

BENEFIT PLAN

Prepared for
Caraday Healthcare, LLC

Comprehensive Dental Max Plan

What Your Plan
Covers and How
Benefits are Paid

Aetna Life Insurance Company
Booklet-certificate

This Booklet-certificate is part of the Group policy between
Aetna Life Insurance Company and the Policyholder



Booklet-certificate

Comprehensive dental insurance plan

Prepared for:

Policyholder: Caraday Healthcare, LLC
Policyholder number: GP-175291-A
Booklet-certificate: 1
Group policy effective date: August 1, 2021
Plan name: Comprehensive Dental Base Plan
Plan effective date: August 1, 2021
Plan issue date: June 24, 2021

Important note:

The insurance policy under which this certificate is issued is not a policy of workers' compensation insurance. You should consult your employer to determine whether your employer is a subscriber to the workers' compensation system.

Underwritten by Aetna Life Insurance Company



Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Aetna, Inc.

To get information or file a complaint with your insurance company or HMO:

Call: Aetna's toll-free telephone number at 1-888-416-2277

Toll-free: 1-888-416-2277

Online: www.aetna.com

Email: aetnamemberservices@aetna.com

Mail: Aetna, Inc., P.O. Box 14464, Lexington, KY 40512

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Aetna, Inc.

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: al numero de teléfono gratis de Aetna al 1-888-416-2277

Teléfono gratuito: 1-888-416-2277

En línea: www.aetna.com

Correo electrónico: aetnamemberservices@aetna.com

Dirección postal: Aetna, Inc., P.O. Box 14464, Lexington, KY 40512

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

Welcome

Thank you for choosing **Aetna**.

This is your booklet-certificate. It is one of three documents that together describe the benefits covered by your **Aetna** plan for services provided by both **contracting dental providers** and **non-contracting dental providers**.

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

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

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

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

Welcome to your **Aetna** plan.

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Let's get started!

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

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

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

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

What your plan does – providing covered benefits

Your plan provides **covered benefits**. These are **eligible dental services** for which your plan has the obligation to pay.

How your plan works – starting and stopping coverage

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

You can lose coverage for many reasons. To learn more see the *When coverage ends* section.

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

How your plan works while you are covered

Your coverage helps you:

- Get and pay for **eligible dental services**

You have coverage whether you get your care from **contracting dental providers** or **non-contracting dental providers**.

When you get care from **non-contracting dental providers** it means:

- You can get care from **dental providers** who are not contracted with **Aetna**.
- You may have to pay for services at the time that they are provided. You may be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of **eligible dental services** that you paid directly to a **dental provider**.

You will find details on:

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

Important note:

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

Eligible dental services

Eligible dental services meet these requirements:

- They are listed in the *Eligible dental services* section in the schedule of benefits.
- They are not carved out in these sections:
 - *What are your eligible dental services?*
 - *What rules and limits apply to dental care?*
 - *What your plan doesn't cover – exclusions* sections. We refer to this section as “Exclusions”.
- They are not beyond any limits in the *What rules and limits apply to dental care?* section and the schedule of benefits

Aetna's contracted dental providers

Aetna's contracting dental providers are there to give you the care you need. You can find **contracting dental providers** and see important information about them most easily on our online **provider directory**. Just log onto our self-service website. See the *How to contact us for help* section.

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

For more information about the **provider directory** and **contracting dental providers**, see the *Who provides the care* section.

Paying for eligible dental services– the general requirements

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

- The **eligible dental service** is **medically necessary**
- You get the **eligible dental service** from **contracting** or **non-contracting dental providers**

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

Paying for eligible dental services– sharing the expense

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

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

How to contact us for help

We are here to answer your questions. You can contact us by registering and logging onto our self-service website available 24/7 that requires registration and logon at www.aetna.com.

In our website you can get reliable dental information, tools and resources. Online tools will make it easier for you to:

- Make informed decisions about your dental care
- View claims
- Research care and treatment options
- Access information on health and wellness

You can also contact us by:

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

Your ID card

You don't need to show an ID card. When visiting a **dentist**, just provide your:

- Name
- Date of birth
- ID card number or social security number

The dental office can use that information to verify your eligibility and benefits. Your ID card number is located on your digital ID card which you can view or print by going to our self-service website. If you don't have internet access, call us. You can also access your ID card when you're on the go. To learn more, visit us at www.aetna.com/mobile.

Who the plan covers

You will find information in this section about:

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

Who is eligible

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

When you can join the plan

As an employee you can enroll yourself and your dependents:

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

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

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

You can enroll the following family members on your plan. (They are referred to in this booklet-certificate as your "dependents".)

- Your legal spouse
- Your dependent children – yours or your spouse's
 - Dependent children must be:
 - Under 26 years of age
 - Dependent children include:
 - Natural children
 - Stepchildren
 - Adopted children including any children placed with you for adoption and any child when you become a party in a suit to adopt the child.*
 - Foster children
 - Children you are responsible for under a qualified medical or dental support order or court-order
 - Grandchildren in your legal custody
 - Grandchild who, at the time of application, is your dependent for federal tax purposes
 - A grandchild whose parent is already covered as a dependent on this plan

*Your adopted child may be enrolled as shown in the *Adding new dependents* section, after the date:

