BENEFIT PLAN

Prepared Exclusively for
California Institute of Technology

PPO Dental Extraterritorial Riders

Extraterritorial Riders

Aetna Life Insurance Company

These Extraterritorial Riders are part of the Group Insurance Policy between **Aetna** Life Insurance Company and the Policyholder

Table of Contents

ET Riders ..... Included in this document
Arizona Dental 1
Arkansas Dental 11
Colorado Dental 13
Florida Dental 14
Hawaii Dental 19
Illinois Dental 21
Iowa Dental 22
Kansas Dental 25
Kentucky Dental 27
Maryland Dental 42
Massachusetts Dental 43
Minnesota Dental 49
Nevada Dental 50
New Jersey Dental 51
New Mexico Dental 52
New York Dental 53
Oklahoma Dental 54
Oregon Dental 60
Washington Dental 62
West Virginia Dental 73

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	California Institute of Technology
Group Policy No.:	GP-869105
Rider:	Arizona ET Dental
Issue Date:	December 10, 2019
Effective Date:	January 1, 2020

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Arizona. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Arizona, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

NOTICE: THIS CERTIFICATE OF INSURANCE MAY NOT PROVIDE ALL BENEFITS AND PROTECTIONS PROVIDED BY LAW IN ARIZONA. PLEASE READ THIS CERTIFICATE CAREFULLY.

Appeals Procedure – Health Care Coverage *(GR-9N-32-050-01 AZ)*

Getting Information about the Health Care Appeals Process

We must send you a copy of the Arizona Appeals Information Packet when you first receive your policy, and within 5 business days after we receive your request for an **appeal**. When your insurance coverage is renewed, we must also send you a separate statement to remind you that you can request another copy of the Arizona Appeals Information Packet. We will also send a copy of the Arizona Appeals Information Packet to you or your treating **provider** at any time upon request. To request a copy, just call the Member Services number printed on your Member ID Card.

At the back of the Arizona Appeals Information Packet, you will find forms you can use for your **appeal**. The Arizona Insurance Department ("the Department") developed these forms to help people who want to file a health care **appeal**. You are not required to use them. We cannot reject your **appeal** if you do not use them. If you need help in filing an **appeal**, or you have questions about the appeals process, you may call the Department's Consumer Assistance Office at 602-364-2499 or 1-800-325-2548 (inside Arizona but outside the Phoenix area), or via the internet at http://www.azinsurance.gov, or you may call us at 1-800-756-7039.

How to Know When You Can Appeal

When we do not authorize or approve a service or pay for a claim, we must notify you of your right to **appeal** that decision. Your notice may come directly from us, or through your treating **provider**.

Decisions You Can Appeal

You can **appeal** the following decisions:

1. We do not approve a service that you or your treating **provider** has requested.
2. We do not pay for a service that you have already received.
3. We do not authorize a service or pay for a claim because we say that it is not "medically necessary".
4. We do not authorize a service or pay for a claim because we say that it is not covered under your insurance policy, and you believe it is covered.
5. We do not notify you, within 10 business days of receiving your request, whether or not we will authorize a requested service.
6. We do not authorize a referral to a specialist.
7. You disagree with our decision to issue or not issue a policy to you.

Decisions You Cannot Appeal

You cannot **appeal** the following decisions:

1. You disagree with our decision as to the amount of "usual, customary, and reasonable charges". Where applicable, a usual, customary, and reasonable charge is a charge for a covered benefit which is determined by us to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. We may take into account factors such as the complexity, degree of skill needed, type or specialty of the **provider**, range of services provided by a facility, and the prevailing charge in other areas in determining the usual, customary, and reasonable charge for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of **provider**s in the area.
2. You disagree with how we are coordinating benefits when you have health insurance with more than one insurer.
3. You disagree with how we have applied your claims or services to your Plan deductible.
4. You disagree with the amount of coinsurance or copayments that you paid.
5. You are dissatisfied with any rate increases you may receive under your insurance policy.
6. You believe we have violated any other parts of the Arizona Insurance Code.

If you disagree with a decision that cannot be appealed according to this list, you may still file a complaint with us by calling our Customer Services Department at the number printed on your Member ID Card. In addition, you may also file such complaints with the Arizona Department of Insurance, Consumer Affairs Division, 2910 N. 44th Street, Second Floor, Phoenix, AZ 85018.

Who Can File an Appeal

Either you or your treating **provider** can file an **appeal** on your behalf. At the end of the Arizona Appeals Information Packet is a form that you may use for filing your **appeal**. You are not required to use this form. If you wish, you can send us a letter with the same information. If you decide to **appeal** our decision to deny authorization for a service, you should tell your treating **provider** so the **provider** can help you with the information you need to present your case.

DESCRIPTION OF THE APPEALS PROCESS

I. Levels of Review

We offer expedited as well as standard appeals for Arizona residents. Expedited appeals are for urgently needed services that you have not yet received. Standard appeals are for non-urgent service requests and denied claims for services already provided. Both types of appeals follow a similar process, except that we process expedited appeals much faster because of the patient's condition.

Each type of **appeal** has three levels, as follows:

Expedited Appeals (For urgently needed service you have not yet received)	**Standard Appeals** (For non-urgent services or denied claims)
Level One: Expedited Medical Review	Informal Reconsideration
Level Two: Expedited Appeal	Formal Appeal
Level Three: Expedited External, Independent Medical	External, Independent Medical Review

We make the decisions at Level One and Level Two. An outside reviewer, who is completely independent from Aetna, makes Level Three decisions. You are not responsible to pay the costs of the external review if you choose to **appeal** to Level Three. These three levels of Appeals are discussed more fully below:

Before requesting a level three, you must exhaust the internal **appeal** process unless:

- We waive the exhaustion requirement
- We fail to comply with the requirements of the internal **appeal** process except failures that are based on *de minimis* violations
- You request a simultaneous expedited internal and external **appeal**.

You may supply additional information that you would like us to consider. In addition, you may request copies of documents relevant to your claim (free of charge) by contacting us at the number on your member identification card.

EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Expedited Medical Review (Level One)

Your Request: You may obtain Expedited Medical Review of your denied request for a service that has not already been provided if:

- You have coverage with us;
- We denied your request for a covered service; and
- Your treating **provider** certifies that the time required to process your request through the Informal Reconsideration (Level One) and Formal Appeal (Level Two) **appeal** process (about 30 days) is likely to cause a significant negative change in your medical condition. (At the end of the Arizona Appeals Information Packet is a form that your **provider** may use for this purpose. Your **provider** could also send a letter or make up a form with similar information.) Your treating **provider** must send the certification and documentation to:

  Name: Aetna Life Insurance Company
  Title: Customer Resolution Team
  Address: P.O. Box 14002, Lexington, KY 40512

  Phone: 1-800-545-2211
  Fax: 859-425-3379

Our Decision: We must call and inform you and your treating **provider** of our decision within **1 business day or 36 hours from request receipt, whichever is less**. We will then mail our decision in writing to both you and your treating **provider**. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You may immediately **appeal** to Level Two.

If we grant your request: We will authorize the service and the **appeal** process is complete.

If we refer your case to Level Three: We may decide to skip Level One and Level Two and send your case straight to an independent reviewer at Level Three.

Expedited Appeal (Level Two)

Your request: If we deny your request at Level One, you may request an Expedited Appeal. After you receive our Level One denial, your treating **provider *must immediately*** send us a request (to the same person and address listed above under Level One) to tell us you are appealing to Level Two. To help your **appeal**, your **provider** should also send us any more information that the **provider** hasn't already sent us to show why you need the requested service.

Our Decision: We must call and inform you and your treating **provider** of our decision within **1 business day or 36 hours from request receipt, whichever is less**. We will then mail our decision in writing to both you and your treating **provider**. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You may immediately **appeal** to Level Three.

If we grant your request: We will authorize the service and the **appeal** process is complete.

If we refer your case to Level Three: We may decide to skip Level Two and send your case straight to an independent reviewer at Level Three.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

Informal Reconsideration (Level One)

Your request: You may obtain Informal Reconsideration of your denied request for a service or a denied claim for services already provided to you if:

- You have coverage with us;
- We denied your request for a covered service or denied your claim for services already provided,
- You do not qualify for an expedited **appeal**, and
- You or your treating **provider** asks for Informal Reconsideration within 2 years of the date we first deny the requested service or claim by calling, writing, or faxing your request to:

Name:	Aetna Life Insurance Company
Title:	Customer Resolution Team
Address:	P.O. Box 14002, Lexington, KY 40512
Phone:	1-800-545-2211
Fax:	859-425-3379

Our acknowledgement: Aetna has 5 business days after we receive your request for Informal Reconsideration ("the receipt date") to send you and your treating **provider** a notice that we received your request.

Our decision: Aetna has the following timeframes after the receipt date within which to decide whether we should change our decision and authorize your requested service or pay your claim. Within that same timeframe, we must send you and your treating **provider** our written decision. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request for a Pre-Service Claim--within 15 calendar days. A Pre-Service Claims is a claim for a benefit that requires approval of the benefit in advance of obtaining medical care. **You have 60 days to appeal to Level Two.**

If we deny your request for a Concurrent Care Claim Extension--within 15 calendar days. A Concurrent Care Claim Extension is a request to extend or a decision to reduce a previously approved course of treatment. **You have 60 days to appeal to Level Two.**

If we deny your request for a Post-Service Claim--within 30 calendar days. A Post-Service Claim is any claim for a benefit that is not a pre-service claim. **You have 60 days to appeal to Level Two**.

If we grant your request: The decision will authorize the service or pay the claim and the **appeal** process is complete.

If we refer your case to Level Three: We may decide to skip Level One and Level Two and send your case straight to an independent reviewer at Level Three.

You must exhaust the internal **appeal** process unless:

- We waive the exhaustion requirement
- We fail to comply with the requirements of the internal **appeal** process except for failures that are based on unimportant or minor violations

Formal Appeal (Level Two)

Your request: You may request Formal Appeal if we denied your request or claim at Level One. After you receive our Level One denial, you or your treating **provider** must send us a written request within 60 days to tell us you are appealing to Level Two. To help us make a decision on your **appeal**, you or your treating **provider** should also send us any more information (that you haven't already sent us) to show why we should authorize the requested service or pay the claim.

A Member and/or an authorized representative may attend the Level Two Appeal hearing and question the representative of Aetna and/or any other witnesses, and present their case. The hearing will be informal. A Member's Physician or other experts may testify. Aetna also has the right to present witnesses.
Send your **appeal** request and information to:

Name:	Aetna Life Insurance Company
Title:	Customer Resolution Team
Address:	P.O. Box 14002, Lexington, KY 40512
Phone:	1-800-545-2211
Fax:	859-425-3379

Our acknowledgement: Aetna has 5 business days after we receive your request for Formal Appeal ("the receipt date") to send you and your treating **provider** a notice that we received your request.

Our decision: For a denied service that you have not yet received, Aetna has the following timeframes after the receipt date within which to decide whether we should change our decision and authorize your requested service. We will send you and your treating **provider** our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request for a Pre-Service Claim--within 15 calendar days. A Pre-Service Claims is a claim for a benefit that requires approval of the benefit in advance of obtaining medical care. **You have four months to appeal to Level Three.**

If we deny your request for a Concurrent Care Claim Extension--within 15 calendar days. A Concurrent Care Claim Extension is a request to extend or a decision to reduce a previously approved course of treatment. **You have four months to appeal to Level Three.**

If we deny your request for a Post-Service Claim--within 30 calendar days. A Post-Service Claim is any claim for a benefit that is not a pre-service claim. **You have four months to appeal to Level Three**.

If we grant your request: We will authorize the service or pay the claim and the **appeal** process is complete.

If we refer your case to Level Three: We may decide to skip Level Two and send your case straight to an independent reviewer at Level Three.

II. The Role of the Director of Insurance

Arizona law (A.R.S. §20-2533(F)) requires "any Member who files a Complaint or Appeal with the Department relating to an adverse decision to pursue the review process prescribed" by law. This means, that for decisions that are appealable, you must pursue the health care Appeals process before the Director of Insurance can investigate a Complaint or Appeal you may have against Aetna based on the decision at issue in the Complaint or Appeal.

The Appeal process requires the Director to:

1. Oversee the Appeals process.
2. Maintain copies of each utilization review Plan submitted by Aetna.
3. Receive, process, and act on requests from Aetna for External Independent Medical Review.
4. Enforce the decisions of Aetna.
5. Review decisions of Aetna.
6. Report to the Legislature.
7. Send, when necessary, a record of the proceedings of an Appeal to Superior Court or to the Office of Administrative Hearings (OAH).
8. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at the OAH.

III. Obtaining Medical Records

Arizona law (A.R.S. §12-2293) permits the Member to ask for a copy of their medical records. Your request must be in writing and must specify who you want to receive the records. The health care **Provider** who has your records will provide you or the person you specify with a copy of your records.

Designated Decision-Maker: If you have a designated health care decision-maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision-maker or a person designated in writing by your health care decision-maker unless you limit access to your medical records only to you or your health care decision-maker.

Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the Appeal process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

IV. Documentation for an Appeal

If you decide to file an Appeal, the Member must give us any material justification or documentation for the Appeal at the time the Appeal is filed. If you gather new information during the course of your Appeal, you should give it to us as soon as you receive it. You must also give Aetna the address and phone number where you can be contacted. If the Appeal is already at Expedited External Independent Medical Review, you should also send the information to the Department of Insurance.

V. Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed (your last known address) on the fifth business day after being mailed.

VI. Record Retention

Aetna shall retain the records of all Complaints and Appeals for a period of at least 7 years.

VII. Fees and Costs

Nothing herein shall be construed to require Aetna to pay counsel fees or any other fees or costs incurred by a Member in pursuing a Complaint or Appeal.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a **provider** you must write Member Services. The complaint must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. **Aetna** will review the information and provide you with a written response within 30 calendar days of the receipt of the **complaint**, unless more information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Definitions

Adverse Benefit Determination (Decision): A denial; reduction; termination of; or failure to; provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage.
- Coverage determinations, including Plan limitations or exclusions.

Appeal: A written request to **Aetna** to reconsider an **adverse benefit determination**.

Complaint: Any written expression of dissatisfaction about quality of care or the operation of the Plan.

External Independent Review *(GR-9N-32-051-01 AZ)*

EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Expedited External, Independent Review (Level Three)

Your request: You may Appeal to Expedited External Independent Medical Review only after you have appealed through Level Two. You have four months after you receive Aetna's Level Two decision to send Aetna your written request for Expedited External Independent Medical Review. Your request should include any additional information to support your request for the service. Your written request for Expedited External Independent Medical Review should be sent to:

Name:	Priscilla Bugari, R.N.
Title:	Director, Aetna National External Review Unit
Address:	1100 Abernathy Rd, Suite 375, Atlanta, GA 30328
Phone:	1-877-848-5855 (Toll-free number)
Fax:	860-975-1526

You and your treating **provider** are not responsible for the cost of any Expedited External Independent Medical Review.

Process

There are 2 types of Expedited External Independent Medical Review Appeals, depending on the issues in your case:

1. Medical Necessity Appeals are cases where Aetna has decided not to authorize a service because Aetna believes the service(s) you or your treating Provider are asking for, are not Medically Necessary to treat your condition. The expedited external independent reviewer is a Provider retained by an outside independent review organization ("IRO"), that is procured by the Arizona Department of Insurance, and not connected with Aetna. The IRO Provider must be a Provider who typically manages the condition under review.

Within 1 business day of receiving your request, Aetna must:

- Mail a written acknowledgement of the request to the Director of Insurance, you, and your treating Provider.
- Send the Director of Insurance: the request for review; your Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna's decision; a summary of the applicable issues including a statement of Aetna's decision; the criteria used and clinical reasons for Aetna's decision; and the relevant portions of Aetna utilization review guidelines. Aetna must also include the name and credentials of the Provider who reviewed and upheld the denial at the earlier appeal levels.

Within 2 business days of receiving Aetna information, the Director of Insurance must send all the submitted information to an expedited, external independent reviewer organization (the "IRO").

Within 72 hours of receiving the information, the IRO must make a decision and send the decision to the Director of Insurance.

Within 48 hours of receiving the IRO's decision, the Director of Insurance must mail a notice of the decision to Aetna, you, and your treating Provider.

2. Contract Coverage issues are Appeals where Aetna has denied coverage because Aetna believes the requested service is not covered under your Certificate of Coverage or Group Insurance Certificate. For these Appeals, the Arizona Department of Insurance is the expedited external independent reviewer.

   Within 1 business day of receiving your request, Aetna must:

   - Mail a written acknowledgement of your request to the Director of Insurance, you, and your treating Provider.
   - Send the Director of Insurance: the request for review, your Aetna Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna's decision; a summary of the applicable issues including a statement of Aetna's decision, the criteria used and any clinical reasons for our decision and the relevant portions of Aetna's utilization review guidelines.

   Within 2 business days of receiving this information, the Director of Insurance must determine if the service or claim is covered, issue a decision, and send a notice to Aetna, you, and your treating Provider.

   The Director of Insurance is sometimes unable to determine issues of coverage. If this occurs, the Director of Insurance will forward your case to an IRO. The IRO will have 72 hours to make a decision and send it to the Director of Insurance. The Director of Insurance will have 48 hours after receiving the IRO's decision to send the decision to Aetna, you, and your treating Provider.

Decision

Medical Necessity Decision: If the IRO decides that Aetna should provide the service, Aetna must authorize the service. If the IRO agrees with Aetna decision to deny the service, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Decision: If you disagree with the Director of Insurance's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If Aetna disagrees with the Director's final decision, Aetna may also request a hearing before the OAH. A hearing must be scheduled within 30 days of receiving the Director's decision. OAH must promptly schedule and complete a hearing for Appeals from Expedited External Independent Medical Review Appeals decisions.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

External, Independent Review (Level Three)

Your request: You may obtain External Independent Medical Review only after you have sought any Appeals through standard and expedited Level One and Level Two. You have four months after receipt of written notice from Aetna that your Formal Appeal or Expedited Medical Review has been denied to request External Independent Medical Review. You must send a written request for External Independent Medical Review and any material justification or documentation to support your request for the covered service or claim for a covered service to:

Name: Priscilla Bugari, R.N.
Title: Director, Aetna National External Review Unit
Address: 1100 Abernathy Rd, Suite 375, Atlanta, GA 30328

Phone: 1-877-848-5855 (Toll-free number)
Fax: 860-975-1526

Neither you nor your treating Provider is responsible for the cost of any External Independent Medical Review.

Process

There are 2 types of External Independent Medical Review Appeals, depending on the issues in your case:

1. Medical Necessity Appeals are cases where Aetna has decided not to authorize a service because Aetna believes the service(s) you or your treating Provider are asking for, are not Medically Necessary to treat your condition. The external independent reviewer is a Provider retained by an outside Independent Review Organization ("IRO") that is procured by the Arizona Department of Insurance, and not connected with Aetna. The IRO Provider must be one who typically manages the condition under review.

   Within 6 business days of receiving your or the Director of Insurance's request, or if Aetna initiates an External Independent Medical Review, Aetna must:

   - Mail a written acknowledgement to the Director of Insurance, you, and your treating Provider.
   - Send the Director of Insurance: the request for review; your Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna's decision; a summary of the applicable issues including a statement of Aetna's decision; the criteria used and clinical reasons for Aetna decision; and the relevant portions of Aetna's utilization review guidelines. We must also include the name and credentials of the Provider who reviewed and upheld the denial at the earlier Appeal levels.

   Within 5 business days of receiving Aetna information, the Director of Insurance must send all the submitted information to an expedited, external independent review organization (the "IRO").

   Within 45 calendar days of receiving the information, the IRO must make a decision and send the decision to the Director of Insurance.

   Within 5 business days of receiving the IRO's decision, the Director of Insurance will mail a notice of the decision to Aetna, you, and your treating Provider.

2. Contract Coverage issues are Appeals where Aetna has denied coverage because Aetna believes the requested service is not covered under your Certificate of Coverage or Group Insurance Certificate. For these Appeals, the Arizona Department of Insurance is the external independent reviewer.

   Within 6 business days of receiving your request or if Aetna initiates an External Independent Medical Review, Aetna must:

   - Mail a written acknowledgement of your request to the Director of Insurance, you, and your treating Provider.

- Send the Director of Insurance: the request for review, your Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna's decision; a summary of the applicable issues including a statement of Aetna's decision, the criteria used and any clinical reasons for our decision and the relevant portions of Aetna's utilization review guidelines.

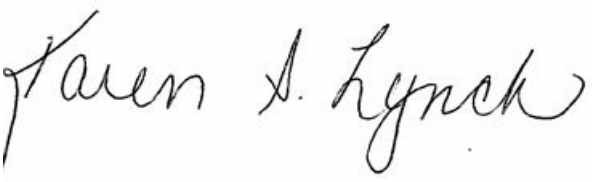
Within 15 business days of receiving this information, the Director of Insurance will determine if the service or claim is covered, issue a decision, and send a notice of determination to Aetna, you, and your treating Provider.

The Director of Insurance is sometimes unable to determine issues of coverage. If this occurs or if the Director of Insurance finds that the case involves a medical issue, the Director of Insurance will forward your case to an IRO. The IRO will have 45 calendar days to make a decision and send it to the Director of Insurance. The Director of Insurance will have 5 business days after receiving the IRO's decision to send the decision to Aetna, you, and your treating Provider.

Decision

Medical Necessity decision: If the IRO decides that Aetna should provide the service, Aetna must authorize the service regardless of whether judicial review is sought. If the IRO agrees with Aetna's decision to deny the service, the Appeal is over. Your only further option is to pursue your claim in Superior Court. However, on written request by the IRO, you or Aetna, the Director of Insurance may extend the 45-day time period for up to an additional 30 days, if the requesting party demonstrates good cause for an extension.

Contract Coverage decision: If you disagree with the Director of Insurance's final decision on a contract coverage issue, the Member may request a hearing with the Office of Administrative Hearings ("OAH"). If Aetna disagrees with the Director's final decision, Aetna may also request a hearing before the OAH. A hearing must be requested within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.



Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	California Institute of Technology
Group Policy No.:	GP-869105
Rider:	Arkansas ET Dental
Issue Date:	December 10, 2019
Effective Date:	January 1, 2020

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Arkansas. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Arkansas, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Important Information

In the event you need to contact someone about your insurance coverage, you may contact Aetna Life Insurance Company at the following address and telephone number:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
(860) 273-0123

If you have been unable to contact or obtain satisfaction from Aetna, you may contact the Arkansas Insurance Department at:

Arkansas Insurance Department
Consumer Services Division
400 University Tower Building
1123 South University Avenue
Little Rock, AR 72204
(501) 686-2945

How and When to Enroll *(GR-9N-29-015-03)*

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. To complete the enrollment process, you will need to provide all requested information. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Your employer will advise you of the required amount of your contributions. Remember plan contributions are subject to change.

If you do not enroll for coverage when you first become eligible, but wish to do so later, your employer will provide you with information on when and how you can enroll.

You will need to enroll within 31 days of your eligibility date.

Newborns are automatically covered for 31 days after birth.

In no event will the covered amount for In-Network charges exceed more than 25% of the covered amount for Out-of-Network charges.

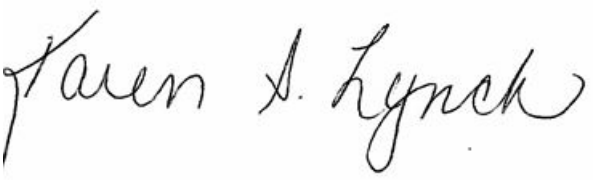
When Extended Health Coverage Ends

Extension of benefits will end on the first to occur of the date:

- You are no longer totally disabled, or become covered under any other group plan with like benefits.
- Your dependent is no longer totally disabled, or he or she becomes covered under any other group plan with like benefits.
- If you are confined in a hospital, the date you are discharged from the hospital

(This does not apply if coverage ceased because the benefit section ceased for your eligible class.)

Important Note
If the Extension of Benefits provision outlined in this section applies to you or your covered dependents, see the *Converting to an Individual Health Insurance Policy* section for important information.



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Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	California Institute of Technology
Group Policy No.:	GP-869105
Rider:	Colorado ET Dental
Issue Date:	December 10, 2019
Effective Date:	January 1, 2020

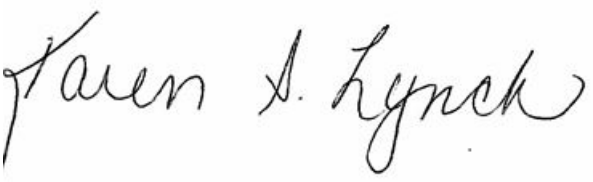
This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Colorado. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Colorado, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

(GR-9N 18-010-01 CO)

Type C Expenses: Major Restorative Care
Oral Surgery
Cleft lip or cleft palate surgery for a child under age 18



Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder: California Institute of Technology
Group Policy No.: GP-869105
Rider: Florida ET Dental
Issue Date: December 10, 2019
Effective Date: January 1, 2020

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other Dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Florida. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Florida, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Coverage for Dependent Children

To be eligible, a dependent child must be:

- Under 19 years of age; or
- Under age 25, as long as he or she solely depends on your support*; and
  - is living in your household, or
  - is a full-time or part-time student.

*Note: Dependent child eligibility ends at the end of the calendar year in which the child reaches the age of 25. Proof of student status is required each year.

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship, or whose parent is your child and is covered as a dependent under the plan.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

How and When to Enroll *(GR-9N 29-015 05 FL)*

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Remember plan contributions are subject to change.

You will need to enroll within 31 days of your eligibility date. Otherwise, you may be considered a Late Enrollee. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify under a Special Enrollment Period, as described below.

Newborns are automatically covered for 31 days after birth. To continue coverage after 31 days, you will need to complete a change form and return it to your employer within 60 days from birth.

Important Reminder *(GR-9N-18-010-01)*
The **deductible**, **coinsurance** and maximums that apply to each type of dental care are shown in the *Schedule of Benefits*.

You may receive services and supplies from **network** and **out-of-network providers**. Services and supplies given by a **network provider** are covered at the **network** level of benefits shown in the *Schedule of Benefits*. Services and supplies given by an **out-of-network provider** are covered at the out-of-network level of benefits shown in the *Schedule of Benefits*.

Refer to *About the PPO Dental Coverage* for more information about covered services and supplies.

