

Dental Plan

Dental PPO/PDN with PPO II Network

Summary Plan Description



December 2014

As revised on June 19, 2018

Table of Contents

Introduction	1
Eligibility and Enrollment	2
Eligibility	2
Enrollment	2
Changing Your Elections	3
Contributions	5
Using the Dental Plan	6
Aetna Provider Network	6
Claims and Benefit Payment	8
Legal Action	8
When Coverage Ends	9
When Employee Coverage Ends	9
Retirement	9
Death	9
When Dependent Coverage Ends	10
Continuation of Coverage	11
During Illness or Injury	11
During Approved Leaves of Absence	11
During Military Leave	11
COBRA Continuation Coverage	12
General Information	13
Privacy Notice for Health Plans	13
Your ERISA Rights	13
Plan Documents	13
Discretionary Authority of Plan Administrator and Claims Administrator	14
No Guarantee of Employment	14
Plan Administration	15
Glossary	16
Aetna Schedule of Benefits	Attached

Aetna Benefit Plan Booklet.....Attached

Refer to subsequent issues of California Resources Corporation benefits newsletters on MyInfo at <https://MyInfo.crc.com> for any material changes to the Plan made after the date of this document.

INTRODUCTION

The Dental Plan is designed to promote and encourage preventive dental care, provide benefits for services that are essential to the proper care of your teeth and help you pay for a portion of your covered dental expenses.

The dental benefits described in this supplement are offered to California Resources Corporation and/or affiliated company employees, as defined in the Eligibility and Enrollment section. This information, along with the attached Schedule of Benefits and Benefit Plan booklet (Booklet) provided by Aetna Life Insurance Company (Aetna) serves as your Summary Plan Description (SPD). You should keep and refer to it when you have questions about your dental benefits. Any capitalized term or phrase not defined in the Glossary of this supplement has the meaning ascribed to it in the Booklet that follows.

The dental benefits described in this SPD are not insured with Aetna or any of its affiliates, but are paid from California Resources Corporation's general assets.

Schedule of Benefits

A Schedule of Benefits is attached to this supplement, showing the deductibles, copayments or coinsurance for major types of covered expenses, and out-of-pocket maximums under the Dental Plan. The Booklet that follows provides information regarding how your plan works, the availability of providers, and details about coverage for specific services and supplies.

ELIGIBILITY AND ENROLLMENT

Eligibility

You are eligible to participate in the Dental Plan if you are a regular, full-time, nonbargaining hourly or salaried employee of California Resources Corporation or an affiliated company (CRC). For this purpose, “affiliated company” means any company in which 80 percent or more of the equity interest is owned by California Resources Corporation. Temporary employees are not eligible to participate. You are considered a full-time employee under the Plan if you are regularly scheduled to work at least 30 hours per week. Generally, you are eligible to participate if you are paid on a U.S. dollar payroll, are designated as eligible to participate by your employer, and do not participate in a similar type of employer-sponsored plan. If you are part of a collective bargaining group, you are eligible to participate in the Dental Plan only if your negotiated bargaining agreement specifically provides for your participation.

You may not be covered as both an employee and a Dependent. If both you and your spouse work for CRC, only one of you may cover your child or children as Dependents.

Dependents

Generally, those persons eligible to be covered as dependents include your legal spouse (unless legally separated) and your children under age 26.

For a complete definition, refer to “Dependent” in the *Glossary* section.

Enrollment

You may enroll yourself and your eligible Dependents within 31 days of your date of hire or eligibility under the Dental Plan. If you enroll within the first 31 days, your coverage will start as of the date of initial eligibility. If you have any questions or need additional information, contact your human resources representative or email the [CRC Benefits](#) department.

When you enroll, you may elect one of the following levels of coverage:

- Employee Only
- Employee + One Dependent
- Family (employee plus two or more Dependents)

Changing Your Elections

Open Enrollment Period

Each year, CRC designates a period of time during which you may change your election for the following Plan year (January 1 through December 31).

Between Open Enrollments

Under IRS rules, once you make your enrollment election, either when you are first eligible or during Open Enrollment, your election will remain in effect for the entire Plan year. However, you may be able to change your election before the next Open Enrollment if:

- A Status Change, as described below, occurs and your election change is consistent with the Status Change as allowed by the IRS regulations.
- Another IRS-recognized event occurs (e.g., Qualified Medical Child Support Orders, judgments, and decree orders).
- You may enroll yourself or an eligible Dependent in the Dental Plan, including when you or an eligible Dependent lose coverage under your spouse's employer-sponsored group medical plan or another group medical plan because of termination of employment, a reduction in work hours, death, plan termination, or expiration of a COBRA* period.

Status Change

Generally, you experience a change in status when you or a Dependent gains or loses eligibility under the Plan. Status Changes include:

- Marriage, divorce or legal separation
- Change in number of Dependents
- Employment status change
- Change in Dependent coverage eligibility
- Change in eligibility under Medicaid or the Child Health Insurance Program (CHIP)
- Change of work location or residence

Any benefits change you elect must be consistent with the Status Change. Below are some examples:

- If you have a newborn or adopt a child, you can add the child and any other eligible dependents to your dental coverage, but you cannot drop dental coverage for your spouse.

* The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

- If your child reached the age limit for coverage under the Dental Plan, you could drop coverage for that child, but you could not add or drop dental coverage for your spouse or another child.
- If you marry you may add your spouse and any other eligible dependents to your dental coverage, but you may not drop coverage for yourself unless you are added to your new spouse's dental coverage.

To change your benefits election, email the [CRC Benefits](#) department. You must submit any required documentation within 31 days of the Status Change, or within 60 days of a Medicaid or CHIP event.

CONTRIBUTIONS

The coverage level you select determines the amount of your contribution. Current monthly rates and annual deductibles are available online at MyInfo.crc.com. Your per-pay-period portion of the monthly contribution amount will be deducted from each paycheck on a pretax basis.

Pretax contributions are deducted from your pay before federal income and Social Security taxes are calculated and withheld. If you live in a state that recognizes the federal tax treatment of pretax dental contributions, your state income tax also will be withheld after your contributions are deducted.

Under current federal law, you may not claim your pretax dental contributions as an itemized deduction on your federal income tax return.

Pretax Contributions: Effect on Social Security and Other Statutory Benefits

Pretax dental contributions reduce the amount of your earnings that are reported for Social Security purposes. Therefore, if you earn less than the Social Security Wage Base (SSWB) or if pretax contributions reduce your earnings below the SSWB, your Social Security withholding will be reduced. This reduced withholding could slightly decrease any Social Security benefits you may receive because Social Security benefits are based on your career earnings history.

In some states, certain other statutory benefits for which you may become eligible (such as unemployment insurance, Workers' Compensation and state disability insurance) are based on taxable earnings. Therefore, any benefit payments from these sources could be slightly reduced.

Pretax Contributions: Effect on Other CRC Benefits

Your pay for purposes of determining pay-related CRC benefits, such as CRC's savings, disability and life insurance plans, will continue to be based on your base pay before pretax Dental Plan contributions are deducted.

USING THE DENTAL PLAN

The attached Aetna Schedule of Benefits and Booklet provide information and resources to help you make the most of your coverage. You will find information about choosing a Dentist and sharing the cost of your care, as well as details about certain important Plan rules and requirements, including:

- How to access care;
- Advance claim reviews;
- Services and supplies that are covered, and what limits may apply;
- What is not covered by the Plan;
- How you share the cost of your covered services and supplies; and
- Other important information such as claim processing, complaints and appeals.

You may also access information regarding current deductibles and maximum benefits online at MyInfo.crc.com.

Covered expenses include:

- Preventative and Diagnostic Services (also referred to as Type A)
- Restorative Service (Type B)
- Major Services (Type C)
- Orthodontic Treatment for dependents under age 19

Aetna Provider Network

To participate in Aetna's network, a Dentist must meet certain standards through a process called credentialing—which looks at factors such as education and licensing.

For assistance in finding a network provider in your area, use the “Find a Doctor” feature on the Aetna Navigator website at www.aetna.com or contact Aetna Member Services.

Alternate Treatment

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. See **Rules and Limits That Apply to the Dental Plan** in the attached Booklet for additional information.

Dental ID Cards

Dental plan ID cards are no longer required to receive dental services. Your provider can confirm coverage and plan information directly with Aetna Member Services.