- You become a party in a suit for adoption, or
- The adoption becomes final

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

Adding new dependents

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

- A spouse - If you marry, you can put your spouse on your plan.
 - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
 - Ask the policyholder when benefits for your spouse will begin. It will be:
 - No later than the first day of the first calendar month after the date we receive your completed enrollment information
 - Within 31 days of the date of your marriage.
- A newborn child – Your newborn child is covered on your dental plan for the first 31 days after birth.
 - To keep your newborn covered, we must receive verbal or written enrollment information within 31 days of birth.
 - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
 - If you miss this deadline, your newborn will not have dental benefits after the first 31 days.
- An adopted child – A child that you, or that you and your spouse adopts is covered on your plan for the first 31 days after you become party in a suit to adopt the child or the adoption is complete.
 - To keep your adopted child covered, we must receive your completed enrollment information within 31 days after you become party in a suit to adopt the child or the adoption is complete.
 - If you miss this deadline, your adopted child will not have dental benefits after the first 31 days.
- A stepchild – You may put a child of your spouse on your plan.
 - You must complete your enrollment information and send it to us within 31 days after the date of your marriage with your stepchild's parent.
 - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage or the first day of the month following the date we receive your completed enrollment information.

Inform us of any changes

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

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

Late entrant rule

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

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

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

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

Special times you and your dependents can join the plan

You can enroll in these situations:

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

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

Effective date of coverage

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

Medical necessity requirements

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

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

Medically necessary/medical necessity

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

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

What are your eligible dental services?

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

Your plan covers many kinds of dental care services and supplies. But some are not covered at all or are covered only up to a limit.

You can find out about exceptions and exclusions in the

- *Dental provider services* benefit below
- *What rules and limits apply to dental care?* section
- *Exclusions* section

Schedule of benefits

Eligible dental services include dental services and supplies provided by **contracting** and **non-contracting dental providers**. Your schedule of benefits includes a detailed list of **eligible dental services** under your dental plan (including any maximums and limits that apply to them).

Dental provider services

The following are not **eligible dental services** under your plan except as described in the *What rules and limits apply to dental care?* section of this booklet-certificate, the schedule of benefits, or a rider or amendment issued to you for use with this booklet-certificate:

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

Dental emergency services

Eligible dental services include **dental emergency services** provided for a **dental emergency**. The care provided must be a **covered benefit**.

If you have a **dental emergency**, you should consider calling your **contracting dental provider** who may be more familiar with your dental needs. However, you can get treatment from any **dentist** including one that is a **non-contracting dental provider**. If you need help in finding a **dentist**, call us.

What rules and limits apply to dental care?

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

Alternate treatment rule

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

If a charge is made for a non-eligible dental service but an **eligible dental service** would have provided acceptable results, then your plan will pay a benefit for the **eligible dental service**.

If a charge is made for an **eligible dental service** but a different **eligible dental service** would have provided acceptable results and is less expensive, then your plan will pay a benefit based upon the least expensive **eligible dental service**.

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

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

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

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

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

Reimbursement policies

We reserve the right to apply our reimbursement policies to all services including involuntary services. Those policies may affect the **negotiated charge** or **recognized charge**. These policies consider:

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

Aetna reimbursement policies are based on our review of:

- Generally accepted standards of dental practice
- The views of **providers** and **dentists** practicing in the relevant clinical areas

Replacement rule

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

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

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

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

Tooth missing but not replaced rule

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

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

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

What your plan doesn't cover – exclusions

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

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

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

Exclusions

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

- The *What are your eligible dental services?* section
- The *What rules and limits apply to dental care?* section
- The schedule of benefits
- A rider or amendment issued to you for use with this booklet-certificate

Charges for services or supplies

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

Charges in excess of any benefit limits

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

Cosmetic services and plastic surgery (except to the extent coverage is specifically provided in the schedule of benefits)

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

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

Court-ordered services and supplies

- This includes those court ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding, unless they are an **eligible dental service** under this plan.

Dental services and supplies

- Those covered under any other plan of group benefits provided by the policyholder

Examinations

Any dental examinations needed:

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

Experimental or investigational

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

Non-medically necessary services

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

Other primary payer

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

Outpatient prescription drugs, and preventive care drugs and supplements

- Prescribed drugs, pre-medication or analgesia

Personal care, comfort or convenience items

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

Providers and other health professionals

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

Services paid under your medical plan

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

Services received outside of the United States

- Non-dental emergency services received outside of the United States. They are not covered even if they are covered in the United States under this booklet-certificate.

Teledentistry

Work related illness or injuries

- Coverage available to you under workers' compensation or under a similar program under local, state or federal law for any **illness** or **injury** related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law.
- If you submit proof that you are not covered for a particular **illness** or **injury** under such law, then that **illness** or **injury** will be considered "not work related" regardless of cause.

Who provides the care

The starting point for coverage under your plan is whether the services and supplies are **eligible dental services**. This section tells you about **contracting** and **non-contracting dental providers**.

Contracting dental providers

We have contracted with **dental providers** to provide **eligible dental services** to you.

For you to receive the **contracting dental provider** level of benefits you must use **contracting dental providers** for **eligible dental services**.

You can find **contracting dental providers** and see important information about them by logging onto our self-service website. You can search our online **provider directory** for names and locations of **contracting dental providers**.

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

Non-contracting dental providers

You also have access to **non-contracting dental providers**. This means you can receive **eligible dental services** from a **non-contracting dental provider**.

If you use a **non-contracting dental provider** to receive **eligible dental services**, you are responsible for submitting your own claims.

What the plan pays and what you pay

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

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

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

The general rule

When you get **eligible dental services**:

- You pay your **deductible**

And then

- The schedule of benefits lists how much you pay and your plan pays. The **coinsurance** percentage may vary by the type of expense.

