefits after the first 31 days.
- An adopted child - A child that you, or that you and your spouse or registered domestic partner adopts is covered on your plan for the first 31 days after the adoption is complete or the date the child is placed for adoption. “Placed for adoption” means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child.
  - To keep your adopted child covered, we must receive your completed enrollment information within 31 days after the adoption or the date the child was placed for adoption.
  - If you miss this deadline, your adopted child will not have dental benefits after the first 31 days.
- A stepchild - You may put a child of your spouse or registered domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild’s parent.
  - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage, the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.

Inform us of any changes

It is important that you inform us of any changes that might affect your benefit status. This will help us effectively deliver your benefits. Please contact us as soon as possible with changes such as:

- Change of address or phone number
- Change in marital status
- Change of covered dependent status
- A covered dependent who enrolls in any other group dental plan

Late entrant rule
The plan does not cover services and supplies given to a person age 5 or older if that person did not enroll in the plan during one of the following:

- The first 31 days the person is eligible for this coverage or
- Any period of open enrollment agreed to by the policyholder and us

This does not apply to charges incurred for any of the following:

- After the person has been covered by the plan for 12 months
- As a result of **injuries** sustained while covered by the plan
- Diagnostic and preventive services such as exams, cleanings, fluoride, and images (orthodontia related services are not included).

Special times you and your dependents can join the plan

You can enroll in these situations:

- When you did not enroll in this plan before because:
  - You were covered by another group dental plan, and now that other coverage has ended.
  - You had COBRA, and now that coverage has ended.
- You have added a dependent because of marriage, birth, adoption or foster care. See the *Adding new dependents* section for more information.
- When a court orders that you cover a current spouse, domestic partner, or a minor child on your dental plan.

We must receive your completed enrollment information from you within 31 days of that date on which you no longer have the other coverage mentioned above.

Effective date of coverage

Your coverage will be in effect as of the date you become eligible for dental benefits.

Medical necessity requirements

The starting point for **covered benefits** under your plan is whether the services and supplies are **eligible dental services.** See the *Eligible dental services* and *Exclusions* sections plus the schedule of benefits.

Your plan pays for its share of the expense for **eligible dental services** only if the **eligible dental service** is **medically necessary**.

This section addresses the **medical necessity** requirements.

Medically necessary / medical necessity

As we said in the *Let's get started!* section, **medical necessity** is a requirement for you to receive a **covered benefit** under this plan.

The **medical necessity** requirements are in the *Glossary* section, where we define "**medically necessary**, **medical necessity**".

What are your eligible dental services?

The information in this section is the first step to understanding your plan's **eligible dental services**. If you have questions about this section, see the *How to contact us for help* section.

Your plan covers many kinds of dental care services and supplies. Your **eligible dental services** are listed in the schedule of benefits. There you will find the detailed list of **eligible dental services**. But sometimes those services are not covered at all or are covered only up to a limit.

You can find out about exclusions in the *Exceptions* and the *What rules and limits apply to dental care* sections, and about the limitations in the schedule of benefits.

Dental emergency

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.

What rules and limits apply to dental care?

Several rules apply to the dental benefits. Following these rules will help you use your plan to your advantage by avoiding expenses that are not covered by your plan.

Alternate treatment rule

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results.

If a charge is made for a non-eligible dental service or supply and an **eligible dental service** that would provide an acceptable result, then your plan will pay a benefit for the **eligible dental service** or supply.

If a charge is made for an **eligible dental service** but another **eligible dental service** that would provide an acceptable result is less expensive, the benefit will be for the least expensive **eligible dental service**.

The benefit will be based on the **in-network provider**'s **negotiated charge** for the **eligible dental service** or, in the case of an **out-of-network provider**, on the **recognized charge**.

You should review the differences in the cost of alternate treatment with your **dental provider**. Of course, you and your **dental provider** can still choose the more costly treatment method. You are responsible for any charges in excess of what your plan will cover.

Coverage for dental work begun before you are covered by the plan

Your plan does not cover dental work that began before you were covered by the plan. This means that the following dental work is not covered:

- An appliance, or modification of an appliance, if an impression for it was made before you were covered by the plan
- A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before you were covered by the plan
- Root canal therapy, if the pulp chamber for it was opened before you were covered by the plan

Orthodontic treatment rule

Orthodontic treatment is covered only for covered dependent children who are under age 20 on the date active **orthodontic treatment** begins.

This benefit does not cover charges for the following:

- Interceptive **orthodontic treatment**
- Limited **orthodontic treatment**
- Replacement of broken appliances
- Re-treatment of orthodontic cases
- Changes in treatment necessitated by an accident
- Maxillofacial surgery
- Myofunctional therapy
- Treatment of cleft palate
- Treatment of micrognathia
- Treatment of macroglossia
- Lingually placed direct bonded appliances and arch wires (i.e. "invisible braces")
- Appliance therapy (to control harmful habits)

The plan will not cover the charges for an orthodontic procedure if an active appliance for that procedure was installed before you were covered by the plan.

Orthodontic limitation for late enrollees

The plan will not cover the charges for an orthodontic procedure for which an active appliance for that procedure has been installed within the 2 year period starting with the date you became covered by the plan. This limit applies only if you do not become enrolled in the plan within 31 days after you first become eligible.

Reimbursement policies

We have the right to apply **Aetna** reimbursement policies. Those policies may reduce the **negotiated charge** or **recognized charge.** These policies take into account factors such as:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided and
- The educational level, licensure or length of training of the provider

Aetna reimbursement policies are based on our review of:

- The Centers for **Medicare** and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of dental practice and
- The views of **providers** and **dentists** practicing in the relevant clinical areas

We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Replacement rule

Some **eligible dental services** are subject to your plan's replacement rule. The replacement rule applies to replacements of, or additions to existing:

- Crowns
- Inlays
- Onlays
- Implants
- Veneers
- Complete dentures
- Removable partial dentures
- Fixed partial dentures (bridges)
- Other prosthetic services

These **eligible dental services** are covered only when you give us proof that:

- While you were covered by the plan:
  - You had a tooth (or teeth) extracted after the existing denture or bridge was installed.
  - As a result, you need to replace or add teeth to your denture or bridge.
- The present item cannot be made serviceable, and is:
  - A crown installed at least 8 years before its replacement.
  - An inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), implant, or other prosthetic item installed at least 8 years before its replacement.
- While you were covered by the plan:
  - You had a tooth (or teeth) extracted.
  - Your present denture is an immediate temporary one that replaces that tooth (or teeth).
  - A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Tooth missing but not replaced rule

The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges or other prosthetic items are needed to replace one or more natural teeth that were removed while you were covered by the plan. (The extraction of a third molar tooth does not qualify.)
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 8 years.

Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

An advance claim review

The purpose of an advance claim review is to provide an estimate, in advance, of what we may pay for proposed services. Knowing ahead of time which services are **eligible dental services** and what your plan may pay helps you and your **dentist** make informed decisions about the care you are considering. The estimate is not a guarantee of coverage and payment.

In estimating the amount of benefits payable, we will look at alternate procedures, services, or courses of treatment for the dental condition in question in order to meet the expected result.

The estimate is voluntary. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups or any other service.

When to get an advance claim review

An estimate is recommended whenever a course of dental treatment is likely to cost more than $100. Here are the steps involved with getting an advance claim review:

1. Ask your **dentist** to write down a full description of the treatment you need. They must either use an **Aetna** claim form or an American Dental Association (ADA) approved claim form.
2. Your **dentist** should send the form to us before treating you.
3. We may request supporting images and other diagnostic records.
4. Once all of the information has been gathered, we will review the proposed treatment plan and provide you and your **dentist** with a statement outlining the estimated benefits payable.
5. You and your **dentist** can then decide how to proceed.

What is a course of dental treatment?

A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more **dentists** to treat a dental condition that was diagnosed by the attending **dentist** as a result of an oral examination. A course of treatment starts on the date your **dentist** first renders a service to correct or treat the diagnosed dental condition.

What your plan doesn't cover –eligible dental service exceptions and exclusions

We already told you about the many dental care services and supplies that are eligible for coverage under your plan in the *What are your eligible dental services* section. In that section we also told you that some dental care services and supplies have exceptions and some are not covered at all (exclusions).

In this section we tell you about the exceptions and exclusions that apply to your plan.

And just a reminder, you'll find benefit and coverage limitations in the schedule of benefits.

Exceptions and exclusions

The following are not **eligible dental services** under your plan except as described in:

- The *Eligible dental services under your plan* section of this booklet-certificate or
- A rider or amendment issued to you for use with this booklet-certificate:

Charges for services or supplies

- Provided by **in-network providers** in excess of the **negotiated charge**
- Provided by an **out-of-network provider** in excess of the **recognized charge**
- Provided for your personal comfort or convenience, or the convenience of any other person, including a **dental provider**
- Cancelled or missed appointment charges or charges to complete claim forms
- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage, including:
  - Care in charitable institutions
  - Care for conditions related to current or previous military service
  - Care while in the custody of a governmental authority

Charges in excess of any benefit limits

Any charges in excess of the benefit, dollar, visit, or frequency limits stated in the schedule of benefits.

Cosmetic services and plastic surgery (except to the extent coverage is specifically provided in the *Eligible Dental Services* section of the schedule of benefits)

- **Cosmetic** services and supplies including:
  - Plastic surgery
  - Reconstructive surgery
  - **Cosmetic** surgery
  - Personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
  - Augmentation and vestibuloplasty and other services to protect, clean, whiten, bleach, alter the appearance of teeth whether or not for psychological or emotional reasons

  Facings on molar crowns and pontics will always be considered **cosmetic**

Court-ordered services and supplies

- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding.

Dental services and supplies

- Acupuncture, acupressure and acupuncture therapy
- Crown, inlays and onlays, and veneers unless for one of the following:
  - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants
- Dentures, crowns, inlays, onlays, bridges, or other prosthetic appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion
- First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth, all of which were lost while you were not covered
- General anesthesia and intravenous sedation, unless specifically covered and done at the same time as and for the same reason as another **eligible dental service**
- Instruction for diet, tobacco counseling and oral hygiene
- Mail order and at-home kits for orthodontic treatment
- **Orthodontic treatment** except as covered in the *Eligible Dental Services* section of the schedule of benefits
- Dental services and supplies made with high noble metals (gold or titanium) except as covered in the *Eligible Dental Services* section of the schedule of benefits
- Services and supplies directly related to treatment or care that is not covered under the plan, (meaning the service or supply is only provided because the noncovered service or supply is provided)
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth
- Surgical removal of impacted wisdom teeth when removed only for orthodontic reasons
- **Temporomandibular joint dysfunction/disorder**

Dental services and supplies that are covered in whole or in part:

- Under any other plan of group benefits provided by the policyholder

Examinations

Any dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- Because a court order requires it.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

Experimental or investigational

- **Experimental or investigational** drugs, devices, treatments or procedures

Non-medically necessary services

- Services, including but not limited to, those treatments, services, prescription drugs and supplies which are not **medically necessary** for the diagnosis and treatment of **illness**, **injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

Other primary payer

- Payment for a portion of the charge that another party is responsible for as the primary payer

Outpatient prescription drugs, and preventive care drugs and supplements

- Prescribed drugs, pre-medication or analgesia

Personal care, comfort or convenience items

- Any service or supply primarily for your convenience and personal comfort or that of a third party

Providers and other health professionals

- Charges submitted for services by an unlicensed **provider** or not within the scope of the **provider's** license.

Services paid under your medical plan

- Your plan will not pay for amounts that were paid for the same services under a medical plan covering you. When a dental service is covered under both plans, we will figure the amount that would be payable under this plan if you did not have other coverage, then subtract what was paid by your medical plan. If there is any difference, this plan will pay it. If the amount paid by your medical plan is equal to or more than the benefit under this plan, this plan will not pay anything for the service.

Services provided by a family member

- Services provided by a spouse, civil union partner, domestic partner, parent, child, step-child, brother, sister, in-law or any household member

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

Network providers
We have contracted with **dental providers** to provide **eligible dental services** to you. These **dental providers** make up the network for your plan. For you to receive the network level of benefits you must use **network providers** for **eligible dental services**.

