This is Your

EXCLUSIVE PROVIDER ORGANIZATION POLICY

issued by

HEALTHPLEX INSURANCE COMPANY (“HIC”)

to

_______________________________________(“Group”)

____
Group Number

This Policy explains the benefits available to Member under a Group Policy between Healthplex Insurance Company (hereinafter referred to as “We”, “Us”, or Our”) and the Group listed in the Group Policy. Amendments, riders or endorsements may be delivered with the Policy or added thereafter.

In-Network Benefits. This Policy only covers in-network benefits. To receive in-network benefits the Member must receive care exclusively from Participating Providers in our network. Care Covered under this Policy must be provided, arranged or authorized in advance by his/her Primary Care Dentist and, when required, approved by Us. In order to receive the benefits under this Policy, he/she must contact his/her Primary Care Dentist before he/she obtains the services except for Emergency Dental Care described in the Pediatric Dental Care and Adult Dental Care Sections of this Policy. Except for Emergency Dental Care described in the Pediatric Dental Care section of this Policy, he/she will be responsible for paying the cost of all care that is provided by Non-Participating Providers.

READ THIS ENTIRE POLICY CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS POLICY.

This Policy is governed by the laws of New York State.

The insurance evidenced by this Policy provides DENTAL insurance ONLY.

This Policy is a New York State of Health, The Official Health Plan Marketplace, certified stand-alone dental plan offered outside the New York State of Health.

Date: Signed By:

DATE

___________________________________ _______________________________________
President

HEALTHPLEX INSURANCE COMPANY
333 EARLE OVINGTON BLVD., SUITE 300
UNIONDALE, NY 11553

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SECTION I – DEFINITIONS

Defined terms will appear capitalized throughout the Policy.

Acute: The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Policy for a description of how the Allowed Amount is calculated.

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

Balance Billing: When a Non-Participating Provider bills the Member for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill him/her for Covered Services.

Child, Children: The Subscriber's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the Who is Covered section of this Policy.

Coinsurance: The Subscriber's share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that the Subscriber are required to pay to a Provider. The amount can vary by the type of Covered Service.

Copayment: A fixed amount the Member pays directly to a Provider for a Covered Service when he/she receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts the Member must pay for Covered Services, expressed as, Copayments, Deductibles and/or Coinsurance.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged or authorized for the Member by Us under the terms and conditions of this Policy.

Deductible: The amount the Member owes before We begin to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. The Member may also have a Deductible that applies to a specific Covered Service that he/she owes before We begin to pay for a particular Covered Service.

Dependents: The Subscriber's Spouse and Children.

Emergency Dental Care: Emergency dental treatment required to alleviate pain and suffering caused by dental disease or trauma. Refer to the Pediatric Dental Care and Adult Dental Care section of this Policy for details.

Exclusions: Dental care services that We do not pay for or Cover.

External Appeal Agent: An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

Grievance: A complaint that the Member communicates to Us that does not involve a Utilization Review determination.

Group: The employer or party that has entered into an Agreement with Us as a policyholder.

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Medically Necessary: See the How the Member's Coverage Works section of this Policy for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Subscriber or a covered Dependent for whom required Premiums have been paid. Whenever a Member is required to provide a notice, "Member" also means the Member's designee.

New York State of Health ("NYSOH"): The New York State of Health, the Official Health Plan Marketplace. The NYSOH is a marketplace where individuals, families and small businesses can learn about their health insurance options; compare plans based on cost, benefits and other important features; apply for and receive financial help with premiums and cost-sharing based on income; choose a plan; and enroll in coverage. The NYSOH also helps eligible consumers enroll in other programs, including Medicaid, Child Health Plus, and the Essential Plan.

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide services to the Member. The services of Non-Participating Providers are Covered only for Emergency Dental Care or when authorized by Us.

Out-of-Pocket Limit: The most the Member pays during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes the Member's Premium, Balance Billing charges or the cost of dental care services We do not Cover.

Participating Provider: A Provider who has a contract with Us to provide services to the Member. A list of Participating Providers and their locations is available on Our Third Party Administrator's website at www.healthplex.com or upon the Member's request to Us. The list will be revised from time to time by Us.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan Year: The 12-month period beginning on the effective date of the Policy or any anniversary date thereafter, during which the Policy is in effect.

Policy: This Policy issued by Healthplex Insurance Company, including the Schedule of Benefits and any attached riders.

Preauthorization: A decision by Us prior to the Member's receipt of a Covered Service, procedure, treatment plan, or device that the Covered Service, procedure treatment plan or device is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this Policy.

Premium: The amount that must be paid for the Member's health insurance coverage.

Premium Tax Credit: Financial help that lowers the Member's taxes to help the Member and his/her family pay for private dental insurance. The Member can get this help if the Member's get health insurance through the NYSOH and the Member's income is below a certain level. Advance payments of the tax credit can be used right away to lower the Member's monthly Premium.

Primary Care Dentist ("PCD"): A Participating Dentist who directly provides or coordinates a range of dental services for the Member.

Provider: An appropriately licensed, registered or certified dentist, dental hygienist or dental assistant under Title 8 of the New York State Education Law (or other comparable state law, if applicable) that the New York State Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Provider's services must be rendered within the lawful scope of practice for that type of Provider in order to be Covered under the Policy.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCD to a Specialist) in order to arrange for additional care for a Member. A Referral can be transmitted electronically or by the Member's Provider completing a paper Referral form. Except as provided in the Access to Care and Transitional Care section of this Policy or otherwise authorized by Us, a Referral will not be made to a Non-Participating Provider. A Referral is not required but needed in order for the Member to pay the lower Cost-Sharing for certain services listed in the Schedule of Benefits section of this Policy.