Visit Aetna Navigator™ at www.aetna.com

Aetna Navigator is a web-based portal designed to provide access to a wide range of tools and information 24 hours a day, 7 days a week. The website is secure, private, and accessible anywhere an internet connection is available. From Aetna Navigator you can obtain health and benefits information using self-service features and interactive tools. After a simple registration process, a personal home page is created where you can:

- Access your claim Explanations of Benefits (EOBs),
- Check remaining deductibles and balances,
- Print an ID card* for you and your Dependents,
- Download a list of claims for each covered family member, and
- Contact Member Services.

You can also take advantage of many other features, including:

- **Find a Doctor**, Aetna's online provider directory,
- **Intelihealth®**, Aetna's health website,
- **Healthwise® Knowledgebase**, an innovative decision-support tool, and
- **Estimate the Cost of Care**, for many diseases and conditions.

Mobile Access

You can also access your benefits information on your mobile phone. To learn more, visit www.aetna.com/mobile.

Contacting Member Services

Member Services is available weekdays (except holidays) from 5:00 a.m. to 3:00 p.m. Pacific Time by calling toll-free 877-238-6200.

Address:

P.O. Box 14027
Lexington, KY 40512-4027

Member Services:

877-238-6200

Website: www.aetna.com

* Dental plan ID cards are no longer required to receive dental services. Your provider can confirm coverage and plan information directly with Aetna.

Claims and Benefit Payment

It is important to keep records of dental expenses for yourself and all covered family members. These will be required when you file a claim for benefits. Of particular importance are:

- Names and addresses of Dentists,
- The dates on which expenses are incurred, and
- Copies of all bills and receipts.

Filing Claims

Generally, if you use an Out-of-Network Provider, you must complete and submit a claim form to be reimbursed for covered expenses. Claim forms are available on Aetna Navigator at www.aetna.com or by calling Aetna Member Services. The form contains instructions on how and when to file a claim, as well as the address to which you should send your completed form.

The attached Aetna Booklet provides additional information regarding the reporting of dental claims, including coordination of benefits, payment of benefits, and the appeal process for dental claims.

Legal Action

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims, as described in the **General Provisions** section of the attached Aetna Booklet.

WHEN COVERAGE ENDS

Your coverage under this Plan can end for a number of reasons. This section explains how and why your coverage can be terminated, and how you may be able to continue coverage after it ends.

When Employee Coverage Ends

Your coverage under this Plan ends on the first to occur of the following events:

- The Plan is discontinued;
- You voluntarily stop your coverage;
- Termination of your employment, except if you receive benefits under CRC's Long-Term Disability Plan*;
- The coverage described in this SPD is terminated;
- You are no longer eligible as defined in the *Eligibility and Enrollment* section of this supplement;
- You fail to make any required contribution; or
- Your employer notifies Aetna that your employment has ended.

Your dental coverage will cease on the last day of the month in which you lose eligibility. You may have a right to continue your coverage as described in the section entitled **COBRA Continuation of Coverage** in the attached Booklet. You may not convert your group dental coverage to an individual policy at termination.

Retirement

Retiree dental coverage is available to those who are eligible for the CRC Retiree Medical Plan coverage. The cost of coverage is fully funded by retirees. Contact your human resources representative or email the [CRC Benefits](#) department for additional information.

Death

If you die in active employment and are covered under the Dental Plan, coverage for your Dependents will continue until the end of the second month following the month in which you die. For example, if you die on March 20, coverage will continue through the following May 31. However, your surviving Dependents may have a right to further continue their coverage under COBRA as described in the section entitled **COBRA Continuation of Coverage** in the attached Booklet. There is no conversion policy available for your surviving Dependents for dental coverage.

* Any CRC employees who are receiving benefits under the Occidental Petroleum Corporation Long-Term Disability Plan are also eligible to continue CRC dental coverage.

If you die as an active employee but are eligible for the CRC Retiree Medical Plan coverage as described above, your spouse may elect retiree coverage under the Plan for your covered Dependents as of the first of the month following your date of death as if you had retired on that date. If coverage is elected, your spouse must pay the applicable retiree contribution. If this coverage is elected it will continue for your Dependents until the earliest occurrence of one of the following events:

- Marriage;
- Eligibility for coverage under another group plan;
- Failure to meet the requirements for Dependent coverage;
- Failure to pay any required contributions; or
- Your spouse's death.

Contact your human resources representative or email the CRC Benefits department for additional information.

When Dependent Coverage Ends

Your Dependent's eligibility for coverage will end on the earliest to occur of the following events:

- Dependent coverage is terminated under this Plan;
- A Dependent becomes covered as an employee;
- A dependent no longer meets the Plan's definition of a Dependent; or
- When your coverage terminates.

Dental coverage will cease on the last day of the month in which your Dependent loses eligibility. You must notify the [CRC Benefits](#) department within 31 days of your Dependent's change in eligibility status. Any applicable contribution change will take effect on the next available pay cycle. There will be no refund of contributions.

Your Dependents may have a right to continue their coverage. See the section entitled **COBRA Continuation of Coverage** in the attached Booklet or contact CRC Benefits for more information.

See the section entitled **COBRA Continuation of Coverage** in the attached Aetna Booklet or email the [CRC Benefits](#) department for further details.

CONTINUATION OF COVERAGE

During Illness or Injury

If you are a CRC employee enrolled in the Dental Plan and you are absent from work because of illness or injury, Dental Plan coverage for you and your Dependents will continue while you remain disabled, pay your required contribution and are receiving payments under CRC's Short-Term Disability (STD) Plan or similar company-sponsored plan.

You will also continue to be eligible for coverage while you receive benefits under CRC's Long-Term Disability (LTD) Plan*, and make any required contributions. If you do not return to active employment at the end of your plan benefits under STD, and LTD if applicable, your eligibility for continued Dental Plan coverage will end, as described in the section entitled *When Coverage Ends*.

During Approved Leaves of Absence

If you are on an approved leave of absence, including a leave under the Family and Medical Leave Act of 1993 (FMLA) or applicable state law, you may continue coverage for yourself and your eligible Dependents during your approved leave, provided you make any required contributions. You can elect to continue your coverage for the duration of your leave of absence, up to a maximum of six months.

If you elect not to continue coverage during an approved leave under FMLA or similar state law, automatic reinstatement will be permitted upon your return to active employment. If you elect not to continue coverage during any other approved leave, you cannot reenroll until the next Open Enrollment period.

For additional information regarding an FMLA leave of absence, contact your human resources representative.

During Military Leave

During a military leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), coverage under the Dental plan may continue for you and/or your covered Dependents for a maximum of six months commencing with the effective date of the leave, provided that you make any required contributions. However, coverage is excluded for service-connected illnesses or injuries. If you elect to discontinue your coverage during your USERRA military leave, automatic re-enrollment will be permitted if you return to work and request reinstatement within 31 days.

* Any CRC employees who are receiving benefits under the Occidental Petroleum Corporation Long-Term Disability Plan are also eligible to continue CRC dental coverage.

More information about the types of military service, the maximum length of military service, your deadline for returning to work, and other requirements for reemployment rights under USERRA is available online at www.dol.gov/vets.

You may contact your human resources representative with any questions regarding continued dental coverage under USERRA. Your human resources representative must be contacted within thirty-one (31) days of the date that you return to work to reinstate your health benefits under the special USERRA rules.

COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and/or your Dependents have the right to continue health coverage if it ends for the reasons (“qualifying events”). Refer to the attached Aetna Booklet for information regarding your COBRA Continuation rights.

Keep the Plan Informed of Changes

In order to protect your family’s rights, you should keep the Plan informed in writing of any changes in the addresses of your family members and any changes in your marital status. You should also keep a copy, for your records, of any notices you provide. You may provide such notices to your human resources representative, email the [CRC Benefits](#) department, or mail to 111 W. Ocean Blvd., Suite 800, Long Beach, CA 90802.

GENERAL INFORMATION

Privacy Notice for Health Plans

A federal law, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), requires the Dental Plan to protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan’s privacy notice, which was distributed to you upon enrollment and is available online at MyInfo.crc.com under Forms, Publications & Info.

The Dental Plan and CRC will not use or further disclose information that is protected by HIPAA (“protected health information”) except as necessary for treatment, payment, Dental Plan operations and Plan administration, or as permitted or required by law. By law, the Dental Plan has required all of its business associates to also observe HIPAA’s privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

The Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA’s privacy rules. For a copy of the notice, you may either contact your human resources representative or email the [CRC Benefits](mailto:CRC_Benefits) department or go directly to MyInfo.crc.com and under Forms, Publications & Info, select the *HIPAA Privacy Notice*. If you have questions about the privacy of your health information or if you wish to file a complaint under HIPAA, contact your human resources representative or email the [CRC Benefits](mailto:CRC_Benefits) department.