Type C Expenses: Major Restorative Care

Oral Surgery
Cleft lip or cleft palate surgery for a child under age 18

Orthodontics
Interceptive orthodontic treatment
Limited orthodontic treatment
Comprehensive orthodontic treatment of adolescent dentition
Comprehensive orthodontic treatment of adult dentition
Post treatment stabilization
Removable appliance therapy to control harmful habits
Fixed appliance therapy to control harmful habits

What The PPO Dental Plan Does Not Cover *(GR-9N 28-025 01-FL)*

Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section or by amendment attached to this Booklet-Certificate. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These dental exclusions are in addition to the exclusions that apply to health coverage.

Any instruction for diet, plaque control and oral hygiene.

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 substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *What the Plan Covers* section.

Crown, inlays and onlays, and veneers unless:

- It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material; or
- The tooth is an abutment to a covered partial denture or fixed bridge.

Dental implants, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.

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

- Under any other part of this plan; or
- Under any other plan of group benefits provided by the policyholder.

Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion.

Except as covered in the *What the Plan Covers* section, treatment of any **jaw joint disorder** and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

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 the person was not covered.

General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply.

Orthodontic treatment except as covered in the *What the Plan Covers* section.

Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium).

Prescribed drugs; pre-medication; or analgesia.

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.

Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

Surgical removal of impacted wisdom teeth only for orthodontic reasons.

Treatment by other than a **dentist**. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a **dentist**. These are:

- Scaling of teeth; and
- Cleaning of teeth.

When Coverage Ends for Dependents *(GR-9N-30-015-02)*

Coverage for your dependents will end if:

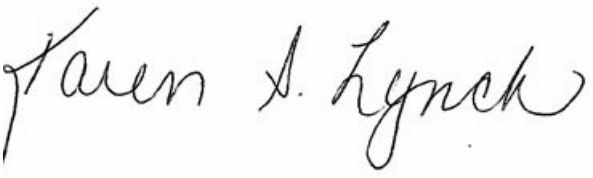
- You are no longer eligible for dependents' coverage;
- You do not make your contribution for the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends* for Employees. (This does not apply if you use up your overall lifetime maximum, if included);
- Your dependent is no longer eligible for coverage. Coverage ends at the end of the calendar year when your dependent does not meet the plan's definition of a dependent; or
- As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group plan offered by your employer.

In addition, a "domestic partner" will no longer be considered to be a defined dependent on the earlier to occur of:

- The date this plan no longer allows coverage for domestic partners.
- The date of termination of the domestic partnership.

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after they reach any limiting age. See *Continuation of Coverage* for more information.

Dental Benefits: Coverage will be available for up to 90 days for covered services and supplies needed for treatment of any dental condition diagnosed prior to the date coverage ends. These include services and supplies which have been rendered and received, including delivered and installed, if these apply, prior to the end of the 90 day period. Not included are routine services and services and supplies for orthodontic treatment.



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The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder: California Institute of Technology
Group Policy No.: GP-869105
Rider: Hawaii ET Dental
Issue Date: December 10, 2019
Effective Date: January 1, 2020

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Hawaii. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Hawaii, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

An eligible dependent child includes:

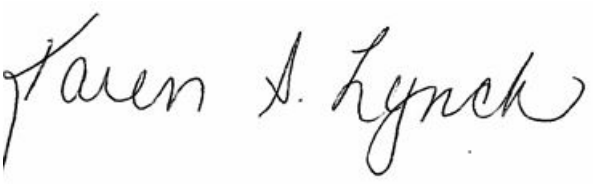
- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

You may also cover as your dependent.

A reciprocal beneficiary.

You must file a notarized "Declaration of Reciprocal Beneficiary Relationship" with the Director of Health of the State of Hawaii. The Director will register the Declaration and send you a Certificate of Reciprocal Beneficiary Relationship.



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Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	California Institute of Technology
Group Policy No.:	GP-869105
Rider:	Illinois ET Dental
Issue Date:	December 10, 2019
Effective Date:	January 1, 2020

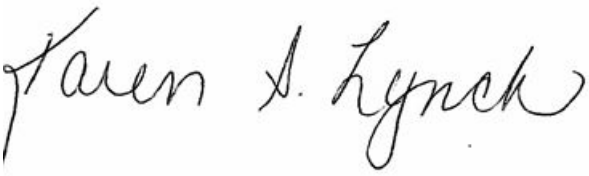
This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Illinois. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Illinois, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Payment of Benefits *(GR-9N 32-025-01 IL)*

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits. For all health coverages, benefits will be paid within 30 days following receipt of written proof to support the claim.



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Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	California Institute of Technology
Group Policy No.:	GP-869105
Rider:	Iowa ET Dental
Issue Date:	December 10, 2019
Effective Date:	January 1, 2020

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Iowa. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Iowa, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Special Enrollment Periods *(GR-9N 29-015 01 LA)*

You will not be considered a **Late Enrollee** if you qualify under a Special Enrollment Period as defined below. If one of these situations applies, you may enroll before the next annual enrollment period.

Loss of Other Health Care Coverage

You or your dependents may qualify for a Special Enrollment Period if:

- You did not enroll yourself or your dependent when you first became eligible or during any subsequent annual enrollments because, at that time:
  - You or your dependents were covered under other **creditable coverage**; and
  - You refused coverage and stated, in writing, at the time you refused coverage that the reason was that you or your dependents had other **creditable coverage**; and
- You or your dependents are no longer eligible for other **creditable coverage** because of one of the following:
  - The end of your employment;
  - A reduction in your hours of employment (for example, moving from a full-time to part-time position);
  - The ending of the other plan's coverage;
  - Death;
  - Divorce or legal separation;
  - Employer contributions toward that coverage have ended;
  - COBRA coverage ends;
  - the employer's decision to stop offering the group health plan to the eligible class to which you belong;

- cessation of a dependent's status as an eligible dependent as such is defined under this Plan; or
- you or your dependents have reached the lifetime maximum of another Plan for all benefits under that Plan.

- You will need to enroll yourself or a dependent for coverage within 31 days of when other **creditable coverage** ends. Evidence of termination of **creditable coverage** must be provided to **Aetna**. If you do not enroll during this time, you will need to wait until the next annual enrollment period.

New Dependents

You and your dependents may qualify for a Special Enrollment Period if:

- You did not enroll when you were first eligible for coverage; and
- You later acquire a dependent, as defined under the plan, through marriage, birth, adoption, or placement for adoption; and
- You elect coverage for yourself and your dependent within 31 days of acquiring the dependent.

Your spouse or child who meets the definition of a dependent under the plan may qualify for a Special Enrollment Period if:

- You did not enroll them when they were first eligible; and
- You later elect coverage for them within 31 days of a court order requiring you to provide coverage.

You will need to report any new dependents by completing a change form, which is available from your employer. The form must be completed and returned to **Aetna** within 31 days of the change. If you do not return the form within 31 days of the change, you will need to make the changes during the next annual enrollment period.

If You Adopt a Child

Your plan will cover a child who is placed for adoption. This means you have taken on the legal obligation for total or partial support of a child whom you plan to adopt.

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 60 days of the placement.
- Proof of placement will need to be presented to **Aetna** prior to the dependent enrollment.
- Any coverage limitations for a pre-existing condition will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage.

When You Receive a Qualified Child Support Order

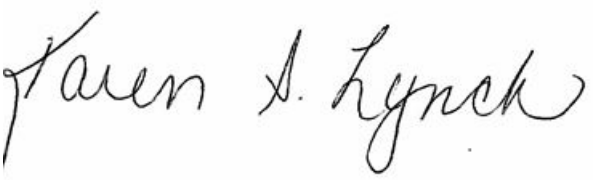
A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. A Qualified Domestic Relations Support Order (QDRSO) is a court order requiring a parent to provide dependent's life insurance coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or a QDRSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a pre-existing condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO or QDRSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.



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Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder: California Institute of Technology
Group Policy No.: GP-869105
Rider: Kansas ET Dental
Issue Date: December 10, 2019
Effective Date: January 1, 2020

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Kansas. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Kansas, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Coverage for Dependent Children *(GR-9N 29 010 KS)*

To be eligible, a dependent child must be:

- Unmarried; and
- Under 19 years of age; or
- Under age 23, as long as he or she is a full-time student at an accredited institution of higher education and solely depends on your support*.

*Note: Proof of full-time student status is required each year. This means that the child is enrolled as an undergraduate student with a total course load of at least 12 credits or is enrolled as a graduate student with a total course load of at least 9 credits.

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children and, as certified by you, any children placed with you for adoption;
- Your foster children;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

Continuation of Coverage After Employment Ceases
Any Health Expense Coverage then in force for you and your eligible dependents may be continued for a maximum period of 18 months after it would terminate for any reason except failure to make any required contributions; but only if:

- Premium payments for such coverage are continued;
- You have been insured for Health Expense Coverage or for Health Expense Coverage and coverage under any prior coverage for at least 3 months in a row;
- You make written request for such continuation within 31 days after the date your coverage would otherwise terminate.

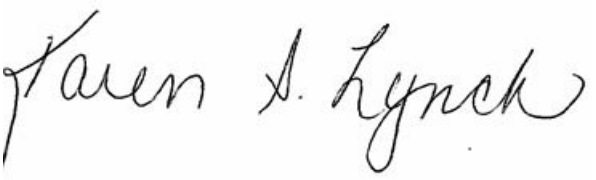
Coverage will not continue for any person who is covered or eligible to be covered for Medicare or under any group plan for which he or she was not eligible prior to the date coverage would terminate.

Coverage will cease before the end of the 18 month period on the first to occur of:

- Failure to make any required contributions to your employer.
- Written mutual agreement for such cessation between you and **Aetna**.

If coverage continues for the 18 month period, the Conversion Privilege will be available at the end of such period, on the same terms as would have applied, if this section had not been included.

Coverage for a dependent may not be continued beyond the date it would otherwise terminate; exclusive of this continuation.



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Extraterritorial Certificate Rider *(GR-9N-CR1)*
Policyholder: California Institute of Technology
Group Policy No.: GP-869105
Rider: Kentucky ET Dental
Issue Date: December 10, 2019
Effective Date: January 1, 2020

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Kentucky. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Kentucky, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Charges made for the following are not covered:

- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care while in the custody of a governmental authority; except if the covered person is incarcerated in a local or regional jail prior to a conviction of a felony.

Coordination of Benefits - What Happens When There is More Than One Health Plan

When Coordination of Benefits Applies

This Coordination of Benefits (COB) provision applies to This Plan when you or your covered dependent has health coverage under more than one Plan. "Plan" and "This Plan" are defined herein. If any provision of this section is deemed to be invalid or illegal, that provision shall be fully severable and the remaining provisions of this section shall continue in full force and effect. The Order of Benefit Determination Rules below determines which Plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense. If you are covered by more than 1 health benefit Plan, you should file all your claims with each Plan.

Plan. Any Plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans;
- **Medicare** or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts are not Plans.

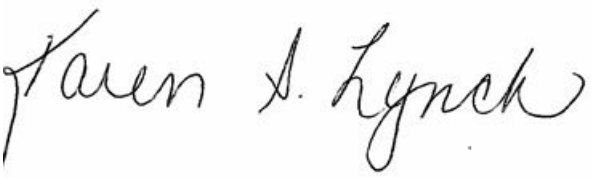
If the Plan includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate plans. For example, Medical coverage will be coordinated with other Medical plans, and dental coverage will be coordinated with other dental plans.

This Plan is any part of the policy that provides benefits for health care expenses.

Non-Occupational Injury

A **non-occupational injury** is an accidental bodily **injury** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an injury which does;
- Is covered under any type of workers' compensation law; and
- Is not covered for that injury under such law.



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Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider

Policyholder:	California Institute of Technology
Group Policy No.:	GP-869105
Rider:	Louisiana ET Dental
Issue Date:	December 10, 2019
Effective Date:	January 1, 2020

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Important Notice: Please read this section first.

The benefits in this rider are specific to residents of Louisiana. Since you are a resident of Louisiana, you are entitled to greater benefits for the following services or provisions than is reflected in your booklet-certificate. Please contract Member Services by calling the telephone number on your ID card with any questions you may have on these benefits and/or provisions. Please review all of your benefit material and this Rider carefully.

Appeals Procedure

Definitions

Adverse Benefit Determination (Decision): A denial; reduction; termination of; or failure to; provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage.
- Plan limitations or exclusions.
- The results of any Utilization Review activities.
- A decision that the service or supply is **experimental or investigational**.
- A decision that the service or supply is not **medically necessary**.

An **adverse benefit determination** also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the Policy or the Booklet- Certificate.

Appeal: An oral or written request to **Aetna** to reconsider an **adverse benefit determination**.

Business Day: Monday through Friday (excluding holidays and days upon which Aetna is unable to conduct business in a normal manner due to an emergency situation declared by state or local government authorities).

Complaint: Any oral or written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension: A request to extend a course of treatment that was previously approved.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a course of treatment that was previously approved.

External Review: A review of an **adverse benefit determination** or a **final adverse benefit determination** by an Independent Review Organization/External Review Organization (ERO) assigned by the State Insurance Commissioner, made up of **physicians** or other appropriate health care **providers**. The ERO must have expertise in the problem or question involved.

Final Adverse Benefit Determination: An **adverse benefit determination** that has been upheld by **Aetna** at the exhaustion of the appeals process.

Grievance: A written or oral complaint, if the complaint involves an urgent care request submitted by or on behalf of a covered person regarding any of the following: (a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (b) Claims payment, handling or reimbursement for health care services; or (c) Matters pertaining to the contractual relationship between a covered person and a health insurance issuer.