There is an exception for **dental emergency services**:

- **Dental emergency services** – refer to the description of a **dental emergency** in the *What are your eligible dental services?* section.

Out-of-network dental providers
You also have access to **out-of-network providers**. This means you can receive **eligible dental services** from an **out-of-network provider**. If you use an **out-of-network provider** to receive **eligible dental services**, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying your out-of-network **deductible**
- Your out-of-network **coinsurance**
- Any charges over our **recognized charge**
- Submitting your own claims

Keeping a provider you go to now (continuity of care)

You may have to find a new **dental provider** when:

- You join the plan and the **dental provider** you have now is not in the network
- You are already under an **Aetna** plan and your **dental provider** stops being in our network (for reasons other than imminent harm to patients, a determination of fraud, or a final state disciplinary action by a licensing board)

However, in some cases, you may be able to keep going to your current **provider** to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

Care will continue during a transitional period that will vary based on your condition.

If you have this condition	**The length of transitional period is**
Acute condition	As long as the condition lasts
Serious chronic condition	No more than 12 months. Usually until you complete a period of treatment and your **physician** can safely transfer your care to another **physician**.
Care of a child under 3 years	Up to 12 months
An already scheduled **surgery** or other procedure	Within 180 days of you joining the **Aetna** plan or your **provider** leaving the network

Acute condition means:

- A medical condition that appears suddenly
- A medical problem that requires immediate medical care and does not last long

Serious chronic condition means:

- A medical condition due to a disease or other medical problem
- A medical disorder that is serious and:
  - Continues without full cure
  - Worsens over time
  - Requires ongoing treatment to maintain remission or prevent deterioration

You or your **provider** should call us for approval to continue any care. You can also call Member Services at the number on the back of your ID card to get a copy of our policy on continuity of care.
Your claim will be paid at the **network provider** cost sharing level.

We will authorize coverage for the transitional period only if the **provider** agrees to our usual terms and conditions for contracting **providers**.

What the plan pays and what you pay

Who pays for your **eligible dental services** – this plan, both of us, or just you? That depends. This section gives the general rule and explains these key terms:

- Your **deductible**
- Your **coinsurance**
- Your maximums

We also remind you that sometimes you will be responsible for paying the entire bill – for example, if you get care that is not an **eligible dental service**.

The general rule

When you get **eligible dental services**:

- You pay your **deductible**

  And then

- Your plan and you share the expense up to any **Calendar Year** and **lifetime maximum**. The schedule of benefits lists how much you pay and how much your plan pays. The **coinsurance** percentage may vary by the type of expense. Your share is called **coinsurance** percentage.

  And then

- You are responsible for any amounts above the **maximum**.

When we say "expense" in this general rule, we mean the **negotiated charge** for **in-network providers**, and **recognized charge** for **out-of-network providers**. See the *Glossary* section for what these terms mean.

Important note – when you pay all

You pay the entire expense for an **eligible dental service**:
When you get a dental care service or supply that is not **medically necessary**. See the *Medical necessity requirements* section.

In all these cases, the **dental provider** may require you to pay the entire charge. And any amount you pay will not count towards your **deductible** or towards your **Calendar Year** or lifetime **maximum**.

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses or costs in excess of the **negotiated charge** for in-network **covered benefits**

Where your schedule of benefits fits in

This section explains some of the terms you will find in your schedule of benefits.

How your deductible works

Your **deductible** is the amount you need to pay for **eligible dental services** per **Calendar Year** before your plan begins to pay for **eligible dental services**. Your schedule of benefits shows the **deductible** amounts for your plan.

How we count your deductible

When you see in-network **providers**, we count the **negotiated charge** toward your in-network **deductible**. When you see **out-of-network providers**, we count the **recognized charge** toward your **out-of-network deductible**.

How your coinsurance works

Your **coinsurance** is the amount your plan pays for **eligible dental services** after you have paid your **deductible**. Your schedule of benefits shows you which **coinsurance** your plan will pay for specific **eligible dental services**.

How your maximum works

The maximum is the most your plan will pay for **eligible dental services** per **Calendar Year** and lifetime incurred by you or your covered dependent after any applicable **deductible** and **coinsurance**. You are responsible for any amounts above the **maximum**.

Important note:
See the schedule of benefits for any **deductibles, coinsurance**, maximum and maximum age, visit limits, and other limitations that may apply.

When you disagree - claim decisions and appeals procedures

In the previous section, we explained how you and we share responsibility for paying for your **eligible dental services**.

When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. We also explain what you can do if you think we got it wrong.

Claim procedures

You or your **dental provider** are required to send us a claim in writing. You can request a claim form from us. We will review that claim for payment to the **provider** or to you as appropriate.

The table below explains the claim procedures as follows:

Notice	Requirement	Deadline
Submit a claim	• You should notify and request a claim form from us. • The claim form will provide instructions on how to complete and where to send the form(s)	• You must send us (or our agent) notice within 20 days of the loss or later, as soon as it's reasonably possible. We will send you a claim form within 15 days of your request • If you are unable to complete a claim form, you may send us: – A description of services – Bill of charges – Any dental documentation you received from your **dental provider**

Proof of loss (claim) When you have received a service from an eligible **dental provider**, you will be charged. The information you receive for that service is your proof of loss.	• A completed claim form and any additional information required by us	• You must send us proof of the loss within 90 days of the loss*
Benefit payment	• Written proof must be provided for all benefits • If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss.	• Benefits will be paid as soon as the necessary proof to support the claim is received, but in no event longer than 30 days after the support is received

*If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if it is filed as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 24 months after the deadline.

Communicating our claim decisions

The amount of time that we have to tell you about our decision on a claim is shown below.

Post-service claim

A post service claim is a claim that involves dental care services you have already received.

Type of notice	**Post-service claim**
Initial decision by us	30 working days*
Extensions	15 working days
If we request more information to help in our review	30 working days
Time you have to send us additional information	45 working days

*If we do not pay:

- A complete claim (after any missing or requested information necessary to process it is received by us)
- The portion of a claim that is neither contested nor denied

within 30 working days of receipt, we will pay interest at the rate of 10% per year beginning with the with the first calendar day after the 30 day working period.