Schedule of Benefits: The section of this Policy that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements; Referral requirements and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York in which We provide coverage. Our Service Area consists of all counties within New York State.

Specialist: A dentist who focuses on a specific area of dentistry, including oral surgery, endodontia, periodontia, orthodontia, and pediatric dentistry or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse. Spouse also includes a domestic partner.

UCR (**Usual, Customary and Reasonable):** The cost of a dental service in a geographic area based on what Providers in the area usually charge for the same or similar dental service.

Us, We, Our: Healthplex Insurance Company. and anyone to whom We legally delegate performance, on Our behalf, under this Policy.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (including treatment for a rare disease or clinical trial).

You, Your: The Group.

SECTION II – HOW THE MEMBER'S COVERAGE WORKS

A. The Member's Coverage under this Policy.
The Member's employer (referred to as the "Group") has purchased a Group dental insurance Policy from Us. We will provide the benefits described in this Policy to covered Members of the Group, that is, to employees of the Group and/or their covered dependents.

B. Covered Services.
The Member will receive Covered Services under the terms and conditions of this Policy only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Policy; and
- Received while the Member's Policy is in force.

C. Participating Providers.
To find out if a Provider is a Participating Provider:

- Check the Member's Provider directory, available at his/her request; or
- Call Healthplex, Inc. our dental administrator, at 888-468-5175; or
- Visit Healthplex's website at www.healthplex.com.

D. The Role of Primary Care Dentists.
This Policy has a gatekeeper, usually known as a Primary Care Dentist ("PCD"). This Policy requires that the Member select a PCD. The Member needs a written Referral from a PCD before receiving Specialist care from a Participating Provider. The Member may select any Participating PCD who is available from the list of PCDs in the EPO Healthplex Network. Each Member may select a different PCD.

1. **Services Not Requiring Referral from the Member's PCD.** The Member's PCD is responsible for determining the most appropriate treatment for his/her dental care needs. The Member does not need a Referral from his/her PCD to a Participating Provider for the following services:
   - Emergency Dental Care
   - Preventive Dental Care; and
   - Routine Dental Care.

   However the Participating Provider must discuss the services and treatment plan with his/her PCD; agree to follow Our policies and procedures including any procedures regarding Referrals or Preauthorization for services rendered by such Participating Provider; and agrees to provide services pursuant to a treatment plan (if any) approved by Us. See the Schedule of Benefit section of this Policy for the services that required a Referral.

2. **Access to Providers and Changing Providers**. Sometimes Providers in Our Provider directory are not available. Prior to notifying Us of the PCD the Member selected, The Member should call the PCD to make sure he or she is a Participating Provider and is accepting new patients.

   To see a Provider, call his or her office and tell the Provider that the Member is a HIC Member, and explain the reason for his/her visit. Have his/her ID card available. The Provider's office may ask him/her for his/her Group or Member ID number. When he/she goes to the Provider's office, bring his/her ID card with his/her.

   The Member may change his/her PCD by calling Healthplex, HIC's Third Party Administrator's Customer Service number at 888-468-5175. This can be done anytime.

E. Services Subject To Preauthorization.

Our Preauthorization is required before the Member receives certain Covered Services. The Member PCD is responsible for requesting Preauthorization for in-network services.

F. Medical Management.

The benefits available to the Member under this Policy are subject to pre-service, concurrent and retrospective reviews to determine when services should be covered by Us. The purpose of these reviews is to promote the delivery of cost-effective dental care by reviewing the use of procedures and, where appropriate, the setting or place of the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

G. Medical Necessity

We Cover certain benefits described in this Policy as long as the dental service, procedure, treatment, test, device or supply (collectively, "service") is Medically Necessary (e.g., crowns, root canal therapy and denture). The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:

- the Member's dental records;
- our dental policies and clinical guidelines;
- professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- the opinion of Health Care Professionals in the generally-recognized health specialty involved;
- and the opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for the Member's illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;

- The Member's condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of dental practice;
- They are not primarily for the convenience of the Member, his/her family, or his/her Provider;
- They are not more costly than an alternative service or sequence of services, that is they are at least as likely to produce equivalent therapeutic or diagnostic results.
- When setting or place of service is part of the review, services that can be safely provided to the Member in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

See the Utilization Review and External Appeals sections of this Policy for the Member's right to an internal Appeal and external appeal of Our determination that a service is not Medically Necessary.

H. Important Telephone Numbers and Addresses.

CLAIMS
Healthplex, Inc.
Att: CLAIMS DEPT.
P.O. Box 9255
Uniondale, NY 11553-9255
* In order to expedite claims adjudication, submit claim forms to this address.

COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
Healthplex, Inc.
333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553
888-468-5175

EMERGENCY DENTAL CARE
888-468-5175
24-hour/7 day coverage

MEMBER SERVICES
888-468-5175
* Member Services Representatives are available Monday – Friday 8:00 a.m. – 6:00 p.m.