Pre-service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a "Pre-Service Claim."

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- seriously jeopardize your life or health;
- jeopardize your ability to regain maximum function;
- cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Full and Fair Review of Claim Determinations and Appeals

As to medical and **prescription drug** claims and **appeals** only, **Aetna** will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the **final adverse benefit determination** is required to be provided so that you may respond prior to that date.

Prior to issuing a **final adverse benefit determination** based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of final adverse determination is required.

Claim Determinations - Group Health Coverage

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. As to medical and **prescription drug** claims only, if **Aetna** makes an **adverse benefit determination**, written notice will be provided to you, or in the case of a concurrent care claim, to your **provider**.

Urgent Care Claims

Aetna will notify you of an **urgent care claim** decision as soon as possible, but not later than 24 hours after the claim is made.

If more information is needed to make an **urgent care claim** decision, **Aetna** will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify the claimant within 48 hours of the earlier to occur:

- the receipt of the additional information; or
- the end of the 48 hour period given the **physician** to provide **Aetna** with the information.

If the claimant fails to follow plan procedures for filing a claim, **Aetna** will notify the claimant within 24 hours following the failure to comply.

Pre-Service Claims

Aetna will make a claim determination as soon as possible, but not later than 2 business days after a pre-service claim request, provided that Aetna has received all appropriate medical information. Aetna will make notification of a claim determination to the provider rendering the service not later than 1 business day after the claim determination has been made. Aetna will provide written confirmation of such notification within 2 business days of making the claim determination.

If an extension is required because Aetna needs additional information to make a claim determination, the covered person will receive a notice of the extension. The notice shall specifically describe the required information. In no event, will the extension period exceed 30 business days from the date of the pre-service claim request unless you or the provider has agreed to the extension period.

Post-Service Claims

Aetna will make a claim determination as soon as possible, but not later than 30 business days after a post-service claim request, provided that Aetna has received all appropriate medical information. Aetna will make notification of a claim determination to the provider rendering the service not later than 5 business days after the claim determination is made.

If an extension is required because Aetna needs additional information to make a claim determination, the covered person will receive a notice of the extension. The notice shall specifically describe the required information. In no event, will the extension period exceed 180 calendar days from the date of the post-service claim request.

Aetna will not retroactively reduce or terminate a previously approved service or supply unless:

- coverage was terminated due to fraud or non-payment of premiums; or
- the approval was based upon a material omission or misrepresentation of the person's health condition by the provider.

Concurrent Care Claim Extension

In the case of a concurrent claim extension request approval, Aetna will provide notification of a claim determination to the provider rendering the service not later than 1 business day after the claim determination has been made. Aetna will make written confirmation of such notification within 2 business days after the claim determination.

In the case of an adverse benefit determination, Aetna will provide notification to the provider rendering the service not later than 1 business day after the claim determination has been made. Aetna will make written confirmation of such notification within 1 business day of providing notification. The service or supply will be continued without liability to the provider or the person (subject to the terms of the Policy) until the provider receives notice of Aetna's decision.

Concurrent Care Claim Reduction or Termination

Aetna will notify you of a claim decision to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.

As to medical and **prescription drug** claims only, if you file an **appeal**, coverage under the plan will continue for the previously approved course of treatment until a final **appeal** decision is rendered. During this continuation period, you are responsible for any **copayments**; **coinsurance**; and **deductibles**; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **appeal**. If **Aetna's** initial claim decision is upheld in the final **appeal** decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a **network provider** you must call or write Member Services within 30 calendar days of the incident. The complaint must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. **Aetna** will review the information and provide you with a written response within 30 calendar days of the receipt of the **complaint**, unless more information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

Informal Process
As to an adverse benefit determination involving a group health claim, the provider rendering the service that was denied may request, on your behalf and within 10 calendar days following the date of the notice of the adverse benefit determination, an informal reconsideration of the claim determination. The informal reconsideration will be completed within 1 business day of Aetna receiving the request from the provider and will be conducted between the provider and the Aetna Medical Director involved in making the adverse benefit determination. If the Medical Director is not available then the Medical Director may designate a clinical peer in his or her place.

In the event that the informal reconsideration does not resolve the differences of opinion to your satisfaction, then the adverse benefit determination may be appealed as described below in the Formal Process.

Formal Process
You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for one level or two levels of **appeal** depending upon the type of coverage provided under the Plan. As to medical and **prescription drug** claims only, a **final adverse benefit determination** notice will also provide an option to request an **External Review.**

You have 180 calendar days with respect to Group Health Claims following the receipt of notice of an **adverse benefit determination** to request your Level One **Appeal**. Your **appeal** may be submitted orally or in writing and must include:

- Your name.
- Your Policyholder's name.
- A copy of **Aetna's** notice of an **adverse benefit determination**.
- Your reasons for making the **appeal**.
- Any other information you would like to have considered.

Send your written **appeal** to Member Services at the address shown on your ID Card.

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf. You must provide written consent to **Aetna**.

As to medical and **prescription drug** claims only, you may be allowed to provide evidence or testimony during the **appeal** process in accordance with the guidelines established by the Federal Department of Health and Human Services.

Contacting the Louisiana Department of Insurance

If you need assistance with the Appeals process, you may contact the Louisiana Department of Insurance at:

Louisiana Department of Insurance Office of
Consumer Advocacy Post Office Box 94214
Baton Rouge, LA 70804

You may also call the toll-free number 1-800-259-5301 or visit the LDI web site at www.ldi.la.gov.

Level One Appeal – Group Health Claims

A review of a Level One **Appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a written decision within 36 hours of receipt of the request for an **appeal**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a written decision within 15 business days of receipt of the request for an **appeal**.

Post-Service Claims
Aetna shall issue a decision within 30 business days of receipt of the request for an **appeal**.

A duly licensed **physician** must concur with any Adverse Benefit Determination that is upheld. The contents of the written decision will comply with any applicable state law.

Level Two Appeal - Group Health Claims

If **Aetna** upholds an **adverse benefit determination** at the first level of **appeal**, and the reason for the decision was based on **medical necessity** or **experimental or investigational** reasons, you or your authorized representative have the right to file a Level Two **Appeal**. The **appeal** must be submitted within 60 calendar days following the receipt of a decision of a Level One **Appeal**.

To request a Level Two Appeal for an **adverse determination** that is based on **experimental or investigational** reasons:

- you must meet the eligibility requirements of any applicable Louisiana statute or regulation.

Review of a Level Two **Appeal** of an **adverse benefit determination** of an **urgent care claim, a Pre-Service Claim, or a Post-Service Claim** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

The Level Two Appeal review will occur within 45 days of Aetna receiving a request for a Level Two Appeal. You have the right to attend the Level Two Appeal review and will be notified of your rights at least 15 business days in advance of the date of the review. The contents of the notice will comply with any applicable state law. If you cannot attend the review, you may participate by conference call or other available technology. You may also request that Aetna consider postponement and re-scheduling of the hearing.

If requested, Aetna will provide you with all relevant information regarding your Appeal that is not confidential or privileged.

The Aetna Level Two Appeal committee will render its decision or recommendation in accordance with any applicable Louisiana statute or regulation.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a written decision within 36 hours of conclusion of the Level Two **Appeal** review.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a written decision within 5 business days of the date of the Level Two **Appeal** review.

Post-Service Claims

Aetna shall issue a written decision within 5 business days of the date of the Level Two **Appeal** review.

A duly licensed and appropriate clinical peer must concur with any Adverse Benefit Determination that is upheld. The contents of the written decision will comply with any applicable state law including information on your right to request an External Review.

Exhaustion of Process

Aetna encourages you to exhaust the applicable Level One and Level Two processes of the Appeal Procedure before you:

- Contact the Louisiana Department of Insurance to request an investigation of a **complaint** or **appeal**; or
- File a **complaint** or **appeal** with the Louisiana Department of Insurance; or
- Establish any:
- litigation;
- arbitration; or
- administrative proceeding;

regarding an alleged breach of the policy terms by **Aetna** or any matter within the scope of the Appeals Procedure.

As to medical and **prescription drug** claims only, under certain circumstances you may seek simultaneous review through the internal Appeals Procedure and **External Review** processes--these include **Urgent Care Claims** and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

Important Note:
As to medical and **prescription drug** claims only, if **Aetna** does not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the **appeal** requirements and may proceed with **External Review** or any of the actions mentioned above. There are limits, though, on what sends a claim or **appeal** straight to an **External Review**. Your claim or internal **appeal** *will not* go straight to **External Review** if:

a rule violation was minor and isn't likely to influence a decision or harm you;
it was for a good cause or was beyond **Aetna's** control; and
it was part of an ongoing, good faith exchange between you and **Aetna**.

Special Enrollment Periods

If You Adopt a Child

Your plan will cover a child who is placed in your home for adoption or due an act of voluntary surrender. This means you have taken on the legal obligation for total or partial support of a child whom you plan to adopt.

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption or the child is placed in your home due to the execution of an act of voluntary surrender and it becomes irrevocable; and
- You request coverage for the child in writing within 31 days of the placement or the act of voluntary surrender becomes irrevocable.

- Proof of placement will need to be presented to **Aetna** prior to the dependent enrollment.
- Any coverage limitations for a pre-existing condition will not apply to a child placed with you for adoption or due to the act of a voluntary surrender provided that the placement occurs on or after the effective date of your coverage or the date the act of voluntary surrender becomes irrevocable.

When You Receive a Qualified Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or a QDRSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a pre-existing condition will not apply, as long as you submit a written request for coverage within the 31 day period.

If you do not request coverage for the child within the 31 day period, you will need to wait until the next annual enrollment period.

Under a QMCSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

Coordination of Benefits - What Happens When There is More Than One Health Plan

When Coordination of Benefits Applies

Getting Started - Important Terms

Which Plan Pays First

How Coordination of Benefits Works

When Coordination of Benefits Applies

This Coordination of Benefits (COB) provision applies to this plan when you or your covered dependent has health coverage under more than one plan. "Plan" and "This plan" are defined herein. The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

Getting Started - Important Terms

When used in this provision, the following words and phrases have the meaning explained herein.

Allowable Expense means a health care service or expense, including, coinsurance and **copayments** and without reduction of any applicable **deductible**, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

1. If a covered person is confined in a private **hospital** room, the difference between the cost of a semi-private room in the **hospital** and the private room is not an allowable expense. This does not apply if one of the Plans provides coverage for a private room.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.
4. The amount a benefit is reduced or not reimbursed by the primary Plan because a covered person does not comply with the Plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
5. If all Plans covering a person are high deductible Plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible Plan's deductible is not an allowable expense, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

If a person is covered by one Plan that computes its benefit payments on the basis of reasonable or recognized charges and another Plan that provides its benefits or services on the basis of negotiated charges, the primary plan's payment arrangements shall be the allowable expense for all the Plans. However, if the secondary plan has a negotiated fee or payment amount different from the primary plan and if the provider contract permits, that negotiated fee will be the allowable expense used by the secondary plan to determine benefits.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an allowable expense and a benefit paid.

Closed Panel Plan(s). A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan. Any Plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service Plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee Plans, labor organization plans, employer organization Plans, or employee benefit organization Plans;
- Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts;
- Medicare or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the Plan includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate plans. For example, Medical coverage will be coordinated with other Medical plans, and dental coverage will be coordinated with other dental plans.

This Plan is any part of the policy that provides benefits for health care expenses.

Primary Plan/Secondary Plan. The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Which Plan Pays First

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a **Medicare** beneficiary and, as a result of federal law, **Medicare** is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one plan is:
   A. The primary plan is the plan of the parent whose birthday is earlier in the year if:
      i. The parents are married or living together whether or not married;
      ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
   B. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the primary plan.
   C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
      - The plan of the custodial parent;
      - The plan of the spouse of the **custodial parent**;
      - The plan of the non**custodial parent**; and then
      - The plan of the spouse of the non**custodial parent**.

      For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

3. Active Employee or Retired or Laid off Employee. The plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

5. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, or subscriber longer is primary.

6. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, This Plan will not pay more than it would have paid had it been primary.

How Coordination of Benefits Works

When this plan is secondary, it may reduce its benefits so that total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period.

In addition, a secondary plan will credit to its plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of This Plan, the amount normally reimbursed for covered benefits or expenses under This Plan is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under This Plan for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of This Plan and another plan both agree that This Plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more closed panel plans COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this plan and other plans. **Aetna** has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment

Any payment made under another plan may include an amount, which should have been paid under this plan. If so, **Aetna** may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this plan. **Aetna** will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by **Aetna** is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coverage for Dependents

To be eligible, a dependent child must be:

Under 26 years of age.

Anesthesia and Associated Hospitalization For Certain Dental Care

Covered expenses include charges made for general anesthesia and associated **hospital** charges in connection with dental care if the person, as determined by the treating **dentist**, has a mental or physical condition which requires that the dental treatment be rendered in a **hospital** setting.

Such determination must be in accordance with the utilization standards of the "Indications for General Anesthesia" as published in the reference manual of the American Academy of Pediatric Dentistry.

Benefits are payable on the same basis as any other **illness** or **injury**. No other charges incurred in connection with the dental procedure will be paid unless specifically provided for under this Plan.