And then

- You are responsible for any amounts above the **calendar year** and **lifetime maximums**.

When we say “expense” in this general rule, we mean the **negotiated charge** for **contracting dental providers** and **recognized charge** for **non-contracting dental providers**. See the *Glossary* section for what these terms mean.

Important note – when you pay all

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

The **dental provider** may require you to pay the entire charge. And any amount you pay will not count towards your **deductible** or towards your **Calendar Year** and **lifetime maximums**.

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage

Where your schedule of benefits fits in

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

How your deductible works

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

How we count your deductible

When you see **contracting dental providers**, we count the **negotiated charge** toward your **contracting dental provider deductible**. When you see **non-contracting dental providers**, we count the **recognized charge** toward your **non-contracting dental provider deductible**.

How your coinsurance works

Your **coinsurance** is the amount you pay for **eligible dental services** after you have paid your **deductible**. The schedule of benefits shows the **coinsurance** this plan will pay for specific **eligible dental services**. You are responsible for paying any remaining **coinsurance**.

How your maximum works

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

Important note:

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

When you disagree - claim decisions and appeals procedures

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

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

Claim procedures

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

The table below explains the claim procedures as follows:

Notice	Requirement	Deadline
Submit a claim	<ul style="list-style-type: none"> • You should get a claim form from our self-service website or call us no later than 20 days after the date of loss • The claim form will provide instructions on how to complete and where to send the forms 	<ul style="list-style-type: none"> • We must send you a claim form within 15 business days of your request • If the claim form is not sent on or by the 16th day, you are considered to have complied with the requirements for submitting proof of loss • You may send us: <ul style="list-style-type: none"> – A description of services – Itemized bill of charges – Any dental documentation you received from your dental provider
<p>Proof of claim</p> <p>When you have received a service from an eligible dental provider, you will be charged.</p> <p>The information you receive for that service is your proof of loss.</p>	<ul style="list-style-type: none"> • A completed claim form and any additional information required by us 	<ul style="list-style-type: none"> • You must send us notice and proof as soon as reasonably possible

Benefit payment	<ul style="list-style-type: none"> • Written proof must be provided for all benefits • If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss 	<ul style="list-style-type: none"> • We will accept or reject a claim not later than 15 business days of receiving all items, statements and forms • Benefits will be paid not later than 5 business days after the date the notice of acceptance is sent • If we reject the claim the written notice will include the reason for denial • All benefits payable will be paid no later than 60 calendar days from the date proof of loss is received
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If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if it is filed as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 24 months after the deadline.

Communicating our claim decisions

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

Retrospective claim

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

Type of notice	Retrospective claim
Initial decision by us	30 days
Extensions	15 days
If we request more information	30 days
Time you have to send us additional information	45 days

If we approve the care and services, we will send you a letter no later than 2 business days after we receive the request. The *Adverse determinations* section explains how and when we tell you about an adverse determination.

Adverse determinations

We pay many claims at the full rate **negotiated charge** with **contracting dental providers** and the **recognized charge** with **non-contracting dental providers**, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we don't pay at all. Any time we don't pay even part of the claim, that is called an "adverse determination" or "adverse decision".

An adverse determination is our determination that the health care services you have received or may receive, are:

- **Experimental or investigational**
- Not **medically necessary**

If we make an adverse determination, we will tell you in writing. Our written decision will tell you:

- The main reason for the denial
- The clinical basis for the denial
- The source of the screening criteria used as a guideline to make the decision
- How to ask for an appeal of the denial, including your right to appeal to an independent review organization (IRO) and how to obtain an independent review
- How to obtain an immediate review by the IRO when the claim denial involves a life-threatening condition.

The chart below tells you how much time we have to tell you about an adverse determination.

Type of notice	Retrospective review
Initial decision	Within 30 days after the date on which the claim is received
Extensions	15 days
Additional Information Request (us)	30 days
Response to additional information request (you)	45 days

Important note:

We will tell you about an adverse determination within the time appropriate to the circumstances relating to the delivery of the services and your condition. We will always tell you no later than the times shown in the chart above.

The difference between a complaint and an appeal

A complaint

You may not be happy about a **dental provider** or an operational issue, and you may want to complain. You can call or write us. Your complaint should include a description of the issue.

Some other examples of complaints are when you are not happy with:

- How we have administered the plan
- How we have handled the appeal process
- When we deny a service that is not related to **medical necessity** issues
- The manner in which a service is provided
- A disenrollment decision

But it is not a complaint if:

- We resolve a misunderstanding or misinformation, to your satisfaction, by providing an explanation or more information.
- You or your **provider** call or write to tell us you are unhappy with, or disagree with, an adverse determination. Instead, this is an appeal of the adverse determination. See the *Appeal of adverse determinations* and *Timeframes for deciding appeals of adverse determinations* sections for more information.

Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will let you know that we have received your complaint within 5 business days. Our letter will tell you about our complaint procedures and timeframes. If you call us to complain, we will send you a complaint form to complete and return.

We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. If your complaint is for services that you have not already received, we will provide you with a written response within 15 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

If your complaint concerns an emergency, we will do an expedited appeal review. See the *Appeal of adverse determinations* and *Timeframes for deciding appeals of adverse determinations* sections for more information.

An appeal

You can ask us to review an adverse determination. This is called an appeal. You can appeal by calling us.

Appeals of adverse determinations

You can appeal our adverse determination. We will assign your appeal to someone who was not involved in making the original decision.