Your ERISA Rights

For information regarding your rights under the Employee Retirement Income Security Act of 1974 (ERISA), refer to **ERISA Rights** in the Additional Information section of the attached Booklet.

Plan Documents

This benefit plan description summarizes the main features of the Plan, and is not intended to amend, modify, or expand the Plan provisions. In all cases, the provisions of the Plan document and any applicable contracts control the administration and operation of the Plan. If a conflict exists between a statement in this summary and

the provisions of the Plan document or any applicable contracts, the Plan document will govern.

Discretionary Authority of Plan Administrator and Claims Administrator

In accordance with sections 402 and 503 of Title I of ERISA, the Plan sponsor has designated a Named Fiduciary under the Plan, who has complete authority to review all denied claims for benefits under the Plan. The Plan Administrator has discretionary authority to determine who is eligible for coverage under the Plan and the Claims Administrator has discretionary authority to determine eligibility for benefits under the Plan. In exercising its fiduciary responsibilities, the Named Fiduciary shall have discretionary authority to determine whether and to what extent covered Plan participants are eligible for benefits, and to construe disputed or doubtful Plan terms. The Named Fiduciary shall be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

No Guarantee of Employment

By adopting and maintaining the California Resources Corporation Dental Plan for certain eligible employees, CRC has not entered into an employment contract with any employee. Nothing contained in the Plan documents or in this summary gives any employee the right to be employed by CRC or to interfere with CRC's right to discharge any employee at any time. Similarly, this Plan does not give CRC the right to require any employee to remain employed by CRC or to interfere with the employee's right to terminate employment with CRC at any time.

Future of the Plan and Plan Amendment

CRC expects and intends to continue this Plan but does not guarantee any specific level of benefits or the continuation of any benefits during any periods of active employment, inactive employment, disability or retirement. Benefits are provided solely at CRC's discretion. CRC reserves the right, at any time or for any reason, through an action of the Vice President of Compensation and Benefits of California Resources Corporation, to suspend, withdraw, amend, modify, or terminate the Plan (including altering the amount you must pay for any benefit), in whole or in part. In the case of material change in this description of the Plan, such action will be evidenced by a written announcement to affected individuals.

Plan Administration

The additional information in this section is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA) regarding the Dental Plan and the persons who have assumed responsibility for its operation.

The additional information in this section is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA) regarding the Dental Plan and the persons who have assumed responsibility for its operation.

Plan Name	California Resources Corporation Dental Plan
Employer Identification Number	46-5676989
Plan Number	502
Plan Administrative Services Provided by	CRC Services, LLC 9200 Oakdale Avenue, 9th Floor Los Angeles, California 91311 888-848-4754
Type of Administration	<i>Administrative Services Contract with:</i> Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156
Plan Administrator	California Resources Employee Benefits Committee
Plan Sponsor and Address for Legal Process	CRC Services, LLC 9200 Oakdale Avenue, 9th Floor Los Angeles, CA 91311 888-848-4754
Named Fiduciary	Aetna Life Insurance Company
Claims Administrator	Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156
End of Plan Year	December 31
Type of Plan	ERISA Welfare Plan
Source of Contributions	Employee Contributions and Employer General Assets

GLOSSARY

Following are definitions of the capitalized terms and phrases used throughout this document that are not found in the glossary of the attached Booklet.

Dependent

Those persons eligible to be covered as dependents may include your:

- Legal spouse (unless legally separated), and
- Children, up to the end of the month in which their 26th birthday occurs.

Your children may include your:

- Natural children;
- Children legally adopted or placed for adoption with you;
- Stepchildren;
- Foster children; and
- Other children who you claim as dependents on your federal income tax return (e.g., grandchildren), for whom you and/or your spouse have primary legal custody and who live with you in a regular parent/child relationship.

A dependent also includes a child for whom health care coverage is required through a “Qualified Medical Child Support Order” or other court or administrative order and who falls within one of the above categories.

If you have a disabled child, the child’s coverage may be continued past the Plan’s limiting age for dependents.

Your child is considered to be disabled if he or she:

- Is unable to earn a living because of a mental or physical disability that starts before the Plan age limit; and
- Depends mainly on you for support and maintenance.

You must provide proof of your child’s disability to Aetna no later than 31 days after your child reaches the dependent age limit. Aetna may continue to ask you for proof that the child continues to meet these conditions of incapacity and dependency.

The child’s coverage will end on the first to occur of the following:

- Your child is no longer disabled;
- You fail to provide proof that the disability continues;
- You fail to have any required exam performed; or
- Your child’s coverage ends for a reason other than reaching the age limit.

Plan

“Plan” means the California Resources Corporation Dental Plan, and as used in this Summary Plan Description, unless the context otherwise plainly requires, “Plan” further means the dental benefits described here. Also, in this Summary Plan Description, “Plan” is used interchangeably with “Dental Plan.”

Schedule of Benefits

Employer: California Resources Corporation

MSA: 867978

Issue Date: February 4, 2015

Effective Date: December 1, 2014

Schedule: 3A

Booklet Base: 3

For: Passive PPO Dental - Active Employees

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer or refer to your Booklet for additional information.

Comprehensive Dental Plan (PPO)

Schedule of Comprehensive Dental Benefits (GR-9N-S-21-005-01)

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year	Individual \$50	Individual \$50
Deductible	Family \$150	Family \$150

The Calendar Year **deductible** applies to all covered expenses except Type A Expenses and Orthodontic Treatment.

Please refer to the listing of **covered expenses** and the percentage payable appearing below. The percentage the plan will pay varies by the type of expense.

For information regarding plan limitations and exclusions, refer to your Booklet.

PLAN PAYMENT PERCENTAGE	NETWORK PAYMENT PERCENTAGE	OUT-OF-NETWORK PAYMENT PERCENTAGE
Type A Expenses	100%	100%
Type B Expenses	80%	80%
Type C Expenses	50%	50%
Orthodontic Treatment (Covered dependent children under age 19)	50%	50%

Calendar Year Maximum Benefit

Calendar Year Maximum: \$2,000

The most the plan will pay for **covered expenses** incurred by any one covered person in a Calendar Year is called the Calendar Year Maximum Benefit. The Calendar Year Maximum Benefit applies to all covered expenses except Orthodontic Treatment.

The Calendar Year maximum benefit applies to network and out-of-network covered dental expenses combined.

Orthodontic Lifetime Maximum Benefit

Orthodontic Lifetime Maximum: \$2,500

Expense Provisions

The following provisions apply to your dental expense plan.

This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the preceding sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

Covered expenses applied to the **out-of-network provider deductibles** will be applied to satisfy the **network provider deductibles**. **Covered expenses** applied to the **network provider deductibles** will be applied to satisfy the **out-of-network provider deductibles**.

All **covered expenses** accumulate toward the **network provider and out-of-network provider deductibles**.

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

Network Provider Calendar Year Deductible

Individual

This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from a **network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur from a **network provider** for the rest of the Calendar Year.

Family Deductible Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles**, these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Out-of-Network Provider Calendar Year Deductible

Individual

This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from an **out-of-network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**; this Plan will begin to pay benefits for **covered expenses** that you incur from an **out-of-network provider** for the rest of the Calendar Year.

Family Deductible Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles**, these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Payment Provisions

Payment Percentage

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the “Plan Payment Percentage”. Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

Maximum Benefit Provisions

Calendar Year Maximum Benefit

The most the plan will pay for covered expenses incurred by any one covered person in a Calendar Year is called the Calendar Year maximum benefit.

The Calendar Year maximum benefit applies to **network care** and **out-of-network care** expenses combined.

Orthodontic Lifetime Maximum Benefit

The most the plan will pay for covered expenses incurred by any one covered dependent child under age 19 during their lifetime is called the Orthodontic Lifetime Maximum Benefit.

The Orthodontic Lifetime Maximum Benefit applies to **network** and **out-of-network** expenses combined.

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.

BENEFIT PLAN

**Prepared Exclusively for
California Resources Corporation**

Passive PPO Dental – Active Employees

**What Your Plan
Covers and How
Benefits are Paid**



ID Cards

If you are an enrollee with Aetna Dental coverage, you don't need an ID card. When visiting a dentist, simply provide your name, date of birth and Member ID# (or social security number). The dental office can use that information to verify your eligibility and benefits. If you still would like an ID card for you and your dependents, you can print a customized ID card by going to the secure member website at www.aetna.com. You can also access your benefits information when you're on the go. To learn more, visit us at www.aetna.com/mobile or call us at 1-877-238-6200.