Not included are charges:

- incurred for the treatment of temporomandibular joint dysfunction; and
- for any service or supply furnished by a provider who is not:
  - a fully accredited specialist dentist in pediatric dentistry; or
  - a specialist dentist fully accredited in a recognized dental specialty for which hospital privileges are granted.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. Benefits will be payable not more than 30 days after receipt of proof. For all benefits written proof must be provided.

It is the employer's responsibility to notify Aetna when you are no longer eligible for coverage under this Plan. However, Aetna will not:

- deny payment of claims to a health care provider for covered services provided in good faith; or
- recover any monies paid to a health care provider for a covered service beyond 90 days from the expiration of the 30 day period for the payment of the claim;

when the denial or recovery is based upon the determination that you were no longer covered under the Plan at the time the covered service was rendered.

All covered health expense benefits are payable to you. However, **Aetna** has the right to pay any health benefits to the service provider. This will be done unless you have told **Aetna** otherwise by the time you file the claim.

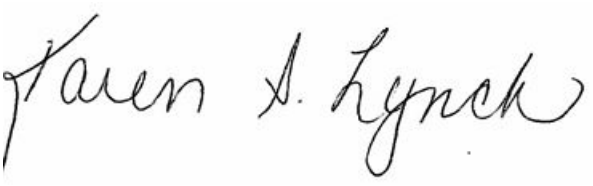
Aetna will notify you in writing, at the time it receives a claim, when an assignment of benefits to a health care provider or facility will not be accepted.

When a **network provider** provides care for you or a covered dependent, the **network provider** will take care of filing claims. However, when you seek care on your own for (**out-of-network services and supplies)**, you are responsible for filing your own claims.

If a health care provider that does not contract with **Aetna** files a claim with **Aetna** for emergency services rendered, **Aetna** shall directly pay such a claim by a non-contracted provider as an amount for which the insured or enrollee is liable. Payment of such claim by **Aetna** shall in no circumstances be made directly to the patient, insured, or enrollee.

Reinstatement of Coverage Due to a Military Leave of Absence

If coverage for you or your covered dependent's terminates due to a military leave of absence, you or your covered dependents may again become covered in accordance with the terms of this Plan provided that coverage is requested from the Employer within 31 days of your return to active work, or in the case of a dependent, within 31 days of returning from active service in the military.



Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	California Institute of Technology
Group Policy No.:	GP-869105
Rider:	Maryland ET Dental
Issue Date:	December 10, 2019
Effective Date:	January 1, 2020

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Maryland. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Maryland, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Physician

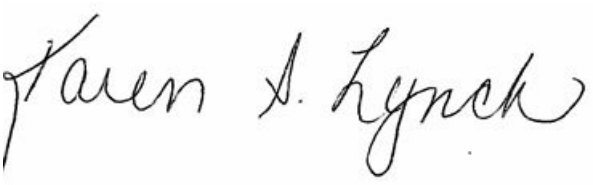
A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition.

A physician is not you or related to you.



Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder: California Institute of Technology
Group Policy No.: GP-869105
Rider: Massachusetts ET Dental
Issue Date: December 10, 2019
Effective Date: January 1, 2020

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Massachusetts. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Massachusetts, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Physician Profiling

Physician profiling information is available from the Massachusetts Board of Registration in Medicine for physicians licensed to practice in Massachusetts.

Interpreter and Translation Services

You may contact Member Services at the toll-free telephone number listed on your I.D. card to receive information on interpreter and translation services related to administrative procedures. A TDD# for the hearing impaired is also available.

French
Services d'interprétation et de traduction
Vous pouvez contacter les services aux membres au numéro de téléphone sans frais indiqué sur votre carte d'identification pour recevoir de l'information sur les services d'interprétation et de traduction se rapportant aux procédures administratives. Les professionnels du service à la clientèle Aetna ont accès à des services de traduction par le biais des services linguistiques téléphoniques de AT&T. Un numéro de téléphone ATME est aussi disponible pour les malentendants.

Greek

Υπηρεσιες Μεταφρασεως

Για να λαβετε πληροφοριες οσον αφορα των υπηρεσιων μας μεταφρασεως σχετικα με την διαδικασια διοικητικη, μπορειτε να ερχοσαστε σε επαφη με την Υπηρεσια για τα Μελη στον αριθμο (χρωις διοδια) που βρισκεται επανω στην εξακριβωση σας ταυτοτητας. Οι επαγγελματικοι υπαλληλοι (του τμηματος της Αετνα το οποιο ανασχολειται με τους πελατες) μπορουν να χρησιμοποιουν την μεταφραστικη υπηρεσια της εταιρειας AT&T.

Italian

Servizi di traduzione e di interpretariato

Per ottenere informazioni sui servizi di traduzione e interpretariato connessi a procedure amministrative, potete rivolgervi al Servizio Membri chiamando il numero di linea verde indicato sulla vostra carta di ID. I professionisti del servizio clientela della Aetna hanno accesso ai servizio di traduzione della linea linguistica della AT&T. È anche disponibile un No TDD per i deboli di udito.

Portuguese

Serviços de Intérprete e de Tradução

Você poderá entrar em contato com os Serviços dos Associados ao telefone livre de tarifa indicado no seu cartão de identificação para obter informações sobre serviços de intérprete e de tradução com relação aos procedimentos administrativos. Os profissionais dos serviços aos clientes têm acesso aos serviços de tradução através da linha de idiomas da AT&T. Existe também uma linha TDD para quem tem dilficuldades com a audição.

Russian

Услуги по устному и письменному переводу

Чтобы получить информацию о предоставляемых услугах устного и письменного перевода, вы можете обращаться в отдел обслуживания членов программы по бесплатному номеру телефона, указанному на вашей членской карточке. Сотрудники Aetna по обслуживанию клиентов имеют доступ к переводческим услугами по языковой линии AT&T. Имеется также устройство связи для лиц с дефектами слуха (TDD).

Spanish

Servicio de Intérprete y Traducción

Usted puede ponerse en contacto con Servicios a Miembros, al número de teléfono gratis que aparece en su tarjeta de identificación para recibir información sobre servicios de intérprete y traducción relativo a los procedimientos administrativos. Los profesionales de servicio a clientes de Aetna tienen acceso a los servicios de traducción por medio de la linea de idiomas de AT&T. Además hay un número de TDD para las personas con impedimento de audición.

Haitian-Creole

Sèvis intèprèt ak tradiktè

Ou kapab pran kontak avèk Sèvis pou manm-yo si ou rele nimewo telefòn gratis ki sou kat I.D.-ou-a (idantifikasyon) pou ou jwenn ransèyman sou sèvis intèprèt ak tradiktè konsènan pwosedi administratif. Pwofesyonnèl nan sèvis kliyan "Aetna" gen mwayden jwenn sèvis tradiksyon nan "AT&T language line" (sèvis lang AT&T). Yon nimewo TDD disponnib tou pou moun ki pa tande byen.

Lao

ການບໍລິການນາຍພາສາແລະການແປພາສາ

ທ່ານສາມາດຕິດຕໍ່ຜແນກບໍລິການສະມາຊິກໄດ້ ໂດຍໃຊ້ເບີໂທບໍລິການຢູ່ທີ່ປາກົດເທິງບັດປະຈຳ ໂອສະມາຊິກຂອງທ່ານ ເພື່ອໄດ້ຮັບລາຍລະອຽດຕ່າງໆ ກ່ຽວກັບການບໍລິການນາຍພາສາແລະ ລິການແປພາສາທີ່ກ່ຽວຂ້ອງກັບການດຳເນີນການທາງດ້ານການບໍລິຫານ. ພະນັກງານຂອງ ແຜນກບໍລິການລູກຄ້າຂອງບໍລິສັດເອັດນາ (Aetna) ສາມາດຕິດຕໍ່ກັບການບໍລິການທາງດ້ານ ານແປພາສາໄດ້ ໂດຍຜ່ານສາຍແປພາສາ (Language Line) ຂອງບໍລິສັດ AT&T. ຍັງ ເບີໂທຂອງລະບົບ TDD ໄວ້ສຳຫລັບຜູ້ທີ່ໄດ້ຍິງສຽງບໍ່ຄ່ອຍໃຊ້ໃນການຕິດຕໍ່ອີກດ້ວຍ.

Cambodian

ៈសេវាកម្មផ្នែកបកប្រែភាសា

អ្នកអាចទាក់ទងសេវាកម្មសមាជិក តាមរយៈលេខ ឥតគិតថ្លៃ ដែលចុះនៅលើកាតសំគាល់របស់ អ្នក ដើម្បីទទួលពត៌មាន អំពី សេវាកម្មផ្នែកបកប្រែភាសា ដែលទាក់ទងនឹងវិធីចាត់ចែងការ ។ អ្នកជំនាញការផ្នែកសេវាកម្មនៃអតិថិជនរបស់ Aetna **មានមធ្យោបាយរកសេវាកម្មបកប្រែ តាមរយៈខ្សែទូរស័ព្ទភាសា** AT&T **។ លេខ** TDD# **សំរាប់មនុស្សគថ្លង់ ក៏មានផងដែរ ។**

Chinese

口譯及筆譯服務

您可以通過撥打列在您會員卡上的免費電話號碼與會員服務處聯絡，以便獲取有關實施程序的口譯及筆譯服務的資訊。**Aetna**的專業用戶服務人員使用**AT&T**語言專線 **(AT&T Language Line)** 的翻譯服務。還有一個專門為聽力有障礙的用戶提供的**TDD**號碼。

Arabic

خدمات الترجمة الشفهية والكتابية

تستطيع الاتصال بدائرة خدمات الأعضاء على رقم الهاتف المجاني المدرج على بطاقة هويتك للحصول على معلومات حول خدمات الترجمة الشفهية والكتابية المتعلقة بالإجراءات الإدارية. فموظفو دائرة خدمة الزبائن لدى شركة Aetna يستطيعون تلقي خدمات الترجمة عن طريق خط اللغات لشركة AT&T. ويتوفر للأصماء أيضاً رقم جهاز إتصالات الأصماء (TDD).

In no event will the covered amount for In-Network charges exceed more than 20% of the covered amount for Out-of-Network charges.

Which Plan Pays First *(GR-9N 33-010 03 MA)*

When two or more **plans** pay benefits, the rules for determining the order of payment are as follows**:**

- The **primary plan** pays or provides its benefits as if the **secondary plan** or **plans** did not exist.
- A **plan** that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the **plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a **closed panel plan** to provide out-of-network benefits.
- A **plan** may consider the benefits paid or provided by another **plan** in determining its benefits only when it is secondary to that other **plan**.
- The first of the following rules that describes which **plan** pays its benefits before another **plan** is the rule to use:

    1. Medical Payments Coverage and PIP Coverage in Motor Vehicle Insurance Policies.
    If a person is covered under a motor vehicle policy and incurs expenses or requires services as a result of an accident with a motor vehicle:

        A. Personal Injury Protection (PIP) is the **primary plan** for the first $2,000 of expenses. After that, **plans** will coordinate benefits in accordance with these coordination of benefits provisions.

            PIP refers to the personal injury protection coverage included in a motor vehicle liability insurance policy.

        B. MedPay means medical coverage that can be purchased in connection with a motor vehicle liability policy. MedPay will always be secondary to and in excess of any other **plan** or PIP.

    2. Non-Dependent or Dependent. The **plan** that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the **plan** that covers the person as a dependent is secondary. However, if the person is a **Medicare** beneficiary and, as a result of federal law, **Medicare** is secondary to the **plan** covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **plans** is reversed so that the **plan** covering the person as an employee, member, subscriber or retiree is secondary and the other **plan** is primary.

    3. Child Covered Under More Than One **Plan**. The order of benefits when a child is covered by more than one **plan** is:

        A. The **primary plan** is the **plan** of the parent whose birthday is earlier in the year if:

            i. The parents are married or living together whether or not married;

            ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the **plan** that covered either of the parents longer is primary.

        B. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the **plan** of that parent has actual knowledge of those terms, that **plan** is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the **primary plan**.

- If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage , the order of benefits is:

  - The **plan** of the **custodial parent**;
  - The **plan** of the spouse of the **custodial parent**;
  - The **plan** of the non**custodial parent**; and then
  - The **plan** of the spouse of the non-**custodial parent**.

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

4. Active Employee or Retired or Laid off Employee. The **plan** that covers a person as an employee who is neither laid off nor retired, or as a dependent of an active employee, is the **primary plan**. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the **secondary plan**. If the other **plan** does not have this rule, and if, as a result, the **plans** do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

5. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another **plan**, the **plan** covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other **plan** does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

6. Longer or Shorter Length of Coverage. The **plan** that covered the person as an employee, member, or subscriber longer is primary.

7. If the preceding rules do not determine the **primary plan**, the allowable expenses shall be shared equally between the **plans** meeting the definition of **plan** under this provision. In addition, **This Plan** will not pay more than it would have paid had it been primary.]

When You Receive a Qualified Child Support Order *(GR-9N 29-015-01 MA)*
A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. A Qualified Domestic Relations Support Order (QDRSO) is a court order requiring a parent to provide dependent's life insurance coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or a QDRSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

If you fail to make an application to obtain coverage of a child, **Aetna** shall enroll such child upon application by such child's other parent, by the division of medical assistance or upon receipt of a national medical support notice from the IVD agency.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a pre-existing condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO or QDRSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

Thirty-One Day Continuation *(GR-9N 31-015-01 MA)*

Coverage under this plan which terminates in accordance with the prior terms of this section will be continued for 31 more days, subject to the following.