PREAUTHORIZATION
Healthplx, Inc.
333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553
888-468-5175

OUR WEBSITE
www.healthplex.com

SECTION III – ACCESS TO CARE AND TRANSITIONAL CARE

A. Referral to a Non-Participating Provider

If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat the Member's condition, We will approve a Referral to an appropriate Non-Participating Provider. The Member's Participating Provider must request prior approval of the Referral to a specific Non-Participating Provider. Approvals of Referrals to Non-Participating Providers will not be made for the convenience of the Member or another treating Provider and may not necessarily be to the specific Non-Participating Provider he/she requested. If We approve the Referral, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with his/her PCD, the Member's Non-Participating Provider and him/her. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. The Member will only be responsible only for any applicable in-network Cost-Sharing. In the event a Referral is not approved, any services rendered by a Non-Participating provider will not be covered.

B. When a Specialist Can Be The Member's Primary Care Dentist

If the Member has a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, he/she may ask that a Specialist who is a Participating Provider be his/her PCD. We will consult with the Specialist and his/her PCD and decide whether the Specialist should be his/her PCD. Any Referral will be pursuant to a treatment plan approved by Us in consultation with his/her PCD, the Specialist and the Member. We will not approve a non-participating Specialist unless We determine that We do not have an appropriate Provider in Our Network. If We approve a non-participating Specialist, Covered Services rendered by the non-participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. The Member will be responsible only for any applicable in-network Cost-Sharing.

C. Standing Referral to a Participating Specialist

If the Member needs ongoing specialty care, he/she may receive a "standing Referral" to a Specialist who is a Participating Provider. This means that he/she will not need a new Referral from his/her PCD every time he/she needs to see that Specialist. We will consult with the Specialist and his/her PCD and decide whether he/she should have a standing Referral. Any Referral will be pursuant to a treatment plan approved by Us in consultation with his/her PCD, the Specialist and the Member. The treatment plan may limit the number of visits, or the period during which the visits are authorized and may require the Specialist to provide the Member's PCD with regular updates on the specialty care provided as well as all necessary medical information. We will not approve a standing Referral to a non-participating Specialist unless We determine that We do not have an appropriate Provider in Our Network. If We approve a standing Referral to a non-participating Specialist, Covered Services rendered by the non-participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. He/she will be responsible only for any applicable in-network Cost-Sharing.

D. When the Member's Provider Leaves the Network

If the Member are in an ongoing course of treatment when his/her Provider leaves Our network, then he/she may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date his/her Provider's contractual obligation to provide services to the Member terminates.

In order for the Member to continue to receive Covered Services for up to 90 days , the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to his/her care and adhere to Our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, he/she will receive the Covered Services as if they were being provided by a Participating Provider. He/She will be responsible only for any applicable in-network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

E. New Members In a Course of Treatment

If the Member is in an ongoing course of treatment with a Non-Participating Provider when the Member's coverage under this Policy becomes effective, the Member may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to 60 days from the effective date of the Member's coverage under this Policy. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease.

In order for the Member to continue to receive Covered Services for up to 60 days, the Non-Participating Provider must agree to accept as payment Our fees for such services. The Provider must also agree to provide Us necessary medical information related to his/her care and to adhere to Our policies and procedures including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, he/she will receive the Covered Services as if they were being provided by a Participating Provider. He/She will be responsible only for any applicable in-network Cost-Sharing.

SECTION IV – COST-SHARING EXPENSES AND ALLOWED AMOUNT

A. Deductible

1. If the Member is covered under the Pediatric Dental Essential Health Benefits, except where stated otherwise, the Member must pay the amount in the Schedule of Benefits section of this Policy for Covered Services during each Plan Year before We provide coverage. If the Member has other than individual coverage, the individual Deductible applies to each person covered under this Policy.
2. If the Member is covered under the Adult Dental Health Benefits, there is no Deductible for Covered Services during each calendar year.

B. Copayments

1. If the Member is covered under the Pediatric Dental Essential Health Benefit, there are no Copayments for Covered Services under this Policy.
2. If the Member is covered under the Adult Dental Health Benefit, except where stated otherwise, the Member must pay the Copayments, or fixed amounts in the Schedule of Benefits section of this Policy for Covered Services. However, when the Allowed Amount for a service is less than the Copayment, the Member is responsible for the lesser amount.

C. Coinsurance

There is no Coinsurance for Covered Services under this Policy.

D. Out-of-Pocket Limit for the Pediatric Dental Essential Health Benefit.

When the Member has met his/her Out-of-Pocket Limit in payment of Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Policy for the pediatric dental essential health benefit, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year for the pediatric dental essential health benefit. If this Policy covers more than one Member under age 19, when two (2) or more Members under age 19 covered under this Policy have collectively met the Out-of-Pocket Limit for two (2) or more Members under age 19 in payment of Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Policy, We will provide coverage for 100% of the Allowed Amount for the pediatric dental essential health benefit for the rest of that Plan Year. The Out-of-Pocket Limit runs from January 1 to December 31 of each calendar year.

E. Out-of-Pocket Limit.

When the Member has met his/her Out-of-Pocket Limit in payment of Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Policy for all Covered Services except the pediatric dental essential health benefit, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year. If the Member has other than Individual coverage, the individual Out-of-Pocket Limit applies to each person covered under this Policy. Once a person within a family meets the individual Out-of-Pocket Limit, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person If other than individual coverage applies, when persons in the same family covered under this Policy have collectively met the family Out-of-Pocket Limit in payment of Copayments, Deductibles and Coinsurance for a Plan Year in the

Schedule of Benefits section of this Policy, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year. The Out-of-Pocket Limit runs from January 1 to December 31 of each calendar year.

F. Allowed Amount.

"Allowed Amount" means the maximum amount We will pay for the services or supplies covered under this Policy, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows: The Allowed Amount for Participating Providers will be the amount we have negotiated with the Participating Provider.