Table of Contents

Schedule of Benefits	Issued with Your Booklet
Preface	1
Coverage for You and Your Dependents.....	1
Health Expense Coverage	1
Treatment Outcomes of Covered Services	
When Your Coverage Begins	2
Who Is Eligible	2
Employees	
Determining if You Are in an Eligible Class	
Obtaining Coverage for Dependents	
How and When to Enroll.....	3
Initial Enrollment in the Plan	
Late Enrollment	
Annual Enrollment	
Special Enrollment Periods	
When Your Coverage Begins.....	5
Your Effective Date of Coverage	
Your Dependent's Effective Date of Coverage	
Requirements For Coverage	7
How Your Aetna Dental Plan Works	8
Understanding Your Aetna Dental Plan.....	8
Getting Started: Common Terms	8
About the PPO Dental Plan	8
Getting an Advance Claim Review	9
When to Get an Advance Claim Review	
What The Plan Covers	10
PPO Dental Plan	
Schedule of Benefits for the PPO Dental Plan	
Dental Care Schedule	
Rules and Limits That Apply to the Dental Plan 12	
Orthodontic Treatment Rule	
Replacement Rule	
Alternate Treatment Rule	
Coverage for Dental Work Completed After	
Termination of Coverage	
What The PPO Dental Plan Does Not Cover.....	14
Additional Items Not Covered By A Health Plan	
.....	15
When Coverage Ends.....	16
When Coverage Ends For Employees	
When Coverage Ends for Dependents	
Continuation of Coverage	17
Continuing Health Care Benefits	
Handicapped Dependent Children	
COBRA Continuation of Coverage.....	18
Continuing Coverage through COBRA	
*Defines the Terms Shown in Bold Type in the Text of This Document.	
Who Qualifies for COBRA	
Disability May Increase Maximum Continuation	
to 29 Months	
Determining Your Contributions For	
Continuation Coverage	
When You Acquire a Dependent During a	
Continuation Period	
When Your COBRA Continuation Coverage	
Ends	
Coordination of Benefits - What Happens When	
There is More Than One Health Plan	20
When Coordination of Benefits Applies	20
Getting Started - Important Terms	20
Which Plan Pays First.....	22
How Coordination of Benefits Works.....	23
Right To Receive And Release Needed	
Information	
Facility of Payment	
Right of Recovery	
When You Have Medicare Coverage	25
Effect of Medicare	25
General Provisions	26
Type of Coverage	26
Physical Examinations.....	26
Legal Action	26
Additional Provisions	26
Assignments	26
Misstatements	26
Recovery of Overpayments	27
Health Coverage	
Reporting of Claims.....	27
Payment of Benefits.....	27
Records of Expenses	27
Contacting Aetna.....	28
Effect of Benefits Under Other Plans	28
Effect of An Health Maintenance Organization	
Plan (HMO Plan) On Coverage	
Discount Programs	28
Discount Arrangements	
Incentives.....	29
Appeals Procedure	29
Glossary *	32

Preface

The dental benefits plan described in this *Booklet* is a benefit plan of the Employer. These benefits are not insured with **Aetna** but will be paid from the Employer's funds. **Aetna** will provide certain administrative services under the **Aetna** dental benefits plan.

Aetna agrees with the Employer to provide administrative services in accordance with the conditions, rights, and privileges as set forth in this *Booklet*. The Employer selects the products and benefit levels under the **Aetna** dental benefits plan.

The *Booklet* describes your rights and obligations, what the **Aetna** dental benefits plan covers, and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this *Booklet*. Your *Booklet* includes the *Schedule of Benefits* and any amendments.

This *Booklet* replaces and supercedes all **Aetna Booklets** describing coverage for the dental benefits plan described in this *Booklet* that you may previously have received.

Employer:	California Resources Corporation
Contract Number:	MSA-867978
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Booklet Number:	3

Coverage for You and Your Dependents

Health Expense Coverage

Benefits are payable for covered health care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is “incurred” on the day you receive a health care service or supply.

Coverage under this plan is non-occupational. Only **non-occupational injuries** and **non-occupational illnesses** are covered.

Refer to the *What the Plan Covers* section of the *Booklet* for more information about your coverage.

Treatment Outcomes of Covered Services

Aetna is not a provider of health care services and therefore is not responsible for and does not guarantee any results or outcomes of the covered health care services and supplies you receive. Providers of health care services, including **hospitals**, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of **Aetna** or its affiliates.

When Your Coverage Begins

Who Is Eligible

How and When to Enroll

When Your Coverage Begins

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, “you” means the employee.

Who Is Eligible

Employees

To be covered by this plan, the following requirements must be met:

- You will need to be in an “eligible class,” as defined below; and
- You will need to meet the “eligibility date criteria” described below.

Determining if You Are in an Eligible Class

You are in an eligible class if:

- You are a regular full-time active employee or receiving long term disability benefits under the CRC Long-Term Disability Plan, as defined by your employer.

Determining When You Become Eligible

You become eligible for the plan on your eligibility date, which is determined as follows.

On the Effective Date of the Plan

If you are in an eligible class on the effective date of this plan, your coverage eligibility date is the effective date of the plan.

After the Effective Date of the Plan

If you are hired after the effective date of this plan, your coverage eligibility date is the date you are hired.

If you enter an eligible class after the effective date of this plan, your coverage eligibility date is the date you enter the eligible class.

Obtaining Coverage for Dependents

Your dependents can be covered under this Plan. You may enroll the following dependents:

- Your spouse.
- Your dependent children.

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

Coverage for Dependent Children

To be eligible for coverage, a dependent child must be under 26 years of age.

An eligible dependent child includes:

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

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

Important Reminder

Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

How and When to Enroll

Initial Enrollment in the Plan

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

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

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

Late Enrollment

If you do not enroll during the Initial Enrollment Period, or a subsequent annual enrollment period, you and your eligible dependents may be considered **Late Enrollees** and enrollment eligibility may be deferred until the next annual enrollment period. If, at the time of your initial enrollment, you elect coverage for yourself only and later request coverage for your eligible dependents, they may be considered **Late Enrollees**.

You must complete the enrollment process before the end of the next annual enrollment period as described below.

However, you and your eligible dependents may not be considered **Late Enrollees** if you qualify for one of the circumstances described in the “Special Enrollment Periods” section below.

Annual Enrollment

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. The choices you make during this annual enrollment period will become effective the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period, unless you qualify under one of the Special Enrollment Periods, as described below.

Special Enrollment Periods

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

Loss of Other Health Care Coverage

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

- You did not enroll yourself or your dependent when you first became eligible or during any subsequent annual enrollments because, at that time:
 - You or your dependents were covered under other **creditable coverage**; and
 - You refused coverage and stated, in writing, at the time you refused coverage that the reason was that you or your dependents had other **creditable coverage**; and
- You or your dependents are no longer eligible for other **creditable coverage** because of one of the following:
 - The end of your employment;
 - A reduction in your hours of employment (for example, moving from a full-time to part-time position);
 - The ending of the other plan's coverage;
 - Death;
 - Divorce or legal separation;
 - Employer contributions toward that coverage have ended;
 - COBRA coverage ends;
 - The employer's decision to stop offering the group health plan to the eligible class to which you belong;
 - Cessation of a dependent's status as an eligible dependent as such is defined under this Plan;
 - With respect to coverage under Medicaid or an S-CHIP Plan, you or your dependents no longer qualify for such coverage; or
 - You or your dependents have reached the lifetime maximum of another Plan for all benefits under that Plan.
- You or your dependents become eligible for premium assistance, with respect to coverage under the group health plan, under Medicaid or an S-CHIP Plan.

You will need to enroll yourself or a dependent for coverage within:

- 31 days of when other **creditable coverage** ends;
- within 60 days of when coverage under Medicaid or an S-CHIP Plan ends; or
- within 60 days of the date you or your dependents become eligible for Medicaid or S-CHIP premium assistance.

Evidence of termination of **creditable coverage** must be provided to your employer or the party it designates. If you do not enroll during this time, you will need to wait until the next annual enrollment period.

New Dependents

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

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

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

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

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

If You Adopt a Child

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

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

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 31 days of the placement;
- Proof of placement will need to be presented to your employer prior to the dependent enrollment.