- Termination is not due to discontinuance of the Group Contract, or failure to make any required contributions.
- This plan's benefits will be reduced by any other benefits of like kind for which the person becomes eligible.
- If this plan provides a medical expense benefits conversion privilege the following must be submitted to **Aetna** within the 31 day period of continuation:
  - Application for the personal policy; and
  - The premium.

This applies unless the person elects any other available continuation.

Continuation of Coverage for Your Former Spouse

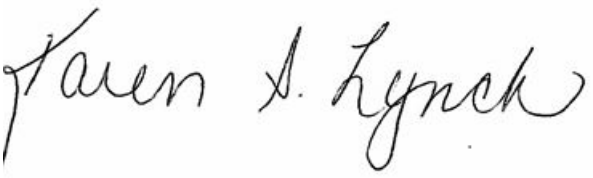
If your health expense benefit coverage for your dependent spouse would terminate because of divorce or of separate support, you may continue any such coverage in force by continuing premium payments.

Coverage may be continued if the valid decree of dissolution of marriage states that you do not have to provide medical or dental coverage for your former spouse.

Coverage will be continued beyond the first to occur of:

- The date you are no longer covered under this Plan.
- The date dependent coverage is discontinued under this Plan for your Eligible Class.
- The end of the period for which required contributions have been made.
- The end of any period set forth in the valid decree of dissolution of marriage during which you are required to provide medical or dental coverage for your former spouse.
- The date you or your former spouse remarries. In the event of remarriage of the group plan member, the former spouse thereafter shall have the right, if so provided in said judgment, to continue to receive benefits as are available to the member, by means of the addition of a rider to the family plan or issuance of an individual plan.

Notice of cancellation of coverage of the divorced or separated spouse of a member shall be mailed to the divorced or separated spouse at their last known address together with notice of the right to reinstate coverage retroactively to the date of cancellation.



Karen S. Lynch
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(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	California Institute of Technology
Group Policy No.:	GP-869105
Rider:	Minnesota ET Dental
Issue Date:	December 10, 2019
Effective Date:	January 1, 2020

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

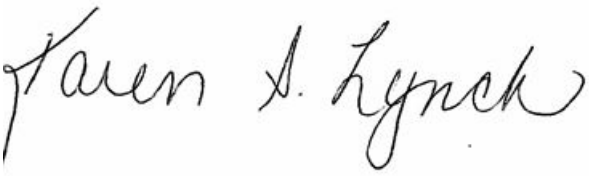
- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of Minnesota. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Minnesota, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Orthodontic Treatment Rule

Orthodontic coverage is only for covered dependent children who are under age 19 on the date active **orthodontic treatment** begins.

The plan does not cover the following orthodontic services and supplies:

- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery;
- Myofunctional therapy;
- Treatment of cleft palate (This exclusion does not apply to dependent children under age 19.);
- Treatment of micrognathia;
- Treatment of macroglossia;
- Treatment of primary dentition;
- Treatment of transitional dentition;
- Lingually placed direct bonded appliances and arch wires (i.e. "invisible braces"); or
- Removable acrylic aligners (i.e. "invisible aligners").



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Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	California Institute of Technology
Group Policy No.:	GP-869105
Rider:	Nevada ET Dental
Issue Date:	December 10, 2019
Effective Date:	January 1, 2020

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Nevada. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Nevada, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

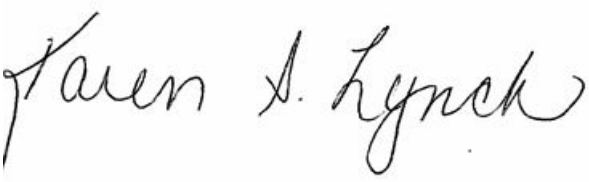
(GR-9N 01-010-01 NV)

The Department of Business and Industry, Division of Insurance of the State of Nevada provides a toll free telephone number which Nevada consumers may use for inquiries and complaints regarding health plans.

Toll Free Telephone Number: 1-888-872-3234

Hours of Operation: 8:00 AM to 5:00 PM Weekdays

Notice: The coverage provided by this certificate shall not deny a claim that involves an act of domestic violence, regardless of whether the insured contributed to any loss or injury.



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Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	California Institute of Technology
Group Policy No.:	GP-869105
Rider:	New Jersey ET Dental
Issue Date:	December 10, 2019
Effective Date:	January 1, 2020

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of New Jersey. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of New Jersey, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Obtaining Coverage for Dependents *(GR-9N 29-010 03 NJ)*

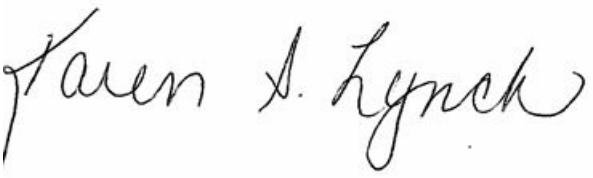
Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse/**civil union partner**; or
- Your domestic partner who meets the rules as defined by the State of New Jersey; and
- Your dependent children; and
- Dependent children of your domestic partner.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

Civil Union Partner *(GR-9N 34-015 02 NJ)*

A person who has established a civil union as defined by New Jersey State Law. If applicable, any references under this Booklet-Certificate made to "marriage", "husband", "wife", "family", "immediate family", "dependent", "next of kin", "widow", "widower", "widowed" or another word which in a specific context denotes a marital or spousal relationship, the same shall include a **civil union partner**. In addition, a same sex relationship entered into outside of New Jersey which is valid under the law of another state or foreign nation that provides substantially all of the rights and benefits of marriage, shall be treated as a **civil union partner** under New Jersey law.



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Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	California Institute of Technology
Group Policy No.:	GP-869105
Rider:	New Mexico ET Dental
Issue Date:	December 10, 2019
Effective Date:	January 1, 2020

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

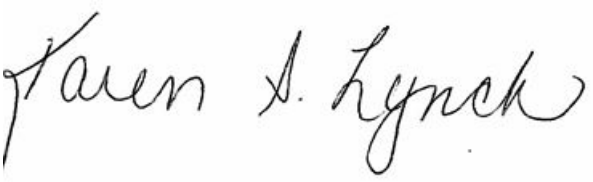
Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of New Mexico. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of New Mexico, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Coverage for Dependent Children

To be eligible, a dependent child must be:

- Unmarried; and
- Under 25 years of age.



Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	California Institute of Technology
Group Policy No.:	GP-869105
Rider:	New York ET Dental
Issue Date:	December 10, 2019
Effective Date:	January 1, 2020

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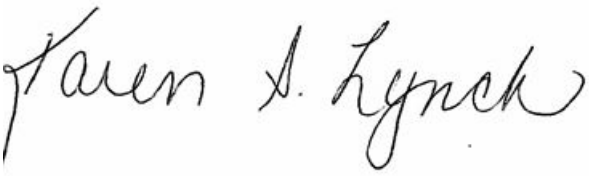
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of New York. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of New York, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Payment of Benefits *(GR-9N 32-025 01 NY)*

Benefits will be paid as soon as the necessary proof to support the claim is received, but not later than 45 days after receipt of such proof. Written proof must be provided for all benefits.



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Extraterritorial Certificate Rider *(GR-9N-CR1)*
Policyholder: California Institute of Technology
Group Policy No.: GP-869105
Rider: Oklahoma ET Dental
Issue Date: December 10, 2019
Effective Date: January 1, 2020

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Oklahoma. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Oklahoma, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Recovery of Overpayments *(GR-9N 32-015 02 OK)*

Health Coverage
If a benefit payment is made by **Aetna**, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, **Aetna** has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right will not apply more than 24 months after the overpayment was made unless: the overpayment was made due to fraud (on the part of the claimant or the health care provider); or the claimant or health care provider has otherwise agreed to return the overpayment.

Such right does not affect any other right of recovery **Aetna** may have with respect to such overpayment.

Appeals Procedure *(GR-9N 32-050-01 OK)*

Definitions

Adverse Benefit Determination (Decision): A denial; reduction; termination of; or failure to; provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage.
- Coverage determinations, including plan limitations or exclusions.
- The results of any Utilization Review activities.
- A decision that the service or supply is **experimental or investigational**.
- A decision that the service or supply is not **medically necessary**.

An **adverse benefit determination** also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the Policy or the Booklet-Certificate.

Appeal: A written request to **Aetna** to reconsider an **adverse benefit determination**.

Complaint: Any written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension: A request to extend a course of treatment that was previously approved.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a course of treatment that was previously approved.

External Review: A review of an **adverse benefit determination** or a **final adverse benefit determination** by an Independent Review Organization/External Review Organization (ERO) assigned by the State Insurance Commissioner and made up of **physicians** or other appropriate health care **providers**. The ERO must have expertise in the problem or question involved.

Final Adverse Benefit Determination: An **adverse benefit determination** that has been upheld by **Aetna** at the exhaustion of the appeals process.

Pre-service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a "Pre-Service Claim."

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- Seriously jeopardize your life or health;
- Jeopardize your ability to regain maximum function;
- Cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Full and Fair Review of Claim Determinations and Appeals

As to medical and **prescription drug** claims and appeals only, **Aetna** will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the **final adverse benefit determination** is required to be provided so that you may respond prior to that date.

Prior to issuing a **final adverse benefit determination** based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of **final adverse determination** is required.

Claim Determinations

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. As to medical and **prescription drug** claims only, if **Aetna** makes an **adverse benefit determination**, written notice will be provided to you, or in the case of a **concurrent care claim**, to your **provider**.

Urgent Care Claims
Aetna will notify you of an **urgent care** claim decision as soon as possible, but not later than 72 hours after the claim is made.

If more information is needed to make an urgent claim decision, **Aetna** will notify the claimant within 72 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify the claimant within 48 hours of the earlier to occur:

- The receipt of the additional information; or
- The end of the 48 hour period given the **physician** to provide **Aetna** with the information.

Pre-Service Claims
Aetna will notify you of a **pre-service** claim decision as soon as possible, but not later than 15 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 15 calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 15 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

Post-Service Claims
Aetna will notify you of a **post-service** claim decision as soon as possible, but not later than 30 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 30 calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 30 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

Concurrent Care Claim Extension
Following a request for a **concurrent care claim extension**, **Aetna** will notify you of a claim decision for **urgent care** as soon as possible, but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided not later than 15 calendar days with respect to all other care, following a request for a **concurrent care claim extension**.

Concurrent Care Claim Reduction or Termination
Aetna will notify you of a claim decision to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.

If you file an **appeal**, coverage under the plan will continue for the previously approved course of treatment until a final **appeal** decision is rendered. During this continuation period, you are responsible for any **copayments**; **coinsurance**; and **deductibles**; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **appeal**. If **Aetna's** initial claim decision is upheld in the final **appeal** decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

Complaints
If you are dissatisfied with the service you receive from the Plan or want to complain about a **provider** you must write Member Services. The complaint must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. **Aetna** will review the information and provide you with a written response within 30 calendar days of the receipt of the **complaint**, unless more information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations
You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for two levels of **appeal**. A **final adverse benefit determination** notice will also provide an option to request an **External Review** (if available).

You have 180 calendar days with respect to Group Health Claims from the date of notice of an **adverse benefit determination** to request your Level One **Appeal**. Your **appeal** must be submitted in writing and must include:

- Your name.
- The employer's name.
- A copy of **Aetna's** notice of an **adverse benefit determination**.
- Your reasons for making the **appeal**.
- Any other information you would like to have considered.

Send your written **appeal** to Member Services at the address shown on your ID Card.

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf. You must provide written consent to **Aetna**.

You may be allowed to provide evidence or testimony during the **appeal** process in accordance with the guidelines established by the Federal Department of Health and Human Services.

Level One Appeal

A review of a Level One **Appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 36 hours of receipt of the request for an **appeal**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 15 calendar days of receipt of the request for an **appeal**.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for an **appeal**.

Level Two Appeal

If **Aetna** upholds an **adverse benefit determination** at the first level of **appeal**, you or your authorized representative have the right to file a Level Two **Appeal**. The **appeal** must be submitted within 60 calendar days from the date of a decision of a Level One **Appeal**.

Review of a Level Two **Appeal** of an **adverse benefit determination** of an **urgent care claim, a Pre-Service Claim, or a Post-Service Claim** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 36 hours of receipt of the request for a Level Two **Appeal**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 15 calendar days of receipt of the request for a Level Two **Appeal**.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for a Level Two **Appeal**.

Exhaustion of Process

You must exhaust the applicable Level One and Level Two processes of the Appeal Procedure before you:

- Contact the Oklahoma Department of Insurance to request an investigation of a **complaint** or **appeal**; or
- File a complaint or **appeal** with the Oklahoma Department of Insurance; or
- Establish any:
  Litigation;
  Arbitration; or
  Administrative proceeding;

regarding an alleged breach of the policy terms by **Aetna** or any matter within the scope of the Appeals Procedure.

Under certain circumstances, you may seek simultaneous review through the internal Appeals Procedure and **External Review** processes—these include **Urgent Care Claims** and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

Important Note:

If **Aetna** does not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the **appeal** requirements and may proceed with **External Review** or any of the actions mentioned above.

There are limits, though, on what sends a claim or **appeal** straight to an **External Review**.

Your claim or internal **appeal** will not go straight to **External Review** if:

- a rule violation was minor and isn't likely to influence a decision or harm you;
- it was for a good cause or was beyond **Aetna's** control; and
- it was part of an ongoing, good faith exchange between you and **Aetna**.