SECTION V – WHO IS COVERED

A. Who is Covered Under this Policy

The Member, to whom this Policy is issued, is covered under this Policy. He/She must live, work or reside in Our Service Area to be covered under this Policy. Members of his/her family may also be covered depending on the type of coverage the Member selected. .

B. Types of Coverage

We offer the following types of coverage:

1. **Individual**. If the Member selected individual coverage, then the Member is covered.

2. **Individual and Spouse.** If the Member selected individual and Spouse coverage, then the Member and the Member's Spouse are covered.

3. **Parent and Child/Children.** If the Member selects parent and child/children coverage, then the Member and his/her Child or Children, as described below, are covered.

4. **Family.** If the Member selects family coverage, then the Member, his/her Spouse and his/her Child or Children, as described below, are covered.

C. Children Covered Under this Policy.

If the Member selects parent and child/children or family coverage, Children covered under this Policy include the Member's natural Children, legally adopted Children, step Children, foster Children and Children for whom he/she is the proposed adoptive parent without regard to financial dependence, residency with the Member, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns 30 years of age. Coverage also includes Children for whom the Member is a permanent legal guardian if the Children are chiefly dependent upon him/her for support and he/she has been appointed the legal guardian by a court order. Grandchildren are not covered.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon the Member for support and maintenance, will remain covered while his/her insurance remains in force and his/her Child remains in such condition. He/She has 31 days from the date of his/her Child's attainment of the termination age to submit an application to request that the Child be included in his/her coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered Members in relation to eligibility for coverage under this Policy at any time.

D. When Coverage Begins

Coverage under this Policy will begin as follows:

1. If the Subscriber elects coverage before becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date he/she becomes eligible, or on the date determined by the Group.
2. If the Subscriber does not elect coverage upon becoming eligible or within 30 days of becoming eligible for other than a special enrollment period, the Subscriber must wait until the Group's next open enrollment period to enroll, except as provided below.
3. If, the Subscriber marries while covered, and We receive notice of such marriage within 30 days thereafter, coverage for his/her Spouse and Child starts on the first day of the month following such marriage. If We do not receive notice within 30 days of the marriage, he/she must wait until the Group's next open enrollment period to add his/her Spouse or Child.
4. If, the Subscriber has a newborn or adopted newborn Child and We receive notice of such birth within 30 days thereafter, coverage for his/her newborn starts at the moment of birth; otherwise, coverage begins on the date on which We receive notice. His/Her adopted newborn Child will be covered from the moment of birth if he/she takes physical custody of the infant as soon as the infant is released from the Hospital after birth and he/she files a petition pursuant to Section 115-c of the New York Domestic Relations Law within 30 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. If he/she has an individual or individual and Spouse coverage, he/she must also notify Us of his/her desire to switch to parent and child/children or family coverage and pay any additional Premium within 30 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice provided that the Subscriber pays additional premium when due.

E. Special Enrollment Periods

The Member, his/her Spouse or Child can also enroll for coverage within 30 days of the loss of coverage in another group dental plan if coverage was terminated because the Member, his/her Spouse or Child are no longer eligible for coverage under the other group dental plan due to:

1. Termination of employment;
2. Termination of the other group dental plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions towards the group dental plan were terminated for the Member or the Member's Dependent's coverage; or
7. A Child no longer qualifies for coverage as a Child under the other group dental plan.

The Member, his/her Spouse or Child can also enroll 30 days from exhaustion of the Member's COBRA coverage or if the Member gains a Dependent or becomes a Dependent through marriage, birth, adoption, or placement for adoption.

We must receive notice and Premium payment within 30 days of the loss of coverage. The effective date of the Member's coverage will depend on when We receive the Member's application. If the Member's application is received between the first and fifteenth day of the month, his/her coverage will begin on the first day of the following month. If the Member's application is received between the sixteenth day and the last day of the month, his/her coverage will begin on the first day of the second month.

In addition, the Member, his/her Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. The Member, his/her Spouse or Child loses eligibility for Medicaid or a state child dental plan; or
2. The Member, his/her Spouse or Child becomes eligible for Medicaid or a state child dental plan.

We must receive notice and Premium payment within 60 days of one of these events. The effective date of the Member's coverage will depend on when We receive his/her application. If the Member's application is received between the first and fifteenth day of the month, his/her coverage will begin on the first day of the following month. If the Member's application is received between the sixteenth day and the last day of the month, his/her coverage will begin on the first day of the second month.

F. Domestic Partner Coverage.

This Policy covers domestic partners of Members as Spouses. If he/she selects family coverage, Children covered under this Policy also includes the Children of his/her domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists; or
2. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.
    a. The affidavit must be notarized and must contain the following:
        - The partners are both 18 years of age or older and are mentally competent to consent to policy;
        - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York;
        - The partners have been living together on a continuous basis prior to the date of the application;
        - Neither individual has been registered as a member of another domestic partnership within the last six (6) months; and
    b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and

c. Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
   - A joint bank account;
   - A joint credit card or charge card;
   - Joint obligation on a loan;
   - Status as an authorized signatory on the partner's bank account, credit card or charge card;
   - Joint ownership of holdings or investments;
   - Joint ownership of residence;
   - Joint ownership of real estate other than residence;
   - Listing of both partners as tenants on the lease of the shared residence;
   - Shared rental payments of residence (need not be shared 50/50);
   - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
   - A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
   - Shared household budget for purposes of receiving government benefits;
   - Status of one (1) as representative payee for the other's government benefits;
   - Joint ownership of major items of personal property (e.g., appliances, furniture);
   - Joint ownership of a motor vehicle;
   - Joint responsibility for child care (e.g., school documents, guardianship);
   - Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
   - Execution of wills naming each other as executor and/or beneficiary;
   - Designation as beneficiary under the other's life insurance policy;
   - Designation as beneficiary under the other's retirement benefits account;
   - Mutual grant of durable power of attorney;
   - Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
   - Affidavit by creditor or other individual able to testify to partners' financial interdependence; or
   - Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