When You Receive a Qualified Child Support Order

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

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

Coverage for the dependent will become effective on the date of the court order.

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

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

When Your Coverage Begins

Your Effective Date of Coverage

If you have met all the eligibility requirements and enroll within 31 days of your eligibility date, your coverage takes effect on the date you are eligible for coverage.

If your completed enrollment information is not submitted within 31 days of your initial eligibility date, the rules under the *Special or Late Enrollment Periods* section will apply.

Important Notice:

You must pay the required contribution in full or coverage will not be effective.

Your Dependent's Effective Date of Coverage

Your dependent's coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan.

Note: New dependents need to be reported to your employer within 31 days because they may affect your contributions. If you do not report a new dependent within 31 days of his or her eligibility date, the rules under the *Special or Late Enrollment Periods* section will apply.

Requirements For Coverage

To be covered by the plan, services and supplies must meet all of the following requirements:

1. The service or supply must be covered by the plan. For a service or supply to be covered, it must:
 - Be included as a covered expense in this Booklet;
 - Not be an excluded expense under this Booklet. Refer to the *Exclusions* sections of this Booklet for a list of services and supplies that are excluded;
 - Not exceed the maximums and limitations outlined in this Booklet. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
 - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet.
2. The service or supply must be provided while coverage is in effect. See the *Who is Eligible, How and When to Enroll, When Your Coverage Begins, When Coverage Ends* and *Continuation of Coverage* sections for details on when coverage begins and ends.
3. The service or supply must be **medically necessary**. To meet this requirement, the dental service or supply must be provided by a **physician**, or other health care provider or **dental provider**, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness, injury**, disease or its symptoms. The provision of the service or supply must be:
 - (a) In accordance with generally accepted standards of dental practice;
 - (b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease; and
 - (c) Not primarily for the convenience of the patient, **physician** or **dental provider** or other health care provider;
 - (d) And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury**, or disease.

For these purposes “generally accepted standards of dental practice” means standards that are based on credible scientific evidence published in peer-reviewed dental literature generally recognized by the relevant dental community, or otherwise consistent with **physician** or dental specialty society recommendations and the views of **physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

Important Note

- Not every service or supply that fits the definition for **medical necessity** is covered by the plan. Exclusions and limitations apply to certain dental services, supplies and expenses. For example some benefits are limited to a certain dollar maximum. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for the plan limits and maximums.

How Your Aetna Dental Plan Works

Common Terms

What the Plan Covers

Rules that Apply to the Plan

What the Plan Does Not Cover

Understanding Your Aetna Dental Plan

It is important that you have the information and useful resources to help you get the most out of your **Aetna** dental plan. This Booklet explains:

- Definitions you need to know;
- How to access care, including procedures you need to follow;
- What services and supplies are covered and what limits may apply;
- What services and supplies are not covered by the plan;
- How you share the cost of your covered services and supplies; and
- Other important information such as eligibility, **complaints** and **appeals**, termination, continuation of coverage and general administration of the plan.

Important Notes:

Unless otherwise indicated, "you" refers to you and your covered dependents.

This Booklet applies to coverage only and does not restrict your ability to receive covered expenses that are not or might not be **covered expenses** under this dental plan.

Store this Booklet in a safe place for future reference.

Getting Started: Common Terms

Many terms throughout this Booklet are defined in the *Glossary* Section at the back of this document. Defined terms appear in bolded print. Understanding these terms will also help you understand how your plan works and provide you with useful information regarding your coverage.

About the PPO Dental Plan

The plan is a Preferred Provider Organization (PPO) that covers a wide range of dental services and supplies. You can visit the **dental provider** of your choice when you need dental care.

You can choose a **dental provider** who is in the dental network. You may pay less out of your own pocket when you choose a **network provider**.

You have the freedom to choose a **dental provider** who is not in the dental network. You may pay more if you choose an **out-of-network provider**.

The *Schedule of Benefits* shows you how the plan's level of coverage is different for **network services and supplies** and **out-of-network services and supplies**.

The Choice is Yours

You have a choice each time you need dental care:

Using Network Providers

- Your out-of-pocket expenses will be lower when your care is provided by a **network provider**.
- The plan begins to pay benefits after you satisfy a **deductible**.
- You share the cost of covered services and supplies by paying a portion of certain expenses (your **payment percentage**). **Network providers** have agreed to provide covered services and supplies at a **negotiated charge**. Your **payment percentage** is based on the **negotiated charge**. In no event will you have to pay any amounts above the **negotiated charge** for a covered service or supply. You have no further out-of-pocket expenses when the plan covers in network services at 100%.
- You will not have to submit dental claims for treatment received from **network providers**. Your **network provider** will take care of claim submission. You will be responsible for **deductibles, payment percentage and copayments**, if any.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **deductible, copayment, payment percentage** or other **non-covered expenses** you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Availability of Providers

Aetna cannot guarantee the availability or continued participation of a particular **provider**. Either **Aetna** or any **network provider** may terminate the provider contract or limit the number of patients accepted in a practice.

Using Out-of-Network Providers

You can obtain dental care from **dental providers** who are not in the network. The plan covers **out-of-network services and supplies**, but your expenses will generally be higher.

You must satisfy a **deductible** before the plan begins to pay benefits.

You share the cost of covered services and supplies by paying a portion of certain expenses (your **payment percentage**).

If your **out-of-network provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge**. The **recognized charge** is the maximum amount **Aetna** will pay for a covered expense from an **out-of-network provider**.

You must file a claim to receive reimbursement from the plan.

Important Reminder

Refer to the *Schedule of Benefits* for details about any **deductibles, copays, payment percentage** and maximums that apply. There is a separate maximum that applies to **orthodontic treatment**.

Getting an Advance Claim Review

The purpose of the advance claim review is to determine, in advance, the benefits the plan will pay for proposed services. Knowing ahead of time which services are covered by the plan, and the benefit amount payable, helps you and your **dentist** make informed decisions about the care you are considering.

Important Note

The pre-treatment review process is not a guarantee of benefit payment, but rather an estimate of the amount or scope of benefits to be paid.

When to Get an Advance Claim Review

An advance claim review is recommended whenever a course of dental treatment is likely to cost more than \$350. Ask your **dentist** to write down a full description of the treatment you need, using either an **Aetna** claim form or an ADA approved claim form. Then, before actually treating you, your **dentist** should send the form to **Aetna**. **Aetna** may request supporting x-rays and other diagnostic records. Once all of the information has been gathered, **Aetna** will review the proposed treatment plan and provide you and your **dentist** with a statement outlining the benefits payable by the plan. You and your **dentist** can then decide how to proceed.

The advance claim review is voluntary. It is a service that provides you with information that you and your **dentist** can consider when deciding on a course of treatment. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

In determining the amount of benefits payable, **Aetna** will take into account alternate procedures, services, or courses of treatment for the dental condition in question in order to accomplish the anticipated result. (See *Alternate Treatment Rule* for more information on alternate dental procedures.)

What is a Course of Dental Treatment?

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

What The Plan Covers

PPO Dental Plan

Schedule of Benefits for the PPO Dental Plan

PPO Dental is merely a name of the benefits in this section. The plan does not pay a benefit for all dental care expenses you incur.

Important Reminder

Your dental services and supplies must meet the following rules to be covered by the plan:

- The services and supplies must be **medically necessary**.
- The services and supplies must be covered by the plan.
- You must be covered by the plan when you incur the expense.

Covered expenses include charges made by a **dentist** for the services and supplies that are listed in the dental care schedule.

The next sentence applies if:

- A charge is made for an unlisted service given for the dental care of a specific condition; and
- The list includes one or more services that, under standard practices, are separately suitable for the dental care of that condition.

In that case, the charge will be considered to have been made for a service in the list that **Aetna** determines would have produced a professionally acceptable result.

Dental Care Schedule

The dental care schedule is a list of dental expenses that are covered by the plan.

These covered services and supplies are grouped as Type A, Type B or Type C.

PPO Dental Expense Coverage Plan

The following additional dental expenses will be considered **covered expenses** for you and your covered dependent if you have medical coverage insured or administered by **Aetna** and have at least one of the following conditions:

- Pregnancy;
- Coronary artery disease/cardiovascular disease;
- Cerebrovascular disease; or
- Diabetes

Additional Covered Dental Expenses

- One additional prophylaxis (cleaning) per year.
- Scaling and root planing, (4 or more teeth); per quadrant;
- Scaling and root planing (limited to 1-3 teeth); per quadrant;
- Full mouth debridement;
- Periodontal maintenance (one additional treatment per year); and
- Localized delivery of antimicrobial agents. (Not covered for pregnancy)

Payment of Benefits

The additional prophylaxis, the benefit will be payable the same as other prophylaxis under the plan.