You can appeal by sending a written appeal to the address on the notice of adverse determination or by calling us. You need to include:

- Your name
- The policyholder's name
- A copy of the adverse determination
- Your reasons for making the appeal
- Any other information you would like us to consider
- If you appealed verbally or by phone, we will send you a one page appeal form to be filled out by you or your authorized representative

Another person may submit an appeal for you, including a **dental provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **dental provider**). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form on our website or by contacting us. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

We will let you know that we have received your appeal of the adverse determination within 5 business days. This notice will describe the appeals process and your rights. If you call us to appeal, we will send you an appeal form to complete and return.

The review and decision of your appeal will be made by personnel not involved in making the initial adverse determination.

Expedited internal appeal

You are entitled to an expedited internal appeal process for emergency care denials and denials of care for life-threatening conditions.

The review and decision of your appeal will be made by personnel not involved in making the initial adverse determination.

Important note:

You can skip our standard and expedited internal appeal process and instead appeal to an independent review organization (IRO) in some situations. See the *Exhaustion of appeals process* section.

Timeframes for deciding appeals of adverse determinations

The amount of time that we have to tell you about our decision on an appeal of an adverse determination depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision. We may tell you about our decision verbally or in writing. If we tell you verbally, we will also send you a letter within 3 calendar days after the verbal notice.

Type of appeal	Our response time
Retrospective appeal	As soon as possible but not later than 30 calendar days from receipt of the request for appeal*
Expedited internal appeal	As soon as possible (based on the medical or dental immediacy of the condition, procedure, or treatment under review) but no later than 1 business day from the date all information to complete the review is received

*If your appeal is denied, your **dental provider** may ask us in writing to have a certain type of specialty **provider** review your case. The request must show good cause for specialty review. The request must be made not later than 10 business days after the appeal was denied. A **provider** of the same or a similar specialty who would typically manage this type of condition will do the review. A decision will be made within 15 working days of the date we receive such a request.

Exhaustion of appeals process

In most situations you must complete the appeal process with us before you can appeal through an independent review process. If you have a life-threatening condition, you can have your appeal reviewed through the independent review process.

We encourage you to complete an appeal with us before you pursue voluntary arbitration, litigation or other type of administrative proceeding.

Independent review

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

You have a right to independent review only if:

- Our claim decision involved medical judgment
- We decided the service or supply is not **medically necessary** or not appropriate
- We decided the service or supply is **experimental or investigational**
- You have received an adverse determination

If our claim decision is one for which you can seek independent review, we will say that in the notice of adverse determination we send you. That notice also will describe the independent review process. It will include a copy of the Request for Independent Review form.

You must submit the Request for Independent Review form:

- To **Aetna**
- Within 4 months of the date you received the decision from us
- And you must include a copy of the notice from us and all other important information that supports your request

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

Aetna will send your independent review request to the Texas Department of Insurance (TDI). The TDI will assign it to an IRO and notify us of the assignment. We will send your request and supporting information to the assigned IRO no later than the third business day after we receive it.

The IRO will:

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

We will stand by the decision that the IRO makes, unless we can show conflict of interest, bias or fraud.

How long will it take to get an IRO decision?

The IRO will notify you of their decision. The amount of time they have to make their decision is based on the services you are requesting. The chart below tells you how much time the IRO has to review your request.

IRO Decisions	
When your request involves:	The IRO will notify you within:
Dental emergency services	72 hours
Any other service	The earlier of: <ul style="list-style-type: none">• 15 days after the IRO receives all necessary information• 20 days after the IRO receives the request

Recordkeeping

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

Fees and expenses

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

Coordination of benefits

The Coordination of Benefits (“COB”) provision applies when a person has dental coverage under more than one plan. If you do, we will work together with your other plans to decide how much each plan pays. This is called coordination of benefits (COB). Plan is defined below *Key terms*.

The order of benefit determination rules tell you the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms. Payment is made without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

Key terms

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

<p>Plan:</p> <p>A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.</p>	
<ul style="list-style-type: none">• It includes:	<ul style="list-style-type: none">• Group, blanket or franchise accident and health insurance policies, excluding disability income protection coverage• Individual and group health maintenance organization evidences of coverage• Individual accident and health insurance policies• Individual and group preferred provider benefit plans and exclusive provider benefit plans• Group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care• Dental care components of individual and group long-term care contracts• Limited benefit coverage that is not issued to supplement individual or group in-force policies• Uninsured arrangements of group or group-type coverage• The dental benefits coverage in automobile insurance contracts• Medicare or other governmental benefits, as permitted by law

<ul style="list-style-type: none"> • It does not include: 	<ul style="list-style-type: none"> • Disability income protection coverage • The Texas Health Insurance Pool • Workers' compensation insurance coverage • Hospital confinement indemnity coverage or other fixed indemnity coverage • Specified disease coverage • Supplemental benefit coverage • Accident only coverage • Specified accident coverage • School accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis • Benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services • Medicare supplement policies • A state plan under Medicaid • A governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan • Other nongovernmental plan • An individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible
<ul style="list-style-type: none"> • Each plan for coverage is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan 	
<p>This plan: This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans</p>	
<ul style="list-style-type: none"> • How this plan coordinates with like benefits: 	<p>Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.</p>

<ul style="list-style-type: none"> The order of benefit determination rules for this plan: 	<p>The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan.</p> <ul style="list-style-type: none"> When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100% of the total allowable expense
<p>Allowable expense: Allowable expense is a health or dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person.</p>	
<ul style="list-style-type: none"> Allowable expense for benefits provided in the form of services: 	<p>When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.</p>