External Review *(GR-9N 32-051-01 OK)*

You may receive an **adverse benefit determination** or **final adverse benefit determination**.

In these situations, you may request an **External Review** if you or your **provider** disagrees with **Aetna's** decision.

To request an **External Review**, any of the following requirements must be met:

- You have received an **adverse benefit determination** notice by **Aetna,** and **Aetna** did not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services.
- You have received a **final adverse benefit determination** notice.
- You qualify for a faster review as explained below.
- As to dental, vision and hearing claims only, the cost of the initial service, supply or treatment in question for which you are responsible exceeds $500.

The notice of **adverse benefit determination** or **final adverse benefit determination** that you receive from **Aetna** will describe the process to follow if you wish to pursue an **External Review**, and will include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to the Oklahoma Insurance Commissioner within four calendar months of the date you received the **adverse benefit determination** or **final adverse benefit determination** notice. You also must include a copy of the notice and all other pertinent information that supports your request.

The Oklahoma Insurance Commissioner will contact the ERO that will conduct the review of your claim. This independent clinical reviewer will be selected from the list of approved independent review organizations compiled and maintained by the Oklahoma Insurance Commissioner. The ERO will select one or more independent clinical reviewers with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the *Request for External Review Form*, and will follow **Aetna's** contractual documents and plan criteria governing the benefits. You will be notified of the decision of the ERO usually within 45 calendar days of **Aetna's** receipt of your request form and all the necessary information.

A faster review is possible if your **physician** certifies (by telephone or on a separate *Request for External Review Form*) that a delay in receiving the service would:

- Seriously jeopardize your life or health; or
- Jeopardize your ability to regain maximum function; or
- If the **adverse benefit determination** relates to **experimental or investigational** treatment, if the **physician** certifies that the recommended or requested health care service, supply or treatment would be significantly less effective if not promptly initiated.

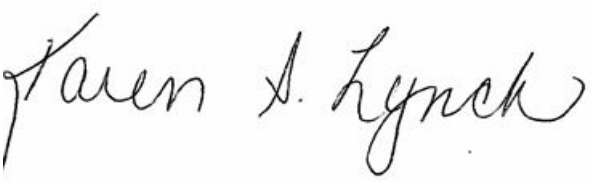
You may also receive a faster review if the **final adverse benefit determination** relates to an admission; availability of care; continued **stay;** or health service for which you received **emergency care**, but have not been discharged from a facility.

Faster reviews are decided within 72 hours after **Aetna** receives the request.

Aetna will abide by the decision of the ERO, except where **Aetna** can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the ERO to **Aetna**. **Aetna** is responsible for the cost of sending this information to the ERO and for the cost of the external review except for dental, vision and hearing claims.

For more information about the Appeals Procedure or **External Review** processes, call the **Member Services** telephone number shown on your ID card.



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Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder: California Institute of Technology
Group Policy No.: GP-869105
Rider: Oregon ET Dental
Issue Date: December 10, 2019
Effective Date: January 1, 2020

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Oregon. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Oregon, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Obtaining Coverage for Dependents *(GR-9N 029-010 02 OR)*

Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse; or
- Your domestic partner who meets the rules outlined in the *Coverage for Domestic Partner* section below; and
- Your dependent children.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

Coverage for Domestic Partner *(GR-9N-29-010-02 OR)*

To be eligible for coverage, you and your domestic partner will need to:

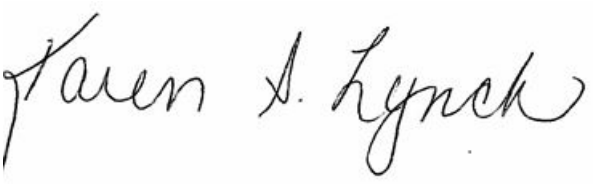
- meet the requirements under Oregon law for entering into a domestic partnership; and
- jointly execute and register a Declaration of Domestic Partnership with the county clerk.

Coverage for Domestic Partner *GR-9N-29-010-02 OR)*

A domestic partner is a person who certifies the following as of the date of enrollment:

- He or she is your sole domestic partner and intends to remain so indefinitely.
- He or she is not married or legally separated from anyone else.
- He or she has not registered as a member of another domestic partnership within the past six months.
- He or she is of the age of consent in your state of residence.
- He or she is not a blood relative to a degree of closeness that would prohibit legal marriage in the state in which you legally reside.

- He or she has cohabitated and resided with you in the same residence for the past six months and intends to cohabitate and reside with you indefinitely.
- He or she is engaged with you in a committed relationship of mutual caring and support, and is jointly responsible for your common welfare and living expenses.
- He or she is not in the relationship solely for the purpose of obtaining the benefits of coverage.
- He or she can demonstrate interdependence with you by submitting proof of at least three of the following:
  - Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property;
  - Common ownership of a motor vehicle;
  - Driver's license listing a common address;
  - Proof of joint bank accounts or credit accounts;
  - Proof of designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under your will; or
  - Assignment of a durable property power of attorney or health care power of attorney.



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Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder: California Institute of Technology
Group Policy No.: GP-869105
Rider: Washington ET Dental
Issue Date: December 10, 2019
Effective Date: January 1, 2020

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- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Washington. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Washington, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Remember plan contributions are subject to change.

Your contributions may be reduced due to **Aetna's** failure to provide agreed upon service levels. Such service levels are guaranteed by **Aetna** and agreed to in writing by **Aetna** and your employer. See your employer for details.

You will need to enroll yourself and any eligible dependents within 30 days of your eligibility date. Otherwise, you or your eligible dependents will be considered a **late enrollee**. If you miss the enrollment period, you and your eligible dependents will not be able to participate in the plan until the next open enrollment period, unless you qualify under a Special Enrollment Period, as described below.

After the initial enrollment period, newborns, adopted children and children placed with you for adoption are automatically covered for 60 days after birth, adoption or placement for adoption. If the addition of your newborn or adopted child will increase your premiums, you will need to complete a change form and return it to your employer within the 60-day enrollment period to continue coverage for your child.

New Dependents
You and your dependents may qualify for a Special Enrollment Period if:

- You did not enroll when you were first eligible for coverage; and
- You later acquire a dependent, as defined under the plan, through marriage, birth, adoption, or placement for adoption; and
- You elect coverage for yourself and your dependent within 30 days of acquiring the dependent through marriage.
- You elect coverage for yourself and your dependent within 60 days of acquiring a dependent through birth, adoption or placement for adoption.

Your spouse or child who meets the definition of a dependent under the plan may qualify for a Special Enrollment Period if:

- You did not enroll them when they were first eligible; and
- You later elect coverage for them within 31 days of a court order requiring you to provide coverage.

If the special enrollment will result in additional premiums, you will need to report any new dependents by completing a change form, which is available from your policyholder. The form must be completed and returned to Aetna within 31 days of the change for the addition of a spouse, and 60 days for the addition of a dependent child, by birth, adoption, or placement with you for adoption. If you do not return the form within these timeframes, you will need to make the changes during the next open enrollment period unless you qualify for another special enrollment period.

Physician
A duly licensed member of a medical profession who:

- Has a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.) degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction within which he or she practices;
- Provides medical services which are within the scope of his or her license or certificate, and
- Is not any person who resides in your home; or who is a member of your family, or a member of your spouse's family or your domestic partner.

Continuation of Coverage During a Labor Dispute

If your coverage under this plan would cease because you cease work due to a strike, lockout or other labor dispute, you can arrange to continue your coverage during your absence from work. You may make the premium payments to your employer. Your employer will transmit the payments to **Aetna**. Call the Member Services toll free number on you ID card for information on the premium payment process. Coverage may continue for up to 6 months. At the end of 6 months you will be eligible for Conversion Coverage.

Continuation will cease when the first of these events occurs:

- You fail to make the required contributions;
- You go to work full time for another employer;
- The labor dispute ends; or
- The 6 month continuation period ends.

The monthly premium required by **Aetna** for each person's coverage will be the applicable effective rate in effect on the date you cease work. If the premium paid by your employer changes during the time you are continuing coverage under this provision, your premiums will change correspondingly.

Coordination of Benefits

Benefits Subject To This Provision: This coordination of benefits (COB) provision applies to **this plan** when you or your covered dependent has medical, dental, vision, or hearing coverage under more than one **plan.** "**Plan**" and "**this plan**" are defined herein. The order of benefit determination rules below determines which **plan** will pay as the **primary plan**. The **primary plan** pays first without regard to the possibility that another **plan** may cover some expenses. A **secondary plan** pays after the **primary plan** and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total **allowable expense**.

Definitions. When used in this provision, the following words and phrases have the meaning explained herein.

Allowable Expense means any health care expense for any **medically necessary** health care service or supply, including, coinsurance and **copayments** and without reduction of any applicable **deductible**, that is covered at least in part by any of the **plans** covering the person. When a **plan** provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an **allowable expense** and a benefit paid. **This plan** limits coordination of health care services or expenses with those services or expenses that are covered under similar types of **plans,** (for example, Medical coverage is coordinated with another Medical **plan**). An expense or service that is not covered by any of the **plans** is not an **allowable expense**. This plan does not coordinate benefits for **prescription drugs**. The following are examples of expenses and services that are not **allowable expense**s:

1. If a covered person is confined in a private **hospital** room, the difference between the cost of a semi-private room in the **hospital** and the private room is not an **allowable expense**. This does not apply if one of the **plans** provides coverage for a private room.
2. If a person is covered by 2 or more **plans** that compute their benefit payments on the basis of **UCR charges** or relative value schedule reimbursement or other similar reimbursement method, any amount in excess of the highest of the reimbursement amount for a specified benefit is not an **allowable expense**.
3. If a person is covered by 2 or more **plans** that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest negotiated charges is not an **allowable expense**.
4. If all plans covering a person are high deductible plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible plan's deductible is not an **allowable expense**, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

When a **plan** provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an **allowable expense** and a benefit paid.

Claim Determination Period. A calendar year.

Closed Panel Plan(s). A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **plan**, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation. In cases where a court decree awards more than half of the calendar year's residential time to one parent without the use of "custodial" terminology, the parent to whom the greater resident time is awarded is considered the **custodial parent**.

Plan. Any **plan** providing benefits or services by reason of medical, dental, vision or hearing care or treatment, which benefits or services are provided by one of the following:

- Group, individual or blanket disability insurance contracts, and group or individual contracts;
- Closed panel plans or other forms of group or individual coverage;
- The medical care components of long term care contracts, such as skilled nursing care; and
- Medicare or other governmental benefits as permitted by law.

Plan does not include:

- Hospital indemnity or fixed payment coverage benefits or other fixed indemnity or payment coverage;
- Accident only coverage;
- Specified disease or specified accident coverage;
- Limited benefit health coverage, as defined in WAC 284-50-370;
- School accident and similar coverages that cover students for accidents only, including athletic injuries, either on a 24 hour basis or on a "to and from school" basis;
- Benefits provided in long-term care insurance policies for non medical services;
- Medicare Supplement policies;
- A state plan under Medicaid;
- A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan'
- Benefits provided as part of a direct agreement with a direct patient-provider primary care practice' and
- Automobile insurance policies required by statute to provide medical benefits.

If the **plan** includes medical, dental, vision and hearing coverage, those coverages will be considered separate **plans**. For example, medical coverage will be coordinated with other medical **plans**, and dental coverage will be coordinated with other dental **plans**. This **plan** does not coordinate coverage for **prescription drugs**.

This plan is any part of the policy that provides benefits for health care expenses.

Primary plan/secondary plan. The order of benefit determination rules state whether **this plan** is a **primary plan** or **secondary plan** as to another **plan** covering the person.

- When **this plan** is a **primary plan**, its benefits are determined before those of the other **plan** and without considering the other **plan's** benefits. A **plan** is considered the **primary plan** if it either has no order of benefit determination rules, or if its rules differ from those permitted by Washington State regulations.
- When **this plan** is a **secondary plan**, its benefits are determined after those of the other **plan** and may be reduced because of the other **plan's** benefits. When coordinating benefits, any **secondary plans** must pay an amount which, together with the payment made by the primary plan, totals the higher of the **allowable expenses**. In no event will a **secondary plan** be required to pay an amount in excess of its maximum benefit plus accrued savings.
- When there are more than two **plans** covering the person, **this plan** may be a **primary plan** as to one or more other **plans**, and may be a **secondary plan** as to a different **plan** or **plans**.

Order of Benefit Determination
When two or more **plans** pay benefits, the rules for determining the order of payment are as follows:

- The **primary plan** pays or provides its benefits as if the **secondary plan** or **plans** did not exist.
- A **plan** that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the **plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a **closed panel plan** to provide out-of-network benefits.
- A **plan** may consider the benefits paid or provided by another **plan** in determining its benefits only when it is secondary to that other **plan**.

- The first of the following rules that describes which **plan** pays its benefits before another **plan** is the rule to use:
  1. Non-Dependent or Dependent. The **plan** that covers the person other than as a dependent, for example as an employee, covered person, subscriber or retiree is primary and the **plan** that covers the person as a dependent is **secondary**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **plan** covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **plans** is reversed so that the **plan** covering the person as an employee, covered person, subscriber or retiree is secondary and the other **plan** is primary.
  2. Child Covered Under More Than One **Plan**. The order of benefits when a child is covered by more than one **plan** is:
     A The **primary plan** is the **plan** of the parent whose birthday occurs earlier in each calendar year if:
        - The parents are married or living together whether or not married;
        - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the **plan** that covered either of the parents longer is primary.