The **payment percentage** applied to the other covered dental expenses above will be 100% for **network** expenses and 100% for out-of-network expenses. These additional benefits will not be subject to any frequency limits except as shown above or any Calendar Year maximum.

Aetna will reimburse the provider directly, or you may pay the provider directly and then submit a claim for reimbursement for **covered expenses**.

Important Reminder

The **deductible, payment percentage** and maximums that apply to each type of dental care are shown in the *Schedule of Benefits*.

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

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

Type A Expenses

- Oral exams twice per calendar year. Prophylaxis (scaling and cleaning of teeth), 3 times per calendar year.
- Problem focused exams.
- Topical application of sodium or stannous fluoride once per calendar year for persons under 16 years of age.
- X-rays for diagnosis and other X-rays, not to exceed one full mouth series in a 3 year period.
- Bitewing X-rays, limited to two sets per calendar year for persons under age 14, and one set per calendar year for persons age 14 and older.
- Emergency palliative treatment.
- First installation of a space maintainer to replace any baby tooth which is lost prematurely.
- Sealants for permanent molars for persons under age 16 not to exceed one application in any 3 year period.

Type B Expenses

- Oral surgery for non-impacted wisdom teeth extractions.
- Oral surgery (including extraction of impacted teeth) if the procedure is not covered under your medical plan.
- Extractions.
- Fillings, other than gold.
- General anesthetics given in connection with covered dental services.
- Treatment of diseased periodontal structures.
- Endodontic treatment. This includes root canal therapy.)
- Injection of antibiotic drugs.
- Repair or recementing of crowns, inlays, bridgework, or dentures.
- Relining or rebasing of dentures.
- The adding of teeth to a partial removable denture or to existing fixed bridgework. But, the "Replacement Rule" below must be met.

Type C Expenses

- Inlays, gold fillings, or crowns. This includes precision attachments for dentures.
- First installation of fixed bridgework to replace one or more natural teeth. This includes inlays and crowns as abutments.
- Replacement of an existing removable denture or fixed bridgework by new fixed bridgework. But, the "Prosthesis Replacement Rule" below must be met.
- First installation of removable dentures to replace one or more natural teeth. This includes adjustments for the 6 month period following the date they were installed.
- Replacement of an existing removable denture or fixed bridgework by a new denture. But, the "Replacement Rule" below must be met.
- Dental implants.

Rules and Limits That Apply to the Dental Plan

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

Orthodontic Treatment Rule

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

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

- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an **accident**;
- Maxillofacial surgery;
- Myofunctional therapy;
- Treatment of micrognathia;
- Treatment of cleft palate;
- Treatment of macroglossia;
- Treatment of primary dentition;
- Treatment of transitional dentition;
- Lingually placed direct bonded appliances and arch wires (i.e. "invisible braces"); or
- Removable acrylic aligners (i.e. "invisible aligners").

Replacement Rule

Veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the plan's replacement rule. That means certain replacements of, or additions to, existing veneers, dentures or bridges are covered only when you give proof to **Aetna** that:

- You had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
- The present veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least 5 years before its replacement and cannot be made serviceable.
- You had a tooth (or teeth) extracted. Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Alternate Treatment Rule (GR-9N-20-015-01)

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the plan's coverage will be limited to the cost of the least expensive service or supply that is:

- Customarily used nationwide for treatment, and
- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition.

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 the plan will cover.

Coverage for Dental Work Completed After Termination of Coverage

Your dental coverage may end while you or your covered dependent is 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 60 days after your coverage ends.

- Inlays;
- Onlays;
- Crowns;
- Removable bridges;
- Cast or processed restorations;
- Dentures;
- Fixed partial dentures (bridges); and
- 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; and
 - Impressions have been taken from which the item will be prepared.

What The PPO Dental Plan Does Not Cover

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

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

Any instruction for diet, plaque control and oral hygiene.

Cosmetic services and supplies including plastic surgery, reconstructive surgery, **cosmetic** surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *What the Plan Covers* section. Facings on molar crowns and pontics may be considered **cosmetic**.

Crown, inlays and onlays, and veneers unless:

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

Except as covered in the *What the Plan Covers* section, dental implants, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.

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

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

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

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

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

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

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

Prescribed drugs; pre-medication; or analgesia.

Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.

Services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

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

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

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

Surgical removal of impacted wisdom teeth only for orthodontic reasons.

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

- Scaling of teeth;
- Cleaning of teeth; and
- Topical application of fluoride.

Additional Items Not Covered By A Health Plan

Not every health service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What The Plan Covers* section or by amendment attached to this Booklet.

Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Plan Covers* section.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet.

Charges submitted for services by an unlicensed **hospital, physician** or other provider or not within the scope of the provider's license.

Charges submitted for services that are not rendered, or not rendered to a person not eligible for coverage under the plan.

Court ordered services, including those required as a condition of parole or release.

Examinations:

- Any dental examinations:
 - required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
 - required by any law of a government, securing insurance or school admissions, or professional or other licenses; and
 - required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity.
- Any charges submitted for special medical reports not directly related to treatment except when provided as part of a covered service.

Experimental or investigational drugs, devices, treatments or procedures, except as described in the *What the Plan Covers* section.

Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

Miscellaneous charges for services or supplies including:

- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
 - Care in charitable institutions;
 - Care for conditions related to current or previous military service; or
 - Care while in the custody of a governmental authority.

Non-**medically necessary** 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**.

Routine dental exams and other preventive services and supplies, except as specifically provided in the *What the Plan Covers* section.

Services rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of this Booklet.

Work related: Any **illness** or **injury** related to employment or self-employment including any **injuries** that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an **occupational illness** or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular **illness** or **injury** under such law, that **illness** or **injury** will be considered "non-occupational" regardless of cause.

When Coverage Ends

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

When Coverage Ends for Employees

Your **Aetna** health benefits coverage will end if:

- The **Aetna** health benefits plan is discontinued;
- You voluntarily stop your coverage;
- You are no longer eligible for coverage; in that case, coverage ends at the end of the month in which you are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under your health plan, if your plan contains such a maximum benefit; or
- Your employer notifies **Aetna** that your employment is ended.

It is your employer's responsibility to let **Aetna** know when your employment ends.

When Coverage Ends for Dependents

Coverage for your dependents will end if:

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

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

Continuation of Coverage

Continuing Health Care Benefits

Continuing Coverage for Dependents After Your Death

If you should die while enrolled in this plan, your dependent's health care coverage, if applicable will continue as long as you were covered at the time of your death.

Your dependent's coverage will end when the first of the following occurs:

- The end of the second month following the month in which your death occurs;
- He or she no longer meets the plan's definition of "dependent"; or
- Dependent coverage is discontinued under the group contract.

Handicapped Dependent Children

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to **Aetna** no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

Aetna will have the right to require proof of the continuation of the handicap. **Aetna** also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

COBRA Continuation of Coverage

If your employer is subject to COBRA requirements, the health plan continuation is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA you and your dependents can continue health coverage, subject to certain conditions and your payment of contributions. Continuation rights are available following a “qualifying event” that would cause you or family members to otherwise lose coverage. Qualifying events are listed in this section.

Continuing Coverage through COBRA

When you or your covered dependents become eligible, Aetna Payflex will provide you with detailed information on continuing your health coverage through COBRA.

You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.
- Submit your application within 60 days of the qualifying event, or within 60 days of the Payflex notice of this COBRA continuation right, if later.
- Agree to pay the required contributions.

Who Qualifies for COBRA

You have 60 days from the qualifying event to elect COBRA. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights.

Below you will find the qualifying events and a summary of the maximum coverage periods according to COBRA requirements.

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect Continuation	Maximum Continuation Periods
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
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependents under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for health coverage and your former employer files for bankruptcy	You and your dependents	18 months

Disability May Increase Maximum Continuation to 29 Months

If You or Your Covered Dependents Are Disabled

If you or your covered dependent qualify for disability status under Title II or XVI of the Social Security Act during the 18 month continuation period, you or your covered dependent:

- Have the right to extend coverage beyond the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.
- Must notify Aetna Payflex within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify Aetna Payflex within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the contributions after the 18th month, through the 29th month.