- Expenses that are not allowable expenses:

An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a **provider** or **physician** by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

Some expenses and services are not allowable expenses. Here are some examples:

- The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.
- If a person is covered by two or more plans that don't have a **negotiated charge** and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
- If a person is covered by two 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.
- If a person is covered by one plan that does not have **negotiated charges** and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides it benefits or services based on **negotiated charges**, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care **provider** or **physician** has contracted with the secondary plan to provide the benefit or service for a specific **negotiated charge** or payment amount that is different than the primary plan's payment arrangement and if the health care **provider's** or **physician's** contract permits, the **negotiated charge** or payment must be the allowable expense used by the secondary plan to determine its benefits.
- The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, preauthorization of admissions, and **provider** and **physician** arrangements.

<p>Allowed amount: Allowed amount is the amount of a billed charge that a carrier determines to be covered for services by an out-of-network provider. The amount includes both the carrier’s payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.</p>
<p>Closed panel plan: Closed panel plan is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care providers and physicians that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care providers and physicians, except in cases of emergency or referral by a panel member.</p>
<p>Custodial parent: Custodial parent is the parent with the right to designate the primary residence of a child by court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation</p>

Order of benefits determination rules

When you are covered by two or more plans, the rules for determining the order of benefit payments are as follows:

<ul style="list-style-type: none"> • The primary plan pays according to its terms of coverage and without regard to the benefits under any other plan.
<ul style="list-style-type: none"> • A plan that does not have a COB provision is always primary unless the provisions of both plans state that the complying plan is primary, except: <ul style="list-style-type: none"> – Coverage that you have because of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are: <ul style="list-style-type: none"> ○ Major medical coverages that are superimposed over base plan hospital and surgical benefits ○ Insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
<ul style="list-style-type: none"> • A plan may consider the benefits paid by another plan in calculating payment of its benefits only when it is secondary to that other plan.
<ul style="list-style-type: none"> • If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay benefits as if it were the primary plan when a covered person uses an out-of-network provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan.
<ul style="list-style-type: none"> • When multiple contracts providing coordinated coverage are treated as a single plan, this applies only to the plan as a whole. Coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with these rules.
<ul style="list-style-type: none"> • If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.

Determining who pays

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

If you are:	Primary plan	Secondary plan
Covered under the plan as an employee, retired employee or dependent	The plan covering you as an employee, member, policyholder, subscriber or retired employee	The plan covering you as a dependent
Eligible for Medicare	If you or a dependent have Medicare coverage, the rule above may be reversed so that the plan covering you or your spouse as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee. Call us if you have questions	
<p>COB rules for dependent children Unless there is a court order stating otherwise, the order of benefits is determined using the following rules that apply.</p>		
Child of: <ul style="list-style-type: none"> • Parents who are married or living together, whether or not they have ever been married 	The “birthday rule” applies. The plan of the parent whose birthday* (month and day only) falls earlier in the Calendar Year *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)* *Same birthdays--the plan that has covered a parent longer is primary
Child of: <ul style="list-style-type: none"> • Parents separated or divorced or not living together, whether or not they have ever been married • With court-order 	The plan of the parent whom the court said is responsible for dental coverage But if that parent has no coverage then their spouse’s plan is primary.	The plan of the other parent. But if that parent has no coverage, then their spouse’s plan is primary.

<p>Child of:</p> <ul style="list-style-type: none"> Parents separated or divorced or not living together, whether or not they have ever been married – court-order states both parents are responsible for coverage or have joint custody 	<p>Primary and secondary coverage is based on the birthday rule</p>
<p>Child of:</p> <ul style="list-style-type: none"> Parents separated or divorced or not living together, whether or not they have ever been married and there is no court-order 	<p>The order of benefit payments is:</p> <ul style="list-style-type: none"> The plan of the custodial parent pays first The plan of the spouse of the custodial parent (if any) pays second The plan of the noncustodial parents pays next The plan of the spouse of the noncustodial parent (if any) pays last
<p>Child covered by:</p> <ul style="list-style-type: none"> Individual who is not a parent (i.e. stepparent or grandparent) 	<p>Treat the person the same as a parent when making the order of benefits determination:</p> <p>See <i>Child of</i> content above</p>
<p>Child of: Persons, who are not his or her parents</p>	<p>The rules shown for parents will apply, as if the persons were parents of the child.</p>
<p>Child of: Parents, who is also covered under a spouse’s plan</p>	<p>The plan that has covered the person longer is primary.</p> <p>If coverage under the plans began on the same date, primary and secondary coverage is based on the birthday rule of the parents and spouse.</p>

<p>Active or inactive employee</p> <p>This rule does not apply if:</p> <ul style="list-style-type: none"> • The plan that covers you as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits • The “Non-dependent or Dependent” paragraph, above, can determine the order of benefits 	<p>The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee)</p>	<p>A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee)</p>
<p>COBRA or state continuation</p> <p>This rule does not apply if:</p> <ul style="list-style-type: none"> • The other plan does not have this rule, and as a result, the plans do not agree on the order of benefits • The “Non-dependent or Dependent” paragraph, above, can determine the order of benefits 	<p>The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage</p>	<p>COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree</p>
<p>Longer or shorter length of coverage</p>	<p>If none of the above rules determine the order of payment, the plan that has covered the person longer is primary</p>	
<p>Other rules do not apply</p>	<p>If none of the above rules apply, the plans share expenses equally</p>	

Effect on the benefits of this plan

- When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan:
 - Will calculate the benefits it would have paid in the absence of other health care coverage. The calculated amount will be applied to any allowable expense under its plan that is unpaid by the primary plan.
 - May reduce its payment so that the total benefits paid or provided by all plans for the claim equal 100% of the total allowable expense for that claim.
 - Must credit to its plan deductible (if any) any amounts it would have credited to its deductible in the absence of other health care coverage.
- If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

Compliance with federal and state laws concerning confidential information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. We will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give us any facts it needs to apply those rules and determine benefits.