Adverse benefit determinations

We pay many claims at the full rate **negotiated charge** with **in-network providers** and the **recognized charge** with **out-of-network providers**, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we don't pay at all. Any time we don't pay even part of the claim that is an "adverse benefit determination" or "adverse decision". It is also an "adverse benefit determination" if we rescind your coverage entirely.

Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

If we make an adverse benefit determination, we will tell you in writing.

The difference between a complaint and an appeal

A complaint

You may not be happy about a **dental provider** or an operational issue, and you may want to complain. You can call or write Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important.

We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

You may also complain directly to the California Department of Insurance. You can contact them by:

- Calling them at 1-800-927-HELP (4357); TDD: 1-800-482-4TDD (4833)
- Writing them at California Department of Insurance, Consumer Services Division, 300 Spring Street, South Tower, Los Angeles, CA 90013
- Accessing their website at www.insurance.ca.gov

An appeal

You can ask us to review an adverse benefit determination. This is called an appeal. You can appeal to us verbally or in writing.

Appeals of adverse benefit determinations

You can appeal our adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination. Or you can call Member Services at 1-877-238-6200. You need to include:

- Your name
- The policyholder's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

Another person may submit an appeal for you, including a **provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form by contacting us. You can use an authorized representative when you appeal.

You can appeal each adverse benefit determination two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Urgent claim appeals
If you have an urgent claim your **provider** may appeal for you without having to fill out a form.

We will provide you with any new or additional information that we used or that was developed by us to review your claim. We will provide this information at no cost to you before we give you a decision at your last available level of appeal. This decision is called the final adverse benefit determination. You can respond to this information before we tell you what our final decision is.

Timeframes for deciding appeals

The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

Type of notice	**Post-service appeal**	**Urgent Claim**
Initial decision by us	30 days	36 hours
Extensions	15 days	None
If we request more information	30 days	
Time you have to send us additional information	45 days	

Exhaustion of appeals process

In most situations you must complete the shorter of:

- One level of appeal with us, or
- 30 days of the complaint process (or 3 days in the event of a complaint that requires expedited review)

Before you can take these other actions:

- Contact the California Department of Insurance to request an investigation of a complaint or appeal.
- File a complaint or appeal with the California Department of Insurance.
- Request an independent medical review from the California Department of Insurance.
- Pursue arbitration, litigation or other type of administrative proceeding.

Independent medical review managed by the California Department of Insurance

Independent medical review (IMR) is a review done by people in an organization outside of **Aetna**. This is called an independent review organization (IRO).

You have a right to request an independent medical review from the California Department of Insurance only if you received an adverse benefit determination and:

- We decided the service or supply is not **medically necessary** or not appropriate, (disputed health care service); or
- We decided the service or supply is **experimental or investigational**.

If our claim decision is one for which you can seek an independent medical review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will include the independent medical review form application at the final adverse determination level. You should complete the form and send it to the California Department of Insurance. The Department will review your request and determine if you are eligible for an independent medical review.

You must submit the Request for an Independent Medical Review form:

- To the California Department of Insurance:
  Consumer Services Division
  300 Spring Street
  South Tower
  Los Angeles, CA 90013
- Within 6 months of the date you received the decision from us (or longer if the Department determines the circumstances of the case permit an extension)
- And you must include a copy of the notice from us and all other important information that supports your request

You may request assistance from the California Department of Insurance at:

1-800-927-HELP (4357)
TDD: 1-800-482-4TDD (4833)
www.insurance.ca.gov

You can also request an IMR online by accessing California's website: https://www.insurance.ca.gov/01-consumers/110-health/60-resources/01-imr/index.cfm.

You will pay for any information that you send and want reviewed by the IRO. We will pay for information we send to the IRO plus the cost of the review.

The California Department of Insurance will contact the IRO that will conduct the review of your claim.
The IRO will:

- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits

Once the review is complete, we will abide by the decision of the independent reviewer.

How long will it take to get an IRO decision?
The California Department of Insurance will send you and us notice of its decision within 30 days of its receipt of your completed Notice of Independent Medical Review Form with all the information you need to send in.

But sometimes you can get a faster IRO decision within 3 days. Your **provider** must certify that a delay in your receiving dental care services would jeopardize your health.

The Department may extend these timeframes for up to an additional 3 days in extraordinary circumstances or for good cause.

Recordkeeping
We will keep the records of all complaints and appeals for at least 10 years.

Expenses
We do not pay any expenses incurred by you when you submit a complaint or appeal.

Coordination of benefits

Some people have dental coverage under more than one plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB).

Key terms
Here are some key terms we use in this section. These terms will help you understand this COB section.

Allowable expense means:

- A dental care expense that any of your dental plans cover to any degree. If the dental care service is not covered by any of the plans, it is not an allowable expense. For example, **cosmetic surgery** generally is not an allowable expense under this plan.

In this section we talk about other "plans" which are those plans where you may have other coverage for dental care expenses, such as:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, policyholder organization plans, or employee benefit organization plans
- An automobile insurance policy
- Governmental benefits other than Medicare
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

Here's how COB works

- The primary plan pays first. When this is the primary plan, we will pay your claims first as if the other plan does not exist.
- The secondary plan pays after the primary plan. When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid.
- We will never pay an amount that, when combined with payments from your other coverage, add up to more than 100% of the allowable expenses.

Determining who pays
Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.

A plan that does not contain a COB provision is always the primary plan.