     B If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the **plan** of that parent has actual knowledge of those terms, that **plan** is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the **primary plan**.
        - If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
          - The **plan** of the **custodial parent**;
          - The **plan** of the spouse of the **custodial parent**;
          - The **plan** of the non-**custodial parent**; and then
          - The **plan** of the spouse of the non-**custodial parent**.

     For a dependent child covered under more than one **plan** of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.
  3. Active Employee or Retired or Laid off Employee. The **plan** that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the **primary plan**. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the **secondary plan**. If the other **plan** does not have this rule, and if, as a result, the **plans** do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
  4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another **plan**, the **plan** covering the person as an employee, covered person, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other **plan** does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
  5. Longer or Shorter Length of Coverage. The **plan** that covered the person as an employee, covered person, or subscriber longer is primary. To determine the length of time a person has been covered under a plan, two successive plans are treated as one if the covered person was eligible under the second plan within twenty-four hours after coverage under the first plan ended. The start of a new plan does not include a change in the amount or scope of a plan's benefits; a change in the entity that pays, provides, or administers the plan's benefits; or a change from one type of plan to another, such as from a single employer plan to a multiple employer plan.
  6. If the preceding rules do not determine the **primary plan**, the **allowable expense**s shall be shared equally between the **plans** meeting the definition of **plan** under this provision. In addition, **this plan** will not pay more than it would have paid had it been **primary** plus any accrued savings.

Effect on Benefits of This Plan
In determining the amount to be paid when this plan is secondary on a claim, the **secondary plan** will calculate the benefits that it would have paid on the claim in the absence of other health insurance coverage and apply that amount to any **allowable expense** under this plan that was unpaid by the **primary plan**. The amount will be reduced so that when combined with the amount paid by the **primary plan**, the total benefits paid or provided by all plans for the claim do not exceed 100% of the total **allowable expense**.

In addition, a **secondary plan** will credit to its plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of **this plan**, the amount normally reimbursed for covered benefits or expenses under **this plan** is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under **this plan** for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of **this plan** and another plan both agree that **this plan** determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more **closed panel plan**s COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans

When a **plan** is the **secondary plan**, it may reduce its benefits so that the total benefits paid or provided by all **plans** during a **claim determination period** do not exceed one hundred percent of the total **allowable expenses**. The **secondary plan** must calculate its savings by subtracting the amount that it paid as a **secondary plan** from the amount it would have paid had it been **primary**. These savings are recorded as a benefit reserve for the covered person and must be used by the **secondary plan** to pay any **allowable expenses** not otherwise paid, that are incurred by the covered person during the **claim determination period**. As each claim is submitted, the issuer of the **secondary plan** must:

- Determine its obligation under its **plan**;
- Determine whether a benefit reserve has been recorded for the covered person; and
- Determine whether there are any unpaid allowable expenses during that **claims determination period**.
- Use any amount that has accrued in the covered person's recorded benefit reserve to make payment so that one hundred percent of the total allowable expenses incurred are paid during the claim determination period.

Multiple Coverage Under Aetna Plans
If a person is covered under **this plan** and another **Aetna** plan both as an employee and a dependent or as a dependent of 2 employees, the following will also apply:

- The person's coverage in each capacity under **this plan** and the other **Aetna** plan will be set up as a separate "**plan**".
- The order in which various **plans** will pay benefits will apply to the "**plans**" set up above and to all other **plans**.
- This provision will not apply more than once to figure the total benefits payable to the person for each claim under this **plan.**

Right to Receive and Release Needed Information
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this **plan** and other **plans**. **Aetna** has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment
Any payment made under another **plan** may include an amount which should have been paid under **this plan**. If so, **Aetna** may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under **this plan**. **Aetna** will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If the amount of the payments made by **Aetna** is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Claims, Appeals, Grievances, Independent Medical Review

Appeals Procedure

Definitions

Adverse Benefit Determination: A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit. Written notice of Adverse Benefit Determinations, including the reasons for the determination, will be provided to you and your provider according to the time frames given below. The notice will include information which will assist you in making an appeal if you wish to do so.

In Washington State, an **adverse benefit determination** is either

- an "**adverse determination and non certification**" which means a decision to deny, modify, reduce, or terminate payment for, coverage of, authorization of or provision of health care services or benefits including the admission to or continued stay in a facility" **or**
- a decision that a service or benefit is not covered for other reasons including, but not limited to, member not eligible for coverage at time service is provided, benefit maximums under the plan have been reached, service or supply is not covered under the plan.

Such **adverse benefit determination** may be based on, among other things:

- Your eligibility for coverage;
- The results of any Utilization Review activities;
- A determination that the service or supply is **experimental or investigational**; or
- A determination that the service or supply is not **medically necessary**.

Appeal: An oral or written request to **Aetna** to reconsider an **adverse benefit determination**.

Complaint: Any oral or written expression of dissatisfaction about quality of care or the operation of the plan.

Concurrent Care Claim Extension: A request to extend a previously approved course of treatment.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a previously approved course of treatment.

Pre-service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a "Pre-Service Claim", "Urgent Care Claim" or a "Concurrent Care Claim".

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- Jeopardize your life;
- Jeopardize your ability to regain maximum function;

- Cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

You or **"the claimant".** For purposes of this amendment "you" also means "you **or** your attending **health care provider** or the facility making the claim on your behalf.

Claim Determinations – Group Health Coverage

Urgent Care Claims

Aetna will make notification of an **urgent care** claim determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, **Aetna** will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify the claimant within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the **health care provider** to provide **Aetna** with the information.

If the claimant fails to follow plan procedures for filing a claim, **Aetna** will notify the claimant within 24 hours following the failure to comply.

Pre-Service Claims

If no additional information is required **Aetna** will make a claim determination as soon as possible but not later than 2 business days after the claim is made. **Aetna** will provide notification 2 calendar days after the pre-service claim determination is made. **Aetna** may determine that an extension is needed because **Aetna** needs additional information to make a claim determination. **Aetna** will notify you within 15 calendar days from receipt of a pre-service claim if additional information is needed. The notice of the extension shall specifically describe the required information. You will have 30 calendar days, from the date of the notice, to provide **Aetna** with the required information. **Aetna** will make the claim determination within 2 business days of receipt of all necessary information and will provide notification to the member and the attending **health care provider** or ordering provider or facility within 2 calendar days of the determination.

Post-service Claims

If all information necessary to evaluate a claim is provided when the post service claim is received, **Aetna** will make notification of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. **Aetna** may determine that we need additional information in order to make a claim determination, in which case we may request an extension. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 30 calendar day period. The notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

Concurrent Care Claim Extension

Following a request for a **concurrent care claim extension**, **Aetna** will make notification of a claim determination for **emergency** or **urgent care** as soon as possible but not later than 24 hours, with respect to **emergency** or **urgent care** provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. With respect to all other care, **Aetna** will make a determination within 14 days following a request for a **concurrent care claim extension** and will provide notification within one day of the determination.

Concurrent Care Claim Reduction or Termination

Aetna will make notification of a claim determination to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal,** but in no event will the timeframe for the notification be longer than one day. If you choose to appeal **Aetna**'s determination, **Aetna** will continue to provide the previously approved course of treatment until the appeal is resolved, including Independent Medical Review if requested. If **Aetna**'s decision is affirmed then you will be responsible for the cost of the services provided after the termination date provided in the notification.

Notification of Adverse Determination and Noncertification
Notifications of claim determinations which include an **adverse determination and noncertification** will include the actual reasons for the determination, instructions for obtaining an appeal of the decision, a written statement of the clinical rationale for the decision, and instructions for obtaining the clinical review criteria used to make the determination. Notifications of an adverse determination and noncertification are provided to the member and the treating **health care provider** or provider or facility making the claim.

Complaints

If you are dissatisfied with the service you receive from the plan or want to complain about a **provider** you must call or write Aetna Member Services within 180 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. **Aetna** will review the information and provide you with a notification of receipt of your **complaint** within 5 days, and a written response within 14 calendar days of the receipt of the **complaint**, unless additional information is needed and it cannot be obtained within this period. If additional information is necessary to respond to your complaint **Aetna** will notify you within the initial 14 day period and may extend the response time to 30 days from the date of receipt of the complaint. **Aetna** will not take longer than 30 days to respond to your complaint without your written permission. The notice of the decision will tell you what you need to do to request an External Review.

Appeals of Adverse Benefit Determinations

You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. This plan provides for one level of **appeal**. It will also provide an option to request an external review of the **adverse benefit determination**.

You have 180 calendar days following the receipt of notice of an **adverse benefit determination** to request your **appeal**. Your **appeal** may be submitted orally or in writing and should include:

- Your name;
- Your **policyholder's** name
- A copy of **Aetna's** notice of an **adverse benefit determination**;
- Your reasons for making the **appeal**; and
- Any other information you would like to have considered.

Send in your **appeal** to Member Services at the address shown on your ID Card, or call in your **appeal** to Member Services using the toll-free telephone number shown on your ID Card.

Alternatively, you may send your **appeal** to the address shown on the notice of **adverse benefit determination**, or you may call in your **appeal** using the toll-free telephone number listed on such notice.

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf by providing written consent to **Aetna**.

Appeal – Group Health Claims

An **appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel not involved in making the **adverse benefit determination**. You may request assistance making your appeal by calling the toll free Member Services number listed on your ID card. **Aetna** will send you notification that your appeal has been received.

Urgent care claims (May Include **concurrent care claim reduction or termination**)
Aetna shall issue a decision within 36 hours of receipt of the request for an **appeal**.

Pre-service claims (May Include **concurrent care claim reduction or termination**)
Aetna shall issue a decision within 14 calendar days of receipt of the request for an **appeal** unless additional information is necessary to complete review of the appeal. You will be notified within the initial 14 day period if additional information is necessary. **Aetna** will make a decision on the claim within 30 days of the receipt of the claim, unless we have your written consent to extend the appeal period. For appeals of claims decisions based on the determination that the requested treatment, service or supply is **experimental or investigational**, **Aetna** will issue a decision within 20 working days.

Post-Service Claims
Aetna shall issue a decision within 14 calendar days of receipt of the request for an **appeal** unless additional information is necessary to complete review of the appeal. You will be notified within the initial 14 day period if additional information is necessary. **Aetna** will make a decision on the claim within 30 days of the receipt of the claim, unless we have your written consent to extend the appeal period.

Exhaustion of Process

You are encouraged to exhaust the applicable process of the Appeal Procedure before you:

- Contact the Office of the Insurance Commissioner to request an investigation of a **complaint** or **appeal**; or
- File a complaint or **appeal** with the Office of the Insurance Commissioner; or
- Establish any:
  - Litigation;
  - Arbitration; or
  - Administrative proceeding;

regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

External Review Group Health Claims
If you do not agree with **Aetna's** decision of your **appeal**, or if **Aetna** takes longer than 30 days from the date of receipt of your **appea**l to reach a decision without your written consent, you or your provider may request an independent external review. An external review is a review by an External Review Organization, who assigns a reviewer with expertise in the problem or question involved to review your request and reach an independent decision.

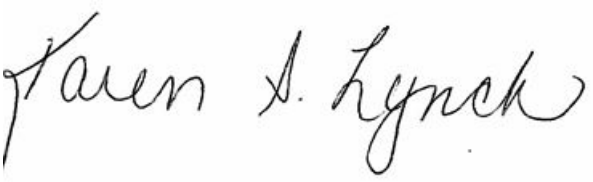
The appeal denial letter you receive from **Aetna** will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to **Aetna** within 180 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will contact the External Review Organization, according to the requirements of Washington Law, that will conduct the review of your claim and not later than the third business day after the date we receive your request for external review, will forward the required documents, including the material you sent to us to the External Review Organization. You may request a copy of the material we send, and we may request a copy of any additional material you or your treating provider send to the External Review Organization. The External Review Organization will select an independent **physician** or contract specialist with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow **Aetna's** contractual documents and plan criteria governing the benefits. You will be notified of the decision of the External Review Organization usually within 30 calendar days of **Aetna's** receipt of your request form and all necessary information. A quicker review is possible if your **health care provider** certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Expedited reviews are decided within 3 to 5 calendar days after **Aetna** receives the request.

Aetna will abide by the decision of the External Review Organization.

Aetna is responsible for the cost of sending the information that was used to make the initial determination and the claim determination, and any information from you or your provider to the External Review Organization and for the cost of the external review. You are responsible for the cost of compiling and sending the information, other than medical records, that you wish to be reviewed by the External Review Organization to **Aetna**.



Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	California Institute of Technology
Group Policy No.:	GP-869105
Rider:	West Virginia ET Dental
Issue Date:	December 10, 2019
Effective Date:	January 1, 2020

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other dental extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

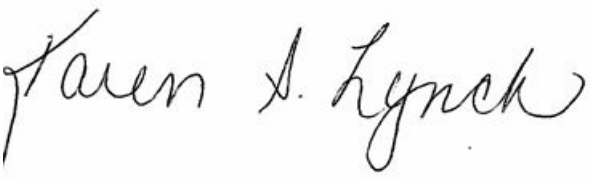
- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of West Virginia. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of West Virginia, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

(GR-9N 29-010-01 WV)

Coverage for Dependent Children

To be eligible, a dependent child must be:

- Unmarried; and
- Under 25 years of age.



Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)