Facility of payment

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

Right of recovery

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid. Or, we may recover from 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 the benefits provided in the form of services.

Other dental coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

When coverage ends

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

When will your coverage end?

Coverage under this plan will end if:

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

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

When coverage may continue under the plan

Your coverage under this plan will continue if:

<p>Your employment ends because of illness, injury, sabbatical or other authorized leave as agreed to by the policyholder and us.</p>	<p>If premium payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below:</p> <ul style="list-style-type: none"> Your coverage may continue, until stopped by the policyholder, but not beyond 30 months from the start of your absence.
<p>Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by the policyholder and us.</p>	<p>If premium payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below:</p> <ul style="list-style-type: none"> Your coverage will stop on the date that your employment ends.
<p>Your employment ends because either:</p> <ul style="list-style-type: none"> Your job has been eliminated You have been placed on severance This plan allows former employees to continue their coverage 	<p>You may be able to continue coverage. See the <i>Special coverage options after your plan coverage ends</i> section.</p>
<p>Your employment ends because of a paid or unpaid medical leave of absence</p>	<p>If premium payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below:</p> <ul style="list-style-type: none"> Your coverage may continue until stopped by the policyholder but not beyond 30 months from the start of the absence.
<p>Your employment ends because of a leave of absence that is not a medical leave of absence</p>	<p>If premium payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below:</p> <ul style="list-style-type: none"> Your coverage may continue until stopped by the policyholder but not beyond 1 month from the start of the absence.
<p>Your employment ends because of a military leave of absence.</p>	<p>If premium payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below:</p> <ul style="list-style-type: none"> Your coverage may continue until stopped by the policyholder but not beyond 24 months from the start of the absence.

Notification of when your employment ends

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

When will coverage end for any dependents?

Coverage for your dependent will end if:

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

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

What happens to your dependents if you die?

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

Why would we end your coverage?

We will give you 30 days advance written notice before we end your coverage because you commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on loss of coverage.

On the date your coverage ends, we will refund to the policyholder any prepayments for periods after the date your coverage ended.

Special coverage options after your plan coverage ends

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

Consolidated Omnibus Budget Reconciliation Act (COBRA)

What are your COBRA rights?

COBRA gives some people the right to keep their dental coverage for 18, 29 or 36 months after a “qualifying event”. COBRA usually applies to policyholders of group sizes of 20 or more.

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

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

When do I receive COBRA information?

The chart below lists who is responsible for giving the notice, the type of notice they are required to give and the timing.

Policyholder/Group dental plan notification requirements		
Notice	Requirement	Deadline
General notice – policyholder or Aetna	Notify you and your dependents of COBRA rights	Within 90 days after active employee coverage begins
Notice of qualifying event – policyholder	<ul style="list-style-type: none"> • Your active employment ends for reasons other than gross misconduct • Your working hours are reduced • You die • You are a retiree eligible for retiree dental coverage and your former policyholder files for bankruptcy 	Within 30 days of the qualifying event or the loss of coverage, whichever occurs later
Election notice – policyholder or Aetna	Notify you and your dependents of COBRA rights when there is a qualifying event	Within 14 days after notice of the qualifying event
Notice of unavailability of COBRA – policyholder or Aetna	Notify you and your dependents if you are not entitled to COBRA coverage.	Within 14 days after notice of the qualifying event
Termination notice – policyholder or Aetna	Notify you and your dependents when COBRA coverage ends before the end of the maximum coverage period	As soon as practical following the decision that continuation coverage will end

You/your dependents notification requirements		
Notice of qualifying event – qualified beneficiary	Notify the policyholder if: <ul style="list-style-type: none"> You divorce or legally separate and are no longer responsible for dependent coverage Your covered dependent children no longer qualify as a dependent under the plan 	Within 60 days of the qualifying event or the loss of coverage, whichever occurs later
Disability notice	Notify the policyholder if: <ul style="list-style-type: none"> The Social Security Administration determines that you or a covered dependent qualify for disability status 	Within 60 days of the decision of disability by the Social Security Administration, and before the 18 month coverage period ends
Notice of qualified beneficiary’s status change to non-disabled	Notify the policyholder if: <ul style="list-style-type: none"> The Social Security Administration decides that the beneficiary is no longer disabled 	Within 30 days of the Social Security Administration’s decision
Enrollment in COBRA	Notify the policyholder if: <ul style="list-style-type: none"> You are electing COBRA 	60 days from the qualifying event. You will lose your right to elect, if you do not: <ul style="list-style-type: none"> Respond within the 60 days And send back your application

How can you extend the length of your COBRA coverage?

The chart below shows qualifying events after the start of COBRA (second qualifying events):

Qualifying event	Person affected (qualifying beneficiary)	Total length of continued coverage
Disabled within the first 60 days of COBRA coverage (as determined by the Social Security Administration)	You and your dependents	29 months (18 months plus an additional 11 months)
<ul style="list-style-type: none"> You die You divorce or legally separate and are no longer responsible for dependent coverage Your covered dependent children no longer qualify as dependent under the plan 	You and your dependents	Up to 36 months

How do you enroll in COBRA?