If There Are Multiple Qualifying Events

A covered dependent could qualify for an extension of the 18 or 29 month continuation period by meeting the requirements of another qualifying event, such as divorce or death. The total continuation period, however, can never exceed 36 months.

Determining Your Contributions For Continuation Coverage

Your contributions are regulated by law, based on the following:

- For the 18 or 36 month periods, contributions may never exceed 102 percent of the plan costs.
- During the 18 through 29 month period, contributions for coverage during an extended disability period may never exceed 150 percent of the plan costs.

When You Acquire a Dependent During a Continuation Period

If through birth, adoption or marriage, you acquire a new dependent during the continuation period, your dependent can be added to the health plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent,
- Aetna Payflex is notified about your dependent within 31 days of eligibility, and
- Additional contributions for continuation are paid on a timely basis.

Important Note

For more information about dependent eligibility, see the *Eligibility, Enrollment and Effective Date* section.

When Your COBRA Continuation Coverage Ends

Your COBRA coverage will end when the first of the following events occurs:

- You or your covered dependents reach the maximum COBRA continuation period – the end of the 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is not disabled nor eligible for an extended maximum).
- You or your covered dependents do not pay required contributions.
- You or your covered dependents become covered under another group plan that does not restrict coverage for preexisting conditions. If your new plan limits preexisting condition coverage, the continuation coverage under this plan may remain in effect until the preexisting clause ceases to apply or the maximum continuation period is reached under this plan.
- The date your employer no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies.

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

When Coordination of Benefits Applies

Getting Started - Important Terms

Which Plan Pays First

How Coordination of Benefits Works

When Coordination of Benefits Applies

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

Getting Started - Important Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Which Plan Pays First

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

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:
 1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.
 2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one **plan** is:
 - A. The primary plan is the plan of the parent whose birthday is earlier in the year if:
 - i. The parents are married or living together whether or not married;
 - ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
 - B. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the primary plan.
 - C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
 - The plan of the **custodial parent**;
 - The plan of the spouse of the **custodial parent**;
 - The plan of the **noncustodial parent**; and then
 - The plan of the spouse of the **noncustodial parent**.

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

3. Active Employee or Retired or Laid off Employee. The plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
5. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, subscriber longer is primary.
6. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, this plan will not pay more than it would have paid had it been primary.

How Coordination of Benefits Works

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

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

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

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

Right To Receive And Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

When You Have Medicare Coverage

Effect of Medicare

Effect of Medicare

Health Expense Coverage under this Plan will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- Is covered under it;
- Is not covered under it because of:
 - Having refused it;
 - Having dropped it;
 - Having failed to make proper request for it.

These are the changes:

- The total amount of "regular benefits" under all Health Expense Benefits will be figured. (This will be the amount that would be payable if there were no Medicare benefits.) If this is more than the amount Medicare provides for the expenses involved, this Plan will pay the difference. Otherwise, this Plan will pay no benefits. This will be done for each claim.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by **Aetna**. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Any benefits under Medicare will not be deemed to be an "Allowable Expense."

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

General Provisions

Type of Coverage

Coverage under the plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational illnesses** are covered. The plan covers charges made for services and supplies only while the person is covered under the plan.

Physical Examinations

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you.

Legal Action

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

Additional Provisions

The following additional provisions apply to your coverage:

- This Booklet applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under the plan because you are connected with more than one employer.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the plan. If you have any questions about the terms of the plan or about the proper payment of benefits, contact your employer or **Aetna**.
- The plan may be changed or discontinued with respect to your coverage.

Assignments

Coverage and your rights under this plan may not be assigned. A direction to pay a provider is not an assignment of any right under this plan or of any legal or equitable right to institute any court proceeding.

Misstatements

Aetna's failure to implement or insist upon compliance with any provision of this plan at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times.

Fraudulent misstatements in connection with any claim or application for coverage may result in termination of all coverage under this plan.

Recovery of Overpayments

Health Coverage

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

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

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

Reporting of Claims

A claim must be submitted to **Aetna** in writing. It must give proof of the nature and extent of the loss. Your employer has claim forms.

All claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the loss.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 2 years after the deadline.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

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

The Plan may pay up to \$1,000 of any other benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release.

Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

- Names of **dentists** who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna's** Home Office at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may also use **Aetna's** toll free Member Services phone number on your ID card or visit **Aetna's** web site at www.aetna.com.

Effect of Benefits Under Other Plans

Effect of An Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an eligible class and have chosen dental coverage under an HMO Plan offered by your employer, you will be excluded from dental expense coverage on the date of your coverage under such HMO Plan.

If you are in an eligible class and are covered under an HMO Plan providing dental coverage, you can choose to change to coverage for yourself and your covered dependents under this plan. If you:

- Live in an HMO Plan enrollment area and choose to change dental coverage during an open enrollment period, coverage will take effect on the group contract anniversary date after the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change dental coverage when there is not an open enrollment period, coverage will take effect only if and when **Aetna** gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change dental coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when **Aetna** gives its written consent.

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

Discount Programs

Discount Arrangements

From time to time, we may offer, provide, or arrange for discount arrangements or special rates from certain service providers such as pharmacies, optometrists, **dentists**, alternative medicine, wellness and healthy living providers to you under this plan. Some of these arrangements may be made available through third parties who may make payments to **Aetna** in exchange for making these services available.

The third party service providers are independent contractors and are solely responsible to you for the provision of any such goods and/or services. We reserve the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance. There are no benefits payable to you nor do we compensate providers for services they may render through discount arrangements.

Incentives

In order to encourage you to access certain medical services when deemed appropriate by you in consultation with your **physician** or other service providers, we may, from time to time, offer to waive or reduce a member's **copayment, payment percentage**, and/or a **deductible** otherwise required under the plan or offer coupons or other financial incentives. We have the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the covered persons to whom these arrangements are available.

Appeals Procedure

Definitions

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

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

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

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

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

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

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

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

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

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

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

Claim Determinations

Urgent Care Claims

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

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

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

Pre-Service Claims

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

Post-Service Claims

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

Concurrent Care Claim Extension

Following a request for a **concurrent care claim extension**, Aetna will make notification of a claim determination for **emergency or urgent care** as soon as possible but not later than 24 hours, with respect to **emergency or urgent care** provided the request is received at least 24 hours prior to the expiration of the approved course of treatment, and 15 calendar days with respect to all other care, following a request for a **concurrent care claim extension**.

Concurrent Care Claim Reduction or Termination

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

Complaints

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

Appeals of Adverse Benefit Determinations

You may submit an **appeal** if Aetna gives notice of an **adverse benefit determination**. This Plan provides for two levels of **appeal**.

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

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

The notice of an **adverse benefit determination** will include the address where the appeal can be sent. If your appeal is of an urgent nature, you may call Aetna's Customer Service Unit at the toll-free phone number on your ID card.

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

Level One Appeal - Group Health Claims

A level one **appeal** of an **adverse benefit determination** shall be provided by Aetna personnel not involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include **concurrent care claim reduction or termination**)

Aetna shall issue a decision within 36 hours of receipt of the request for an **appeal**.

Pre-Service Claims (May Include **concurrent care claim reduction or termination**)

Aetna shall issue a decision within 15 calendar days of receipt of the request for an **appeal**.

Post-Service Claims

Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim.

A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

Level Two Appeal

If Aetna upholds an **adverse benefit determination** at the first level of **appeal**, you or your authorized representative have the right to file a level two **appeal**. The **appeal** must be submitted within 60 calendar days following the receipt of notice of a level one **appeal**.

A level two **appeal** of an **adverse benefit determination** of an **urgent care claim**, a **Pre-Service Claim**, or a **Post-Service Claim** shall be provided by Aetna personnel not involved in making an **adverse benefit determination**.

Urgent Care Claims (May Include **concurrent care claim reduction or termination**)

Aetna shall issue a decision within 36 hours of receipt of the request for a level two **appeal**.

Pre-Service Claims (May Include **concurrent care claim reduction or termination**)

Aetna shall issue a decision within 15 calendar days of receipt of the request for level two **appeal**.

Post-Service Claims

Aetna shall issue a decision within 30 calendar days of receipt of the request for a level two **appeal**.

If you do not agree with the final determination on review, you have the right to bring a civil action, if applicable.

Exhaustion of Process

You must exhaust the applicable Level one and Level two processes of the Appeal Procedure before you:

- establish any:
 - litigation;
 - arbitration; or
 - administrative proceeding;

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

Glossary

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet.