SECTION VI –PEDIATRIC DENTAL CARE

Please refer to the Schedule of Benefits section of this Policy for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We cover the following dental care services for Members through the end of the month in which the Member turns 19 years of age:

A. Emergency Dental Care: We Cover Emergency Dental Care, which includes emergency dental treatment required to alleviate pain and suffering caused by dental disease or trauma. Emergency Dental Care is not subject to Our Preauthorization.

B. Preventive Dental Care: We Cover preventive dental care, that includes procedures which help to prevent oral disease from occurring, including:

- Prophylaxis (scaling and polishing) the teeth at six (6) month intervals;
- Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
- Sealants on unrestored permanent molar teeth; and
- Unilateral or bilateral space maintainers will be covered for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

C. Routine Dental Care: We Cover routine dental care provided in the office of a dentist, including:

- Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
- X-ray, full mouth x-rays or panoramic x-rays at thirty-six (36) month intervals, bitewing x-rays at six (6) month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
- Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
- In-office conscious sedation;
- Amalgam, composite restorations and stainless steel crowns; and
- Other restorative materials appropriate for children.

D. Endodontics: We Cover routine endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.

E. Periodontics. We Cover limited periodontic services. We Cover non-surgical periodontic services. We Cover periodontic surgical services necessary for treatment related to hormonal disturbances, drug therapy, or congenital defects. We also Cover periodontic services in anticipation of, or leading to orthodontics that are otherwise Covered under this Policy.

F. Prosthodontics. We Cover prosthodontic services as follows:

- Removable complete or partial dentures, for Members 15 years of age and above, including six (6) months follow-up care;
- Additional services including insertion of identification slips, repairs, relines and rebases and treatment of cleft palate; and
- Interim prosthesis for Members five (5) to 15 years of age.
- We do not Cover implants or implant related services.

Fixed bridges are not Covered unless they are required:

- For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth;
- For cleft palate stabilization; or
- Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

G. Oral Surgery. We Cover non-routine oral surgery, such as partial and complete bony extractions, tooth re-implantation, tooth transplantation, surgical access of an unerupted tooth, mobilization of erupted or malpositioned tooth to aid eruption, and placement of device to facilitate eruption of an impacted tooth. We also Cover oral surgery in anticipation of, or leading to orthodontics that are otherwise Covered under this Policy

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H. Orthodontics: We Cover orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

Procedures include but are not limited to:

- Rapid Palatal Expansion (RPE);
- Placement of component parts (e.g. brackets, bands);
- Interceptive orthodontic treatment;
- Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted);
- Removable appliance therapy; and
- Orthodontic retention (removal of appliances, construction and placement of retainers).

SECTION VII –ADULT DENTAL CARE

Please refer to the Schedule of Benefits section of this Policy for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Adult Members shall be eligible to receive the Adult Dental Care benefits under this Section VII of this Policy. In addition, Children who are covered under this Policy who are no longer eligible to receive the Pediatric Dental Care under Section VI hereof, shall then be eligible to receive the Adult Dental Care benefits under this Section VII until the end of the month in which the child turns 30 years of age.

A. Emergency Dental Care: We Cover emergency dental care, which includes emergency treatment rendered by a dentist required to alleviate pain and suffering caused by dental disease or trauma. Emergency dental care is not subject to Our Preauthorization.

B. Preventive Dental Care: We Cover preventive dental care, that includes procedures which help to prevent oral disease from occurring, including:

- Prophylaxis (scaling and polishing the teeth at six (6) month intervals;
- Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated.

C. Routine Dental Care: We Cover routine dental care provided in the office of a dentist, including:

- Dental examinations, visits and consultations once within a six (6) month consecutive period;
- X-ray, full mouth x-rays or panoramic x-rays at thirty-six (36) month intervals, bitewing x-rays at six (6) month intervals, and other x-rays if Medically Necessary;
- Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
- In-office conscious sedation;
- Amalgam and composite restorations; and
- Other restorative materials appropriate for Adults.

D. Endodontics: We Cover essential endodontic services with documented medical necessity, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required. Please note that molar root canal therapy is not covered for beneficiaries 21 years of age and over, except when an extraction would be medically contraindicated or the tooth is a critical abutment for an existing prosthesis provided by this plan.

E. Periodontics: We Cover limited periodontic services. Non-surgical periodontic services are covered with documented medical necessity. We Cover limited periodontic surgical services necessary for treatment related to hormonal disturbances, drug therapy or congenital defects, and those periodontic services in anticipation of, or leading to orthodontics only if the orthodontics is Covered under this plan. Implants and/or implant related services are considered beyond the scope of the program.

F. Prosthodontics: We Cover essential prosthodontic services as follows:

- Removable complete or partial dentures for beneficiaries 15 years of age or over, including six (6) months follow-up care; and
- Additional services including insertion of identification slips, repairs, relines and rebases.