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

When is your first premium payment due?

Your first **premium** payment must be made within 45 days after the date of the COBRA election.

How much will COBRA coverage cost?

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

Can you add a dependent to your COBRA coverage?

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

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

When does COBRA coverage end?

COBRA coverage ends if:

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

Continuation of coverage for other reasons

What exceptions are there for dental work when coverage ends?

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

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

Ordered means:

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

How can you extend coverage for your disabled child beyond the plan age limits?

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

- Is not able to be self-supporting because of mental or physical disability
- Depends mainly on you for support

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

We may ask you to send us proof of the disability within 31 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year. You must send it to us within 31 days of our request. If you don't, we can terminate coverage for your dependent child.

Your disabled child's coverage will end on the earlier of:

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

General provisions – other things you should know

Administrative provisions

How you and we will interpret this booklet-certificate

We prepared this booklet-certificate according to ERISA, and according to other federal and state laws that apply. You and we will interpret it according to these laws.

How we administer this plan

We apply policies and procedures we've developed to administer this plan.

Who's responsible to you

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

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

Coverage and services

Your coverage can change

Your coverage is defined by the **group policy**. This document may have amendments and riders too. Under certain circumstances, we or the policyholder or the law may change your plan. But only as permitted by the **group policy**. When an emergency or epidemic is declared, we may modify or waive requirements under the plan or your cost share if you are affected. Only we may waive a requirement of your plan. No other person, including the policyholder or **provider**, can do this.

Financial sanctions exclusions:

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

Legal action

You must complete the appeal process before you take any legal action against us for any expense or bill. See the *When you disagree - claim decisions and appeals procedures* section. You cannot take any action until 60 days after we receive written submission of claim.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Physical examinations and evaluations

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

Records of expenses

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

Things that would be important to keep are:

- Names of **dental providers, dentists** and other **providers** who provide services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception

Honest mistakes

You or the policyholder may make an honest mistake when facts are shared with us. When we learn of the mistake, we may make a fair change in **premium** contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years after the booklet-certificate effective date.

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past. If we paid claims for your past coverage, we will want the money back.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

Loss of coverage, starting at some time in the past will not occur due to an intentional deception if the deception happened more than 2 years after the booklet-certificate effective date.

In the absence of fraud, any statement made on your application for coverage is considered a representation and not a warranty. We will only use a statement during a dispute if it is shared with you and your beneficiary, or the person making the claim.

Some other money issues

Assignment of benefits

When you see **contracting dental providers** they will bill us directly. When you see **non-contracting dental providers**, we may choose to pay you or to pay the **providers** directly. You may request to assign benefits to the **provider**. This may include:

- The benefits due
- The right to receive payments
- Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this **group policy**

If you assign benefits to such a **provider**, we will pay them directly.

To request assignment you must complete an assignment form. The assignment form is available from the policyholder.

Notice of claim

We must receive your claim within 20 days (or as soon as reasonably possible) after you get a covered medical service. You can send the claim to us or to one of our authorized agents. We will send you a claim form within 15 days after we receive your notice of a claim. If we do not send you a claim form within those 15 days, you will automatically be considered to have met the proof of loss requirements. See the *Proof of loss* section below.

Proof of loss

We must receive written proof of loss from you within 90 days after your loss occurs. If you couldn't reasonably provide this proof within 90 days, we will still accept your claim. But you must provide the proof as soon as possible, but no later than one year after the 90 days ends (unless you were legally incapacitated).

Time of payment of claims

We will pay benefits to you or your assignee. After we receive your timely proof of loss, we will pay claims within 60 days after we receive the proof of loss. Please see the *Proof of loss* section above for more information.

Recovery of overpayments

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

Premium contribution

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

Payment of premiums

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

Payment to a conservator, other than you

Sometimes a court order gives another person certain rights and duties to act on behalf of your dependent child. Such a person is called a managing or possessory conservator. We may pay that person benefits on behalf of your dependent child. To receive benefits, they must send us a written certified copy of the court order with the claim form. But they are not entitled to benefits if:

- We received a valid assignment of benefits on an unpaid medical bill
- You sent us a claim for benefits for an **eligible dental service** that you paid

Reimbursement to Texas Health and Human Services Commission

We will repay the actual costs of medical expenses the Texas Health and Human Services Commission pays through medical assistance for you or your dependent if you or your dependent are entitled to payment for the medical expenses.

Repayment of these medical expenses for your dependent child will be paid to the Texas Health and Human Services Commission if, when you submit proof of loss, you notify us in writing that:

- Your dependent child is covered under the financial and medical assistance service program in Texas and you either:
 - Have possession or access to the child through a court order; or
 - Are not entitled to possession of or access to the child and are required by the court to pay child support

You will need to ask us to make direct payment to the Texas Health and Human Services Commission.

Your dental information

We will protect your dental information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your **providers'** claims and manage your plan.

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

Effect of prior plan coverage

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. Your current and prior plan must be offered through the same policyholder.

Glossary

Aetna

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

Calendar year

A period of 12 months beginning on January 1st and ending on December 31st.

Calendar year maximum

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

Coinsurance

Coinsurance is the percentage of the bill that you and this plan have to pay for an **eligible dental service**. The schedule of benefits shows the percentage that this plan pays.

Contracting dental provider

A **provider** listed in the **directory** for your plan.