If you are:	Primary plan	Secondary plan
Covered under the plan as an employee, retired employee or dependent	The plan covering you as an employee or retired employee	The plan covering you as a dependent
COB rules for dependent children		
Child of: • Parents who are married or living together	The "birthday rule" applies The plan of the parent whose birthday* (month and day only) falls earlier in the **calendar year** *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)* *Same birthdays--the plan that has covered a parent longer is primary
Child of: • Parents separated or divorced or not living together • With court-order	The plan of the parent whom the court said is responsible for dental coverage But if that parent has no coverage then the other spouse's plan	The plan of the other parent But if that parent has no coverage, then his/her spouse's plan is primary
Child of: • Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody	Primary and secondary coverage is based on the birthday rule	
Child of: • Parents separated or divorced or not living together and there is no court-order	The order of benefit payments is: • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parents pays next • The plan of the spouse of the noncustodial parent (if any) pays last	
• Child covered by: Individual who is not a parent (i.e. stepparent or grandparent)	Treat the person the same as a parent when making the order of benefits determination: See *Child of* content above	

Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee)	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee)
COBRA or state continuation	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally	
How are benefits paid?		
Primary plan	The primary plan pays your claims as if there is no other dental plan involved	
Secondary plan	The secondary plan calculates payment as if the primary plan did not exist, and then applies that amount to any allowable expenses under the secondary plans that were not covered by the primary plan. The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense	

Other dental coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly. See the *How to contact us for help* section for details.

Right to receive and release needed information

We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other dental plans.

Right to pay another carrier

Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

Right of recovery

If we pay more than we should have under the COB rules, we may recover the excess from:

- Any person we paid or for whom we paid
- Any other plan that is responsible under these COB rules.

When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends.

When will your coverage end?

Coverage under this plan will end if:

- This plan is discontinued
- You voluntarily stop your coverage
- The **group policy** ends
- You are no longer eligible for coverage
- Your employment ends
- You do not pay any required **premium** payment
- We end your coverage
- You become covered under another dental plan offered by your policyholder

Your coverage will end on either the date your employment ends, or the day before the first **premium** contribution due date that occurs after you stop active work.

When coverage may continue under the plan

Your coverage under this plan will continue if:

Your employment ends because of **illness, injury**, sabbatical or other authorized leave as agreed to by the policyholder and us.	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue, until stopped by the policyholder, but not beyond 30 months from the start of your absence.
Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by the policyholder and us.	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage will stop on the date that your employment ends.
Your employment ends because: • Your job has been eliminated • You have been placed on severance, or • This plan allows former employees to continue their coverage.	You may be able to continue coverage. See the *Special coverage options after your plan coverage end*s section.
Your employment ends because of a paid or unpaid medical leave of absence	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 30 months from the start of the absence.
Your employment ends because of a leave of absence that is not a medical leave of absence	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 1 month from the start of the absence.
Your employment ends because of a military leave of absence.	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 24 months from the start of the absence.

It is your policyholder's responsibility to let us know when your employment ends. The limits above may be extended only if we and the policyholder agree in writing to extend them.

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage
- The **group policy** ends
- You do not make the required **premium** contribution toward the cost of dependents' coverage
- Your coverage ends for any of the reasons listed above

Legally separated spouses are eligible for coverage until the date of divorce.

Your dependents coverage will end on the earlier of the date the **group policy** terminates or as defined by the policyholder.

What happens to your insured dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your plan coverage ends* section for more information.

Special coverage options after your plan coverage ends

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have.

Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

What are your COBRA rights?
COBRA gives some people the right to keep their dental coverage for 18, 29 or 36 months after a "qualifying event". COBRA usually applies to policyholders of group sizes of 20 or more.

Here are the qualifying events that trigger COBRA continuation, who is eligible for continuation and how long coverage can be continued.

Qualifying event causing loss of coverage	Covered persons eligible for continued coverage	Length of continued coverage (starts from the day you lose current coverage)
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
Your covered dependent children no longer qualify as dependent under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for retiree dental coverage and your former policyholder files for bankruptcy	You and your dependents	18 months

When do I receive COBRA information?
The chart below lists who is responsible for giving the notice, the type of notice they are required to give and the timing.

Policyholder/Group dental plan notification requirements		
Notice	**Requirement**	**Deadline**
General notice – policyholder or **Aetna**	Notify you and your dependents of COBRA rights	Within 90 days after active employee coverage begins
Notice of qualifying event – policyholder	• Your active employment ends for reasons other than gross misconduct • Your working hours are reduced • You die • You are a retiree eligible for retiree dental coverage and your former policyholder files for bankruptcy	Within 30 days of the qualifying event or the loss of coverage, whichever occurs later
Election notice – policyholder or **Aetna**	Notify you and your dependents of COBRA rights when there is a qualifying event	Within 14 days after notice of the qualifying event
Notice of unavailability of COBRA – policyholder or **Aetna**	Notify you and your dependents if you are not entitled to COBRA coverage.	Within 14 days after notice of the qualifying event
Termination notice **–** policyholder or **Aetna**	Notify you and your dependents when COBRA coverage ends before the end of the maximum coverage period	As soon as practical following the decision that continuation coverage will end

You/your dependents notification requirements		
Notice of qualifying event – qualified beneficiary	Notify the policyholder if: • You divorce or legally separate and are no longer responsible for dependent coverage • Your covered dependent children no longer qualify as a dependent under the plan	Within 60 days of the qualifying event or the loss of coverage, whichever occurs later
Disability notice	Notify the policyholder if: • The Social Security Administration determines that you or a covered dependent qualify for disability status	Within 60 days of the decision of disability by the Social Security Administration, and before the 18 month coverage period ends
Notice of qualified beneficiary's status change to non-disabled	Notify the policyholder if: • The Social Security Administration decides that the beneficiary is no longer disabled	Within 30 days of the Social Security Administration's decision
Enrollment in COBRA	Notify the policyholder if: • You are electing COBRA	60 days from the qualifying event. You will lose your right to elect, if you do not: • Respond within the 60 days • And send back your application

How can you extend the length of your COBRA coverage?
The chart below shows qualifying events after the start of COBRA (second qualifying events):

Qualifying event	Person affected (qualifying beneficiary)	Total length of continued coverage
Disabled within the first 60 days of COBRA coverage (as determined by the Social Security Administration)	You and your dependents	29 months (18 months plus an additional 11 months)
• You die • You divorce or legally separate and are no longer responsible for dependent coverage • Your covered dependent children no longer qualify as dependent under the plan	You and your dependents	Up to 36 months

How do you enroll in COBRA?
You enroll by sending in an application and paying the **premium**. Your policyholder has 30 days to send you a COBRA election notice. It will tell you how to enroll and how much it will cost. You can take 60 days from the qualifying event to decide if you want to enroll. You need to send your application and pay the **premium**. If this is completed on time, you have enrolled in COBRA.