Fixed bridges are considered beyond the scope of the program unless required:

- For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth
- For cleft palate stabilization; or
  Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

G. Oral Surgery: We Cover routine and non-routine oral surgery which is dental in nature with documentation of necessity. Any Oral Surgery service in anticipation of, or leading to orthodontics is covered only if the orthodontics is Covered under this plan.

RESTRICTIONS FOR ADULT CARE SERVICES

"ESSENTIAL" SERVICES:

When reviewing requests for services the following guidelines will be used:

Treatment will not be routinely approved when functional replacement with less costly restorative materials, including prosthetic replacement, is possible.

Caries index, periodontal status, recipient compliance, dental history, medical history and the overall status and prognosis of the entire dentition, among other factors, will be taken into consideration. Treatment is not considered appropriate when the prognosis of the tooth is questionable or when a reasonable alternative course of treatment would be extraction of the tooth and replacement. Treatment such as endodontics or crowns will not be approved in association with an existing or proposed prosthesis in the same arch, unless the tooth is a critical abutment for a prosthesis provided under this Section VII, or unless replacement by addition to an existing prosthesis or new prosthesis is not feasible. If the total number of teeth which require, or are likely to require treatment would be considered excessive or when maintenance of the tooth is not considered essential or appropriate in view of the overall dental status of the recipient, treatment will not be covered. As a condition for payment, it may be necessary to submit, upon request, radiographic images and other information to support the appropriateness and necessity of these services.

Eight (8) posterior natural or prosthetic teeth (molars and/or bicuspids) in occlusion (four (4) maxillary and four (4) mandibular teeth in functional contact with each other) will be considered adequate for functional purposes. Requests will be reviewed for necessity based upon the presence/absence of eight (8) points of natural or prosthetic occlusal contact in the mouth (bicuspid/molar contact).

One (1) missing maxillary anterior tooth or two (2) missing mandibular anterior teeth may be considered an esthetic problem that warrants a prosthetic replacement.

SERVICES NOT WITHIN THE SCOPE OF THE PROGRAM

- Dental implants and related services;
- Fixed bridgework, except for cleft palate stabilization, or when a removable prosthesis would be contraindicated;
- Immediate full or partial dentures;
- Molar root canal therapy for beneficiaries 21 years of age and over, except when extraction would be medically contraindicated or the tooth is a critical abutment for an existing serviceable prosthesis provided under this Section VII;
- Crown lengthening;
- Dental work for cosmetic reasons or because of the personal preference of the recipient or provider;
- Periodontal surgery, except for procedure D4210 – gingivectomy or gingivoplasty, for the sole correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects;
- Restorative treatment of teeth that have a poor prognosis and should be extracted

SECTION VIII – EXCLUSIONS AND LIMITATIONS

No Coverage is available under this Policy for the following:

A. Aviation.
We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care.
We do not Cover services related to rest cures, custodial care and transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered services determined to be Medically Necessary.

C. Cosmetic Services.
We do not Cover cosmetic services or surgery unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect except for pediatric orthodontics as described in the Pediatric Dental Care section of this Policy. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeals section of this Policy unless medical information is submitted.

D. Coverage Outside of the United States, Canada or Mexico.
We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Dental Care as described in the Pediatric and Adult Dental Care sections of this Policy.

E. Experimental or Investigational Treatment.
We do not Cover any health care service, procedure, treatment or device that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for the Member's rare disease or patient costs for the Member's participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials We will not Cover the costs of any investigational drugs or devices, non-health services required for the Member to receive the treatment, the costs of managing the research, or costs that would not be Covered under the Policy for non-investigational treatments. See the Utilization Review and External Appeal sections of this Policy for a further explanation of the Member's Appeal rights.

F. Felony Participation.
We do not Cover any illness, treatment or medical condition due to the Member's participation in a felony, riot or insurrection.

G. Government Facility.
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

H. Medical Services.
We do not Cover medical services or dental services that are medical in nature, including any Hospital charges or prescription drug charges.

I. Medically Necessary.
In general, We will not Cover any dental service, procedure, treatment, test or device that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test or device, for which coverage has been denied, to the extent that such service, procedure, treatment, test or device is otherwise Covered under the terms of this Policy.

J. Medicare or Other Governmental Program.
We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

K. Military Service.
We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

L. No-Fault Automobile Insurance.
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if the Member does not make a proper or timely claim for the benefits available to the Member under a mandatory no-fault policy.

M. Services not Listed.
We do not Cover services that are not listed in this Policy as being Covered.

N. Services Provided by a Family Member.
We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of the Member or the Member's Spouse.

O. Services Separately Billed by Hospital Employees.
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

P. Services With No Charge.
We do not Cover services for which no charge is normally made.

Q. War.
We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

R. Workers' Compensation.
We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

SECTION IX – CLAIM DETERMINATIONS

A. Claims.

A claim is a request that benefits or services be provided or paid according to the terms of this Policy. When the Member receives services from a Participating Provider he/she will not need to submit a claim form. However, if he/she receives services from a Non-Participating Provider either he/she or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, the Member will need to file it with Us. See the Coordination of Benefits section of this Policy for information on how We coordinate benefit payments when he/she also have group health coverage with another plan.

B. Notice of Claim.

Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to, Member identification number, name, date of birth, date of service, type of service, the charge for each service, procedure code for the service as applicable, diagnosis code, name and address of the Provider making the charge, and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on the Member's ID card. Completed claim forms should be sent to the address in the How The Member's Coverage Works section of this Policy. The Member may also submit a claim to Us electronically by visiting Our website www.healthplex.com.