Cosmetic

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

Covered benefits

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

Deductible

The amount you pay for **eligible dental services** per **Calendar Year** before your plan starts to pay.

Dental emergency

Any dental condition that:

- Occurs unexpectedly
- Requires immediate diagnosis and treatment in order to stabilize the condition
- Is characterized by symptoms such as severe pain and bleeding

Dental emergency services

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

Dental provider

Any individual legally qualified to provide dental services or supplies.

Dentist

A legally qualified **dentist** licensed to do the dental work he or she performs.

Directory

The list of **contracting dental providers** for your plan. The most up-to-date **provider directory** for your plan appears on our self-service website. When searching for **contracting dental providers**, you need to make sure that you are searching for **providers** that participate in your specific plan. **Contracting dental providers** may only be considered **contracting dental providers** for certain **Aetna** plans.

Effective date of coverage

The date your coverage begins under this booklet-certificate as noted in our records.

Eligible dental services

The benefits, subject to varying cost shares, covered in this plan. These are:

- Listed and described in the schedule of benefits.
- Not listed as an exception or exclusion in these sections:
 - *What are your eligible dental services?*
 - *What rules and limits apply to dental care?*
 - *Exclusions.*
- Not beyond any maximums and limitations in the *What rules and limits apply to dental care?* section and schedule of benefits.
- **Medically necessary.** See the *Medical necessity requirements* section and the *Glossary* for more information.

Experimental or investigational

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

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

Group policy

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

- The group application
- The **group policy**
- The booklet-certificates
- The schedules of benefits
- Any amendments or riders to the **group policy** the booklet-certificate, and the schedule of benefits

Health professional

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

Illness

Poor health resulting from disease of the teeth or gums.

Injury or injuries

Physical damage done to the teeth or gums.

In-network provider

A **provider** listed in the **directory** for your plan.

Lifetime maximum

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

Medically necessary/medical necessity

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

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

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

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

Medicare

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

Negotiated charge

This is either:

- The amount **contracting dental providers** have agreed to accept

The amount we agree to pay directly to **contracting dental providers** or third party vendors (including any administrative fee in the amount paid

for providing **eligible dental services** to covered persons in the plan.

Non-contracting dental provider

A **provider** who is not a **contracting dental provider** and does not appear in the **directory** for your plan.

Physician

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

Premium

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

Provider

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

Recognized charge

The amount of a **non-contracting dental provider's** charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage. The **recognized charge** may be less than the **provider's** full charge.

The **recognized charge** depends upon the geographic area where you receive the **eligible dental service**. The table below shows the method for calculating the **recognized charge** for specific services or supplies:

Service or supply	Recognized charge
Eligible dental expenses	100% of the Aetna out-of-network rate (AONR)
Important note: If the provider bills less than the amount calculated using the method above, the recognized charge is what the provider bills.	

Special terms used:

- **Aetna** out-of-network rates (AONR) are our standard rates used to begin contract talks with **providers** in a specific geographic area. For geographic areas where we do not maintain these standard rates, AONR shall equal 100% of the Medicare allowed rates.
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- Involuntary services are **eligible dental services** that are one of the following:
 - Not available from a **contracting dental provider**
 - **Dental emergency services**

We will calculate your cost share for involuntary services in the same way as we would if you received the services from a **contracting dental provider**.

Get the most value out of your benefits:

We have online tools to help you decide the type of care to get and where. Our self-service website offers tools to help you determine the cost of **eligible dental services**, compare **contracting dental providers** and schedule office visits with them. See the *How to contact us for help* section for the website.

Wellness and other rewards

You may be eligible to earn rewards for completing certain activities that improve your health, coverage and experience with us. We may encourage you to access certain dental services or categories of **dental providers**, participate in programs, including but not limited to financial wellness programs, utilize tools, improve your health metrics or continue participation as an **Aetna** member through incentives. We may provide incentives based on your participation and outcomes such as:

- Modifications to **deductible** or **coinsurance** amounts
- Merchandise
- Coupons
- Gift or debit cards
- Any combination of the above

The award of a participation incentive shall not depend upon the result of a wellness or health improvement activity or upon a member's health status. Rather, you can obtain these benefits simply by participating in a wellness or health improvement program that we offer you. Once you earn benefits, you can accept or decline them. And we won't charge you for choosing to accept any benefits you earn. You can earn benefits as long as we offer wellness and health improvement programs and you participate in them. If we stop offering a wellness and health improvement program or you stop participating in a program, you won't continue to earn these benefits. We will let you know at least 60 days in advance before we stop offering these benefits.

Additional Information Provided by

Caraday Healthcare, LLC

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

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

Name of Plan:

Caraday Healthcare, LLC Welfare Benefit Plan

Employer Identification Number:

84-3394616

Plan Number:

501

Type of Plan:

Welfare

Type of Administration:

Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:

Caraday Healthcare, LLC
102 Whitetail Dr.
San Marcos, TX 78666
Telephone Number: (737) 221-5058

Agent For Service of Legal Process:

Caraday Healthcare, LLC
102 Whitetail Dr.
San Marcos, TX 78666

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

End of Plan Year:

July 31

Source of Contributions:

Employee

Procedure for Amending the Plan:

The Employer may amend the Plan from time to time by a written instrument signed by the Senior Vice President and/or Human Resources.

ERISA Rights

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

Receive Information about Your Plan and Benefits

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

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

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

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

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

Assistance with Your Questions

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

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

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

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

Confidentiality Notice

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

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

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

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

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.