When is your first premium payment due?
Your first **premium** payment must be made within 45 days after the date of the COBRA election.

How much will COBRA coverage cost?
For most COBRA qualifying events you and your dependents will pay 102% of the total plan costs. This additional 2% covers administrative fees. If you apply for COBRA because of a disability, the total due will be 150% of the plan costs.

Can you add a dependent to your COBRA coverage?
You may add a new dependent during a period of COBRA coverage. They can be added for the rest of the COBRA coverage period if:

- They meet the definition of an eligible dependent.
- You notified the policyholder within 31 days of their eligibility.
- You pay the additional required **premiums**.

When does COBRA coverage end?
COBRA coverage ends if:

- Coverage has continued for the maximum period.
- The plan ends. If the plan is replaced, you may be continued under the new plan.
- You and your dependents fail to make the necessary payments on time.
- You or a covered dependent become covered under another group dental plan.
- You or your dependents are continuing coverage during the 19th to 29th months of a disability, and the disability ends.

Continuation of coverage for other reasons

What exceptions are there for dental work when coverage ends?
Your dental coverage may end while you or your covered dependent are in the middle of treatment. The plan does not cover dental services that are given after your coverage terminates. There is an exception. The plan will cover the following services if they are ordered while you were covered by the plan, and installed within 30 days after your coverage ends:

- Inlays
- Onlays
- Crowns
- Removable bridges
- Cast or processed restorations
- Dentures
- Fixed partial dentures (bridges)
- Root canals

Ordered means:

- For a denture: The impressions from which the denture will be made were taken
- For a root canal: The pulp chamber was opened
- For any other item: The teeth which will serve as retainers or supports, or the teeth which are being restored:
  - Must have been fully prepared to receive the item
  - Impressions have been taken from which the item will be prepared

How can you extend dental coverage for your disabled child beyond the plan age limits?
You have the right to extend dental coverage for your dependent child beyond the plan age limits. If your disabled child:

- Is not able to be self-supporting because of mental or physical disability, and
- Depends mainly (more than 50% of income) on you for support

We will notify you 90 days before your dependent child coverage ends due to the plan age limits. You must send us within 60 days of our notice a request for us to extend coverage. Coverage will continue for the child while we determine if the child is disabled.

We may ask you to send us proof of the disability. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

The right to coverage will continue only as long as a **physician** certifies that your child still is disabled.

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year after 2 years from the date you first send us proof. You must send it to us within 60 days of our request. If you don't, we can terminate coverage for your dependent child.

Your disabled child's coverage will end:

- On the date the child is no longer disabled and dependent upon you for support or
- As explained in the *When will* coverage *end for any dependents* section

How can you extend coverage for a child in college on medical leave?
You have the right to extend coverage for your dependent college student who takes a **medically necessary** leave of absence from school. The right to coverage will be extended until the earlier of:

- One year after the leave of absence begins, or
- The date coverage would otherwise end

To extend coverage the leave of absence must:

- Begin while the dependent child is suffering from a serious **illness** or **injury**,
- Cause the dependent child to lose status as a full-time student under the plan
- Be certified by the treating **physician** as **medically necessary** due to a serious **illness** or **injury**

We must receive documentation or certification of the **medical necessity** for a leave of absence:

- At least 30 days prior to the absence, if the medical reason for the absence and the absence are foreseeable, or
- 30 days after the start date of the medical leave of absence from school

The **physician** treating your child will be asked to keep us informed of any changes.

Reinstatement
If your coverage ends because you have not paid your **premium**, you may not be covered again for a period of 2 years from the date your coverage ends. If you are in an eligible class, you may request reinstatement for yourself and your eligible dependents at the end of such 2 years period. Your dental coverage will be subject to the rules under the *Late entrant rule*, and will be effective as described in the *Effective date of coverage* section.

General provisions – other things you should know

Administrative provisions

How this booklet-certificate will be interpreted
We prepared this booklet-certificate according to ERISA, and according to other federal and state laws that apply. This booklet-certificate will be interpreted according to these laws.

How we administer this plan
We apply policies and procedures to administer this plan.

Who's responsible to you
We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your **providers**. They are not our employees or agents.

Coverage and services

Your coverage can change
Your coverage is defined by the **group policy**. This document may have amendments too. Under certain circumstances, we or the policyholder or the law may change your plan. Only **Aetna** may waive a requirement of your plan. No other person – including the policyholder or **provider** – can do this.

If a service cannot be provided to you
Sometimes things happen that are outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen. But if we can't, we may refund you or your policyholder any unearned **premium**.

Financial sanctions exclusions:
If coverage provided under this booklet-certificate violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **eligible dental 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 Assets Control (OFAC). You can find out more by visiting http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Legal action
You cannot take any action at law or in equity until 60 days after we receive written proof of loss.

No legal action can be brought to recover payment under any benefit after 3 years from the time written proof of loss is required.

Physical examinations and evaluations
At our expense, we have the right to have a **provider** of our choice examine you. This will be done at all reasonable times while a claim for benefits is pending or under review.

Records of expenses
You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:
- Names of **dental providers**, **dentists** and others **providers** who provide services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes
You or your policyholder may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in **premium** contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years before we learned of it. All statements made by you or your employer will be deemed representations and not warranties.

Intentional deception of a material fact under the terms of coverage
If we learn that you defrauded us or you intentionally misrepresented material facts within the first 24 months of coverage, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:
- Loss of coverage, starting on the date the act of fraud or intentional misrepresentation of a material fact happened.
- Loss of coverage, from its effective date in the past. This is called rescission. If we paid claims for your past coverage, we will want the money back.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

You have special rights if we rescind your coverage.
- We will give you written notice via certified mail at least 30 days before the effective date of any rescission of coverage. The notice will explain the reason we are rescinding your coverage.
- You have the right to an **Aetna** appeal.
- You have the right to a third party review conducted by an independent medical review organization.
- You have the right to appeal to the California Department of Insurance.