C. Timeframe for Filing Claims.

Claims for services must be submitted to Us for payment within 120 days after the Member receives the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120 day period, he/she must submit it as soon as reasonably possible. . In no event, except in the absence of legal capacity, may a claim be filed more than one (1) year from the time the claim was required to be filed.

D. Claims for Prohibited Referrals.

We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

E. Claim Determinations.

Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our Claim determination procedure applies to contractual benefit denials and Referrals. If the Member disagrees with Our claim determination, he/she may submit a Grievance pursuant to the Grievance Procedures section of this Policy.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Policy.

F. Pre-service Claim Determinations.

1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a Referral or a covered benefit determination), We will make a determination and provide notice to The Member (or the Member's designee) within 15 days from receipt of the claim.

   If We need additional information, We will request it within 15 days from receipt of the claim. The Member will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to his/her (or his/her designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

2. **Urgent Pre-service Reviews.** With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to the Member (or the Member's designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. He/she will then have 48 hours to submit the information. We will make a determination and provide notice to the Member (or the Member's designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

G. Post-service Claim Determinations.

A post-service claim is a request for a service or treatment that the Member have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify him/her (or his/her designee) within 30 calendar days of the receipt of the claim. If We need additional information, We will request it within 30 calendar days. He/She will then have 45 calendar days to provide the information. We will make a determination and provide notice to him/her (or his/her designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period.

SECTION X – GRIEVANCE PROCEDURES

A. Grievances

Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns the Member has regarding Our administrative policies or access to Providers.

B. Filing a Grievance

The Member can contact Us by phone at 888-468-5175 or in writing to file a Grievance. He/She may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that he/she sign a written acknowledgement of his/her oral Grievance, prepared by Us. He/She or his/her designee has up to 180 calendar days from when the Member receives the decision the Member is asking Us to review to file the Grievance.

When We receive his/her Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling his/her Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of his/her issue. We have a process for both standard and expedited Grievances, depending on the nature of his/her inquiry.

C. Grievance Determination.

Qualified personnel will review the Member's Grievance, or if it is a clinical matter, a licensed, certified or registered health care professional will look into it. We will decide the Grievance and notify him/her within the following timeframes:

Expedited/Urgent Grievances:	By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of the Member's Grievance. Written notice will be provided within 72 hours of receipt of the Member's Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of the Member's Grievance.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	In writing, within 30 calendar days of receipt of the Member's Grievance.
All Other Grievances: (That are not in relation to a claims or request for a service or treatment)	In writing, within 45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of the Member's Grievance.

D. Grievance Appeals.

If the Member is not satisfied with the resolution of the Member's Grievance, the Member's or the Member's designee may file an Appeal by phone at 888-468-5175; or in writing. However, Urgent Appeals may be filed by phone. The Member has up to 60 business days from receipt of the Grievance determination to file an Appeal.

When We receive the Member's Appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling the Member's Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify the Member in writing within the following timeframes:

Expedited/Urgent Grievances:	The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of the Member's Appeal.
Pre-Service Grievances: (A request for a service or a treatment that has not yet been provided.)	15 calendar days of receipt of the Member's Appeal.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	30 calendar days of receipt of the Member's Appeal.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	30 business days of receipt of all necessary information to make a determination.

E. Assistance

If the Member remains dissatisfied with Our Grievance determination, or at any other time he/she is dissatisfied, he/she may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257

website: www.dfs.ny.gov

If the Member needs assistance filing a Grievance or Appeal, he/she may also contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY. 10017
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org
website: www.communityhealthadvocates.org

SECTION XI - UTILIZATION REVIEW

A. UTILIZATION REVIEW

We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If the Member has any questions about the Utilization Review process, please call 888-468-5175. The toll-free telephone number is available at least 40 hours a week with an after–hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians or; 2) licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the Provider who typically manages the Member's dental condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not or were not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for his/her review upon request. For more information, call 888-468-5175.

B. Preauthorization Reviews

1. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to the Member (or his/her designee) and his/her Provider, by telephone and in writing, within three (3) business days of receipt of the request.

   If We need additional information, We will request it within three (3) business days. The Member or his/her Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to him/her (or his/her designee) and his/her Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

2. **Urgent Preauthorization Reviews**. With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to the Member (or his/her designee) and his/her Provider, by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) business days of receipt of request. If We need additional information, We will request it within 24 hours. He/She or his/her Provider will then have 48 hours to submit the information. We will make a determination and provide notice to him/her (or his/her designee) and his/her Provider by telephone and in writing within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period.

C. Concurrent Reviews

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to the Member (or his/her designee) and his/her Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. He/She (or his/her designee) and his/her Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to him/her (or he/she designee) and his/her Provider, by telephone and in writing, within one (1) business of Our receipt of the information or, if We do not receive the information, within 15 calendar days of the end of the 45-day period.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to the Member (or his/her designee) and his/her Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

   If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to the Member (or his/her designee) and his/her Provider within the earlier of 72 hours or of one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. He/She or his/her Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to him/her (or his/her designee) and his/her Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if We do not receive the information, within 48 hours of the end of the 48-hour period.

D. Retrospective Reviews

If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify the Member and his/her Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. He/She or his/her Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to him/her and his/her Provider in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. Retrospective Review of Preauthorized Services

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. Reconsideration

If We did not attempt to consult with the Member's Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to him/her and his/her Provider, by telephone and in writing.

G. Utilization Review Internal Appeals

The Member, his/her designee, and, in retrospective review cases, his/her Provider, may request an internal Appeal of an adverse determination, either by phone or in writing.

