BENEFIT PLAN

Prepared Exclusively For
Iota Community Schools

PPO Dental Extraterritorial Riders - High Plan

Extraterritorial Riders

Aetna Life Insurance Company

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

aetna™

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Aetna Life Insurance Company

Group Dental
Extraterritorial booklet-certificate amendment

Policyholder: Iota Community Schools

Group policy number: GP-0284189-E

Effective date: July 1, 2024

This amendment is part of your booklet-certificate that describes your dental coverage. It is effective on the date shown above and it replaces any other dental extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in the State/Commonwealth of Arkansas. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

The following is added to the *Welcome* section of your booklet-certificate.

Important Information

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

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

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

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201
(501) 371-2640 or (800) 852-5494

The following revises the *Who the Plan Covers* section of your booklet-certificate.

Newborn children

A newborn child - Your newborn child is covered on your dental plan for the first 90 days after birth.

- To keep your newborn covered, we must receive your completed enrollment information within 90 days of birth.
- You must still enroll the child within 90 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.

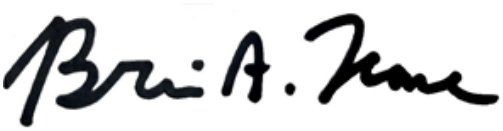
- If you miss this deadline, your newborn will not have dental benefits after the first 90 days.

The following revises the *Schedule of Benefits* section of your booklet-certificate.

Out of network expenses

If your plan uses a network of providers, in no event will the covered amount for In-Network charges exceed more than 25% of the covered amount for Out-of-Network charges.

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



Brian A. Kane
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Arkansas Dental ET
Issue Date: September 6, 2024

Aetna Life Insurance Company

Group Dental
Extraterritorial booklet-certificate amendment

Policyholder: Iota Community Schools

Group policy number: GP-0284189-E

Effective date: July 1, 2024

This amendment is part of your booklet-certificate that describes your dental coverage. It is effective on the date shown above and it replaces any other dental extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in the State/Commonwealth of California. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

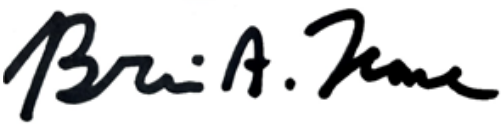
The following revises the *Who the plan covers* section of your booklet-certificate.

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

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

- Your civil union partner
- Your domestic partner who meets the requirements under state law

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



Brian A. Kane
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: California Dental ET
Issue Date: September 6, 2024

Additional Information Provided by Aetna Life Insurance Company

Inquiry Procedure

The plan of benefits described in the Booklet-Certificate is underwritten by:

Aetna Life Insurance Company (Aetna)
151 Farmington Avenue
Hartford, Connecticut 06156

Telephone: (860) 273-0123

If you have questions about benefits or coverage under this plan, call Member Services at the number shown on your Identification Card. You may also call Aetna at the number shown above.

If you have a problem that you have been unable to resolve to your satisfaction after contacting Aetna, you should contact the Consumer Service Division of the Department of Insurance at:

300 South Spring Street
Los Angeles, CA 90013
https://www.insurance.ca.gov/01-consumers/101-help/index.cfm

Telephone: 1-800-927-4357 or 213-897-8921

You should contact the Bureau only after contacting Aetna at the numbers or address shown above.

Participating Providers

We want you to know more about the relationship between Aetna Life Insurance Company and its affiliates (Aetna) and the participating, independent providers in our network. Participating physicians are independent doctors who practice at their own offices and are neither employees nor agents of Aetna. Similarly, participating hospitals are neither owned nor controlled by Aetna. Likewise, other participating health care providers are neither employees nor agents of Aetna.

Participating Providers are paid on a 'Discounted Fee For Service' arrangement. Discounted fee for service means that participating providers are paid a predetermined amount for each service they provide. Both the participating provider and Aetna agree on this amount each year. This amount may be different than the amount the participating provider usually receives from other payers.

Aetna Life Insurance Company

Group Dental
Extraterritorial booklet-certificate amendment

Policyholder: Iota Community Schools

Group policy number: GP-0284189-E

Effective date: July 1, 2024

This amendment is part of your booklet-certificate that describes your dental coverage. It is effective on the date shown above and it replaces any other dental extraterritorial booklet-certificate amendment you may have received before.

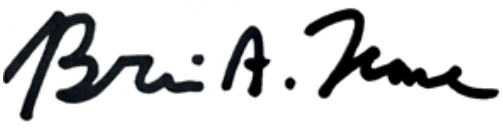
Important note: The following apply only if you live in the State/Commonwealth of Illinois. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

The following is added to the *When you disagree - claim decisions and appeals procedures* section of your booklet-certificate.

Communicating our claim decisions

If a claim is not paid within 30 days after proof of loss is received, you are entitled to 9% interest. Interest will be calculated from the 30th day until the date the benefits are paid. However, interest less than $1 may not be paid.

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



Brian A. Kane
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Illinois Dental ET
Issue Date: September 6, 2024

Aetna Life Insurance Company

Group Dental
Extraterritorial booklet-certificate amendment

Policyholder: Iota Community Schools

Group policy number: GP-0284189-E

Effective date: July 1, 2024

This amendment is part of your booklet-certificate that describes your dental coverage. It is effective on the date shown above and it replaces any other dental extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in the State/Commonwealth of Mississippi. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

The following replaces the *When You Disagree – Claims Decisions and Appeals Procedures* section of your booklet-certificate.