A

Accident

This means a sudden; unexpected; and unforeseen; identifiable **occurrence** or event producing, at the time, objective symptoms of a bodily **injury**. The **accident** must occur while the person is covered under this Contract. The **occurrence** or event must be definite as to time and place. It must not be due to, or contributed by, an **illness** or disease of any kind.

Aetna

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

C

Copay or Copayment

The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various **copayments**, and these **copayment** amounts or percentages are specified in the *Schedule of Benefits*.

Cosmetic

Services or supplies that alter, improve or enhance appearance.

Covered Expenses

Medical, dental, vision or hearing services and supplies shown as covered under this Booklet.

D

Deductible

The part of your **covered expenses** you pay before the plan starts to pay benefits. Additional information regarding **deductibles** and **deductible** amounts can be found in the *Schedule of Benefits*.

Dental Provider

This is:

- Any **dentist**;
- Group;
- Organization;
- Dental facility; or
- Other institution or person.

legally qualified to furnish dental services or supplies.

Dental Emergency

Any dental condition that:

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

Dentist

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

Directory

A listing of all **network providers** serving the class of employees to which you belong. The contractholder will give you a copy of this **directory**. **Network provider** information is also available through **Aetna's** online provider **directory**, DocFind®.

E

Experimental or Investigational

Except as provided for under the Clinical Trials benefit provision, a drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There is not enough outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness or injury** involved; or
- Approval required by the U. S. Food and Drug Administration (FDA) has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational**, or for research purposes; or
- It is a type of drug, device, procedure or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of “phases” indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same:
 - drug;
 - device;
 - procedure; or
 - treatment.

It also includes the written informed consent used by:

- the treating facility; or
- by another facility studying the same:
 - drug;
 - device;
 - procedure; or
 - treatment.

that states that it is **experimental or investigational**, or for research purposes.

H

Hospital

An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

I

Illness

A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

Injury

An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.
- An act or event must be definite as to time and place.

J

Jaw Joint Disorder

This is:

- A Temporomandibular Joint (TMJ) dysfunction or any alike disorder of the jaw joint; or
- A Myofascial Pain Dysfunction (MPD); or
- Any alike disorder in the relationship of the jaw joint and the related muscles and nerves.

L

Lifetime Maximum

This is the most the plan will pay for **covered expenses** incurred by any one covered person in their lifetime.

M

Medically Necessary or Medical Necessity

These are health care or dental services, and supplies or **prescription drugs** that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would give to a patient for the purpose of:

- preventing;
- evaluating;
- diagnosing; or
- treating:
 - an **illness**;
 - an **injury**;
 - a disease; or
 - its symptoms.

The provision of the service, supply or **prescription drug** must be:

- a) In accordance with generally accepted standards of medical or dental practice;
- b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease; and
- c) Not mostly for the convenience of the patient, **physician**, other health care or **dental provider**; and
- d) And do not cost more than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury**, or disease.

For these purposes “generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature. They must be generally recognized by the relevant medical or dental community. Otherwise, the standards are consistent with **physician** or dental specialty society recommendations. They must be consistent with the views of **physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

N

Negotiated Charge

The maximum charge a **network provider** has agreed to make as to any service or supply for the purpose of the benefits under this plan.

Network Provider

A **dental provider** who has contracted to furnish services or supplies for this plan; but only if the provider is, with **Aetna's** consent, included in the **directory** as a **network provider** for:

- The service or supply involved; and
- The class of employees to which you belong.

Network Service(s) or Supply(ies)

Health care service or supply that is:

- Furnished by a **network provider**

Non-Occupational Illness

A **non-occupational illness** is an **illness** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **illness** that does.

An **illness** will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that **illness** under such law.

Non-Occupational Injury

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

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **injury** which does.

O

Occupational Injury or Occupational Illness

An **injury** or **illness** that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an **injury** or **illness** that does.

Occurrence

This means a period of disease or **injury**. An **occurrence** ends when 60 consecutive days have passed during which the covered person:

- Receives no medical treatment; services; or supplies; for a disease or **injury**; and
- Neither takes any medication, nor has any medication prescribed, for a disease or **injury**.

Orthodontic Treatment

This is any:

- Medical service or supply; or
- Dental service or supply;

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

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

whether or not for the purpose of relieving pain.

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

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

Out-of-Network Service(s) and Supply(ies)

Health care service or supply that is:

- Furnished by an **out-of network provider**.

Out-of-Network Provider

A **dental provider** who has not contracted with **Aetna**, an affiliate, or a third party vendor, to furnish services or supplies for this plan.

P

Payment Percentage

Payment percentage is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the “plan **payment percentage**,” and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **payment percentage** amounts.

Physician

A duly licensed member of a medical profession who:

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

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- A physician is not you or related to you.

Precertification or Precertify

A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered expenses** under the plan. It is not a guarantee that benefits will be payable.

Prescriber

Any **physician** or **dentist**, acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

Prescription

An order for the dispensing of a **prescription drug** by a **prescriber**. If it is an oral order, it must be promptly put in writing by the pharmacy.

Prescription Drug

A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

R

Recognized Charge

The **covered expense** is only that part of a charge which is the **recognized charge**.

As to dental expenses, the **recognized charge** for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- The 80th percentile of the Prevailing Charge Rate; for the Geographic Area where the service is furnished.

If **Aetna** has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that **Aetna** will pay for a service or supply, then the **recognized charge** is the rate established in such agreement.

Aetna may also reduce the **recognized charge** by applying **Aetna** Reimbursement Policies. **Aetna** Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service;
- whether multiple procedures are billed at the same time, but no additional overhead is required;
- whether an assistant surgeon is involved and necessary for the service;
- if follow up care is included;
- whether there are any other characteristics that may modify or make a particular service unique; and
- 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.

Aetna Reimbursement Policies are based on **Aetna's** review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with **physician** or dental specialty society recommendations; and the views of **physicians** and **dentists** practicing in the relevant clinical areas. **Aetna** uses a commercial software package to administer some of these policies.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- **Geographic Area:** This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
- **Prevailing Charge Rates:** These are the rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. **Aetna** updates its systems with these changes within 180 days after receiving them from FAIR Health.

Important Note

Aetna periodically updates its systems with changes made to the Prevailing Charge Rates.

What this means to you is that the **recognized charge** is based on the version of the rates that is in use by Aetna on the date that the service or supply was provided.

Additional Information

Aetna's website aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools, or contact our Customer Service Department for assistance.

R.N.

A registered nurse.

S

Skilled Nursing Facility

An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**:
 - Professional nursing care by an **R.N.**, or by a L.P.N. directed by a full-time **R.N.**; and
 - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or an **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of **mental disorders**.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
 - It is licensed or approved under state or local law.
 - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by:
 - The Joint Commission on Accreditation of Health Care Organizations;
 - The Bureau of **Hospitals** of the American Osteopathic Association; or
 - The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation **hospitals** (all levels of care, e.g. acute) and portions of a **hospital** designated for skilled or rehabilitation services.

Skilled nursing facility does not include:

- Institutions which provide only:
 - Minimal care;
 - Custodial care services;
 - Ambulatory; or
 - Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, substance abuse or mental disorders.

Specialist

A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialist Dentist

Any **dentist** who, by virtue of advanced training is board eligible or certified by a Specialty Board as being qualified to practice in a special field of dentistry.

Specialty Care

Health care services or supplies that require the services of a **specialist**.

Additional Information Provided by California Resources Corporation

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA).

Name of Plan:

California Resources Corporation Dental Plan

Employer Identification Number:

46-5676989

Plan Number:

502

Type of Plan:

ERISA Welfare Plan

Type of Administration:

Administrative Services Contract with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:

California Resources Employee Benefits Committee
CRC Services, LLC
10889 Wilshire Blvd.
Los Angeles, CA 90024
Telephone Number: (888) 848-4754

Agent For Service of Legal Process:

CRC Services, LLC
10889 Wilshire Blvd.
Los Angeles, CA 90024

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

Named Fiduciary:

For Dental Claims:

Aetna Life Insurance Company

End of Plan Year:

December 31

Source of Contributions:

Employee Contributions and Employer General Assets

Procedure for Amending the Plan:

The Employer may amend the Plan from time to time by a written instrument signed by the Vice President of Compensation and Benefits.

ERISA Rights

As a participant in the group benefit 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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

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.

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 determined by 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.

If any coverage your Employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage 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 this Plan 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 this Plan 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 this Plan only if and when this Plan 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.