We will not rescind your coverage for any reason after it has been in force for 24 months.

Some other money issues
Assignment of benefits
When you see **in-network providers** they will usually bill us directly. When you see **out-of-network providers,** we may choose to pay you or to pay the **provider** directly. Unless we have agreed to do so in writing and to the extent allowed by law, we will not accept an assignment to an **out-of-network provider** under this **group policy**. This may include:
- The benefits due
- The right to receive payments or
- Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this **group policy**

To request assignment you must complete an assignment form. The assignment form is available from the policyholder. The completed form must be sent to us for consent.

Recovery of overpayments
We sometimes pay too much for **eligible dental services** or pay for something that this plan doesn't cover. If we do, we can require the person we paid – you or your **provider** – to return what we paid. If we don't do that we have the right to reduce any future benefit payments by the amount we paid by mistake.

Grace period
A grace period of 31 days after the **premium** due date will be allowed for the payment of each **premium**. If **premiums** are not paid by the end of the grace period, your coverage will automatically terminate at the end of the grace period.

Premium contribution
This plan requires the policyholder to make **premium** contribution payments. If payments are made through a payroll deduction with the policyholder, the policyholder will forward your payment to us. We will not pay benefits under this booklet-certificate if **premium** contributions are not made. Any benefit payment denial is subject to our appeals procedure. See the *When you disagree - claim decisions and appeals procedures* section.

Premium - missed payments
If you miss a **premium** contribution payment if, for example, you were temporarily absent from work or you have not worked enough hours to cover your payroll deduction, you can make direct payments to us to make your **premium** contributions up to date and keep your coverage active.

To submit a missed **premium** contribution you must follow the missed **premium** contribution payment process set up for this plan. See your policyholder for details. You must also submit your entire missed **premium** contribution amount for all coverages you have.

We must have your payment within 31 days after the date the **premium** contribution was due. If payment is not received by then, we will not pay for losses or expenses you have during any period of time that **premium** is unpaid.

A missed **premium** contribution payment will not be accepted for any period after your eligibility for coverage ends.

Payment of premiums
The first **premium** payment for this policy is due on or before your **effective date of coverage**. Your next **premium** payment will be due the 1st of each month ("**premium** due date"). Each **premium** payment is to be paid to us on or before the **premium** due date.

Your dental information
We will protect your dental information. We will use it and share it with others to help us process your **providers**' claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just call Member Services at 1-877-238-6200. When you accept coverage under this plan, you agree to let your **providers** share your information with us. We will need information about your physical and mental condition and care.

Effect of benefits under other plans

Effect of a Health Maintenance Organization plan (an HMO plan) on coverage
If you are eligible and have chosen dental coverage under an HMO plan offered by the policyholder, you will be excluded from dental coverage under this plan on the date of your coverage under the HMO plan.

If you and your covered dependents:	**Change of coverage:**	**Coverage takes effect:**
Live in an HMO plan enrollment area	During an open enrollment period	**Group policy** anniversary date after the open enrollment period
Live in an HMO plan enrollment area	Not during an open enrollment period	Only if and when we give our written consent
Move from an HMO plan enrollment area or the HMO discontinues	Within 31 days	On the date you elect such coverage
Move from an HMO plan enrollment area or the HMO discontinues	After 31 days	Only if and when we give our written consent

No benefits will be paid for any charges for services rendered or supplies received under an HMO plan.

Effect of prior coverage - transferred business
Prior coverage means:

- Any plan of group coverage that has been replaced by coverage under part or all of this plan.
- The plan must have been sponsored by the policyholder (e.g., transferred business).
- If you are eligible, the replacement can be complete, or in part for your eligible class. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan.

If your coverage under any part of this plan replaces any prior coverage any benefits provided under such prior coverage may reduce benefits payable under this plan. See the *General coverage provisions* section of the schedule of benefits.

Dental coverage under this plan will continue uninterrupted for your dependent college student who takes a **medically necessary** leave of absence from school. See the *Special coverage options after your plan coverage ends – How can you extend dental coverage for a child in college on medical leave?* section.

Glossary

Aetna
Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

Calendar year
A period of 12 month beginning on January 1st and ending on December 31st.

Calendar year maximum
This is the most this plan will pay for **eligible dental services** incurred by you during the **calendar year**.

Coinsurance
The specific percentage we have to pay for **eligible dental services**.

Cosmetic
Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits
Eligible dental services that meet the requirements for coverage under the terms of this plan.

Deductible
The amount you pay for **eligible dental services** per **calendar year** before your plan starts to pay.

Dental emergency
Any dental condition that:
- Occurs unexpectedly
- Requires immediate diagnosis and treatment in order to stabilize the condition, and
- Is characterized by symptoms such as severe pain and bleeding

Dental emergency services
Services and supplies given by a **dental provider** to treat a **dental emergency**.

Dental provider
Any individual licensed to provide dental services or supplies.

Dentist
A **dentist** licensed to do the dental work they perform.

Directory
The list of **in-network providers** for your plan. The most up-to-date **directory** for your plan appears at www.aetna.com. When searching for an **in-network provider**, you need to make sure that you are searching for **providers** that participate in your specific plan. **In-network providers** may only be considered **in-network providers** for certain **Aetna** plans. A paper directory is also available at no cost to you. You can call us at the toll-free number on your ID card to request one.

Effective date of coverage
The date you and your dependent's coverage begins under this booklet-certificate as noted in our records.

Eligible dental services
The dental care services and supplies listed in the schedule of benefits and not listed or limited in the *What rules and limits apply to dental care* and *Exceptions* sections of this plan.

Experimental or investigational
A drug, device, procedure, or treatment that we find is **experimental** or **investigational** because:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the **illness** or **injury** involved.
- The needed approval by the FDA has not been given for marketing.
- A national medical or dental society or regulatory agency has stated in writing that it is **experimental or investigational** or suitable mainly for research purposes.
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.
- Written protocols or a written consent form used by a facility **provider** state that it is **experimental or investigational**.
- It is provided or performed in a special setting for research purposes.