When you disagree - claim decisions and appeals procedures

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

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

When you see a **network provider**, that office will usually send us a detailed bill for your services. If you see an **out-of-network provider**, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you should send it to us as soon as possible with a claim form that you can either get online or contact us to provide. You should always keep your own record of the date, **providers** and cost of your services.

The benefit payment determination is made based on many things, such as your **deductible** or **coinsurance**, the necessity of the service you received, when or where you receive the services, or even what other insurance you may have. We may need to ask you or your **provider** for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the *Complaints, claim decisions and appeal procedures* section for that information.

Time of payment of claims

1. All benefits payable under this policy for any loss, other than loss for which this policy provides any periodic payment, will be paid within twenty-five (25) days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted electronically, and will be paid within thirty-five (35) days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted in paper format. Benefits due under the policies and claims are overdue if not paid within twenty-five (25) days or thirty-five (35) days, whichever is applicable, after the insurer receives a clean claim containing necessary medical information and other information essential for the insurer to administer preexisting condition, coordination of benefits and subrogation provisions. A "clean claim" means a claim received by an insurer for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the insured in order to be processed and paid by the insurer. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. Errors, such as system errors, attributable to the insurer, do not change the clean claim status.

   A clean claim does not include any other the following:

   a. A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim;
   b. Claims which are submitted fraudulently or that are based upon material misrepresentations;
   c. Claims that require information essential for the insurer to administer preexisting condition, coordination of benefits or subrogation provisions; or
   d. Claims submitted by a provider more than thirty (30) days after the date of services; if the provider does not submit the claim on behalf of the insured, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the provider to the insured.

   Not later than twenty-five (25) days after the date the insurer actually receives an electronic claim, the insurer shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation an information is required to adjudicate the claim as clean. Not later than thirty-five (35) days after the date the insurer actually receives a paper claim, the insurer shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) of the reasons why the claim or portion thereof is not clan and will not be paid and what substantiating documentation

an information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by the insurer shall be paid within twenty (20) days after receipt.

For the purposes of this provision, the term "pay" means that the insurer shall either send cash or a cash equivalent by the Unites States mail, or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate benefit due the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured). To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last known address of the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) in a properly addressed, postpaid envelope, or if not so posted, or not send by United States mail, on the date of delivery of payment to the provider or the insured.

2. Subject to due written proof of loss, all accrued benefits for loss for which this policy provides periodic payment will be paid monthly, and any balance remaining unpaid upon the termination of liability will be paid within thirty (30) days after receipt of due written proof.

3. If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, the insurer must pay the provider (where the claim is owed to the provider) or to the insured (where the claim is owed to the insured) interest on accrued benefits at the rate of three percent (3%) per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than One Dollar ($1.00), such amount shall be credited to the account of the person or entity to whom such amount is owed.

4. In the event the insurer fails to pay benefit when due, the person entitled to such benefits may bring action to recover such benefits, any interests which may accrue as provided in subparagraph 3 of this paragraph (h) and any other damages as may be allowable by law. If it is determined in such action that the insurer acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, the person entitled to such benefits (health care provider or insured) shall be entitled to recover damages in an amount up to three (3) times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

Payment of claims

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed in this policy and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured. When payments of benefits are made to an insured directly for medical care or services rendered by a health care provider, the health care provider shall be notified of such payment. If the insured provides the insurer with written direction that all or a portion of any indemnities or benefits provided by the policy be paid to a licensed health care provider rendering hospital, nursing, medical or surgical services, then the insurer shall pay directly the licensed health

care provider rendering such services. That payment shall be considered payment in full to the **provider**, who may not bill or collect from the insured any amount above that payment, other than the deductible, coinsurance, copayment or other charges for equipment or services requested by the insured that are noncovered benefits. Any dispute between a provider and the insured arising under these provisions regarding assignment of benefits and billing may be resolved by the commissioner of Insurance.

Adverse benefit determinations

We pay many claims at the full rate **negotiated charge** with **in-network providers** and the **recognized charge** with **out-of-network providers** (or **dental providers** for plans with no network), except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we don't pay at all. Any time we don't pay even part of the claim, that is called an "adverse benefit determination" or "adverse decision".

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

The difference between a complaint and an appeal

A complaint

You may not be happy about a **dental provider** or an operational issue, and you may want to complain. You can call or write us. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

An appeal

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

Appeals of adverse benefit determinations

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

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

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

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

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

Timeframes for deciding appeals

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

Type of notice	Post-service appeal
Initial decision by us	30 days
Extensions	15 days
If we request more information	30 days
Time you have to send us additional information	45 days

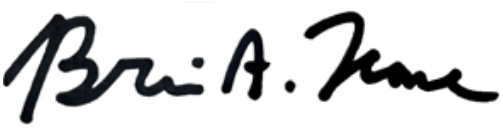
Recordkeeping

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

Fees and expenses

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

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



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Amendment: Mississippi Dental ET
Issue Date: September 6, 2024