Group policy
The **group policy** consists of several documents taken together. These documents are:

- The group application
- The **group policy**
- The booklet-certificate(s)
- The schedule of benefits
- Any riders and amendments to the **group policy**, the booklet-certificate, and the schedule of benefits

Health professional
A person who is licensed, certified or otherwise authorized by law to provide dental care services to the public. For example, **providers** and dental assistants.

Illness
Poor health resulting from disease of the teeth or gums.

Injury or injuries
Physical damage done to the teeth or gums.

In-network provider
A **provider** listed in the **directory** for your plan.

Lifetime maximum
This is the most this plan will pay for **eligible dental services** incurred by a covered person during their lifetime.

Medicare

As used in this plan, **Medicare** means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of **Medicare.**

Medically necessary/medical necessity

Dental care services that we determine a **provider** using sensible clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness, injury**, disease or its symptoms, and that we determine are:

- In accordance with generally accepted standards of dental practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease
- Not primarily for the convenience of the patient, **dentist**, or other health care **provider**
- Not more costly than an alternative service or sequence of services at least as likely to produce the same benefit or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury** or disease

Generally accepted standards of dental practice means standards based on credible scientific evidence published in peer-reviewed dental literature and is:

- Generally recognized by the relevant dental community
- Consistent with the standards set forth in policy issues involving clinical judgment

Negotiated charge

This is either:

- The amount **in-network providers** have agreed to accept
- The amount we agree to pay directly to **in-network providers** or third party vendor (including any administrative fee in the amount paid)

Orthodontic treatment

This is any:

- Medical service or supply
- Dental service or supply

furnished to prevent or to diagnose or to correct a misalignment:

- Of the teeth
- Of the bite
- Of the jaws or jaw joint relationship

whether or not for the purpose of relieving pain.

The following are not considered **orthodontic treatment**:

- The installation of a space maintainer
- A surgical procedure to correct malocclusion

Orthodontic treatment lifetime maximum

The most the plan will pay for **eligible dental services** for **orthodontic treatment** that you incur during your lifetime is called the **orthodontic treatment lifetime maximum.**

Out-of-network provider
A **provider** who is not a **in-network provider** and does not appear in the **directory** for your plan.

Physician
A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

Premium
The amount you or the policyholder are required to pay to **Aetna** to continue coverage.

Provider
A **dentist**, or other entity or person licensed, or certified under applicable state and federal law to provide dental care services to you.

Recognized charge
The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above the **recognized charge.** The **recognized charge** may be less than the **provider's** full charge.

Your plan's **recognized charge** applies to all out-of-network **eligible dental services**. In all cases, the **recognized charge** is based on the geographic area where you receive the service or supply.

Except as otherwise specified below, the **recognized charge** for each service or supply is the lesser of what the **provider** bills and:

- 80% of the **prevailing charge rate**

The **recognized charge** for **providers** in the dental out-of-network savings program is the lesser of what the **provider** bills and the agreed upon rate for **providers**, with whom we have a contract through any third party that is not an affiliate of **Aetna**.

Your out-of-network cost sharing applies when you get care from dental out-of-network savings program **providers**.

Special terms used:

Geographic area
The geographic area made up of the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.

Prevailing charge rate:
The 80th percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, we have the right to substitute an alternative database that we believe is comparable.

Additional information:
Get the most value out of your benefits. Use the "Estimate the Cost of Care" tool on Aetna Navigator® to help decide whether to get care in-network or out-of-network. **Aetna's** secure website at www.aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to access the "Estimate the Cost of Care" feature. Within this feature, view our "Dental Cost of Care" tool.

Temporomandibular joint dysfunction/disorder

This is:

- A **temporomandibular joint** (TMJ) **dysfunction/disorder** or any similar disorder of the jaw joint
- A myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

Discount programs

Discount arrangements
We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called “third party service providers”. These third party service providers may pay us so that they can offer you their services.

Third party service providers are independent contractors. The third party service provider is responsible for the goods or services they deliver. We have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don’t pay the third party service providers for the services they offer. You are responsible for paying for the discounted goods or services.

Wellness and other incentives
We may encourage and incent you to access certain dental services, to use online tools that enhance your coverage and services and to continue participation as an **Aetna** insured. You and your **provider** can talk about these dental services and decide if they are right for you. We may also encourage and incent you to participate in a wellness or health improvement program. Incentives may include but are not limited to:

- Modification to **deductible** or **coinsurance** amounts
- **Premium** discounts or rebates
- Contributions to a health savings account
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards
- Any combination of the above

The award of any such incentive shall not depend upon the result of a wellness or health improvement activity or upon your health status.

Aetna Life Insurance Company

Dental Amendment

Policyholder: California Institute of Technology

Group policy number: 869105

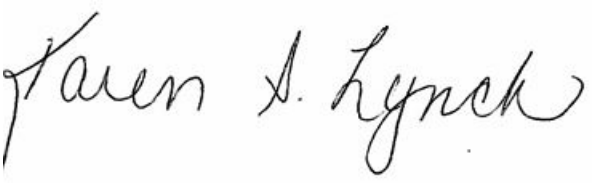
Amendment effective date: January 1, 2020

Your group dental policy has changed. The booklet-certificate is amended to reflect this. The change is effective on the date shown above.

The following describes the change:

The *An advance claim review* section of your booklet-certificate is hereby deleted.

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.



Karen S. Lynch
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Issue Date: December 10, 2019

Additional Information Provided by

California Institute of Technology

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:
Refer to your Plan Administrator for this Information

Employer Identification Number:
95-1643307

Plan Number:
601

Type of Plan:
Welfare Benefit Plan

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
California Institute of Technology
1200 East California Boulevard 169-84
Pasadena, CA 91125
Telephone Number: (626) 395-3421

Agent For Service of Legal Process:
California Institute of Technology
1200 East California Boulevard 169-84
Pasadena, CA 91125

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:
December 31

Source of Contributions:
Employer and Retirees

Procedure for Amending the Plan:

The Employer may amend the Plan from time to time by a written instrument signed by Assistant VP of Human Resources or Delegate.

ERISA Rights

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.