The Member has up to 180 calendar days after he/she receives notice of the adverse determination to file an Appeal. We will acknowledge his/her request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling his/her Appeal and, if necessary, inform him/her of any additional information needed before a decision can be made. A clinical peer reviewer who is a Physician or a health care professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the Appeal.

1. **Out-of-Network Service Denial**. The Member also has the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, he/she, or his/her designee, must submit:
    - A written statement from his/her attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat his/her condition, that the requested out-of-network health service is materially different from the alternate health service

available from a Participating Provider that We approved to treat his/her condition; and

- Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to him/her than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Referral Denial**. The Member also has the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet the Member particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network referral denial, he/she or his/her designee must submit a written statement from his/her attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat his/her condition:
    - That the Participating Provider recommended by Us does not have the appropriate training and experience to meet his/her particular health care needs for the health care service; and
    - Recommending a Non-Participating Provider with the appropriate training and experience to meet his/her particular health care needs who is able to provide the requested health care service.

H. Appeal

1. **Preauthorization Appeal.** If the Member's Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to him/her (or his/her designee) and where appropriate his/her Provider within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If the Member's Appeal relates to a retrospective claim, We will decide the Appeal within 60 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to him/her (or his/her designee) and where appropriate his/her Provider within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

3. **Expedited Appeals.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, the Member's Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. His/Her Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined

within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal.

If the Member is not satisfied with the resolution of his/her expedited Appeal, he/she may file a standard internal appeal or an external appeal.

Our failure to render a determination of the Member's Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

I. Appeal Assistance.

If the Member needs Assistance filing an Appeal, he/she may contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY. 10017
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org
website: www.communityhealthadvocates.org

SECTION XII - EXTERNAL APPEAL

A. The Member's Right to an External Appeal.

In some cases, the Member has a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases) or is an out-of-network treatment, he/she or his/her representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for the Member to be eligible for an external appeal he/she must meet the following two (2) requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under this Policy and

- In general, he/she must have received a final adverse determination through Our internal Appeal process. But, he/she can file an external appeal even though he/she has not received a final adverse determination through Our internal Appeal process if:

  - We agree in writing to waive the internal Appeal. We are not required to agree to his/her request to waive the internal Appeal; or
  - The Members file an external appeal at the same time as he/she applies for an expedited internal Appeal; or
  - We fail to adhere to Utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to the Member, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between him/her and Us).

B. The Member's Right to Appeal A Determination that A Service Is Not Medically Necessary.

If We have denied coverage on the basis that the service is not Medically Necessary, the Member may appeal to an External Appeal Agent if he/she meets the requirements for an external appeal in paragraph "A" above.

C. The Member's Right to Appeal A Determination that A Service is Experimental or Investigational.

If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), the Member must satisfy the two (2) requirements for an external appeal in paragraph "A" above and his/her attending Physician must certify that his/her condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; or
2. There does not exist a more beneficial standard service or procedure covered by Us; or
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, the Member's attending Physician must have recommended one (1) of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to the Member than any standard Covered Service (only certain documents will be considered in support of this recommendation – his/her attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which he/she is eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which his/her attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to him/her than the requested service, the requested service is likely to benefit him/her in the treatment of his/her rare disease, and such benefit outweighs the risk of the service. In addition, his/her attending Physician must certify that his/her condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, the Member's attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat his/her condition or disease. In addition, for a rare disease treatment, the attending Physician may not be his/her treating Physician.

D. The Member's Right to Appeal A Determination that a Service is Out-of-Network.

If We have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, the Member may appeal to an External Appeal Agent if he/she meets the two (2) requirements for an external appeal in paragraph "A" above, and he/she has requested Preauthorization for the out-of-network treatment.

In addition, the Member's attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested

health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, the Member's attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat his/her for the health service.

E. The Member's Right to Appeal an Out-of-Network Referral Denial to a Non-Participating Provider.

We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet the Member's particular health care needs who is able to provide the requested health care service, he/she may appeal to an External Appeal Agent if he/she meets the two (2) requirements for an external appeal in paragraph "A" above.

In addition, the Member's attending Physician must: 1) certify that the Participating Provider recommended by Us does not have the appropriate training and experience to meet his/her particular health care needs; and 2) recommend a Non-Participating Provider with the appropriate training and experience to meet his/her particular health care needs who is able to provide the requested health care service.

For purposes of this section, the Member's attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat him/her the health service.

F. The External Appeal Process.

The Member has four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If he/she is filing an external appeal based on Our failure to adhere to claim processing requirements, he/she has four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through Our internal Appeal process or Our written waiver of an internal Appeal. The Member may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If he/she meets the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

The Member can submit additional documentation with his/her external appeal request. If the External Appeal Agent determines that the information he/she submits represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm

Our decision. Please note that in the case of an expedited appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of the Member's completed application. The External Appeal Agent may request additional information from him/her, his/her Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify him/her in writing of its decision within two (2) business days.

If the Member's attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to his/her health; or if his/her attending Physician certifies that the standard external appeal time frame would seriously jeopardize his/her life, health or ability to regain maximum function; or if he/she received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, he/she may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of his/her completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify him/her and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify him/her in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, We will provide coverage subject to the other terms and conditions of this Policy. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the costs of services required to provide treatment to the Member according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be Covered under this Policy for non-experimental or non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both the Member and Us. The External Appeal Agent's decision is admissible in any court proceeding.

G. The Member's Responsibilities

It is the Member's responsibility to start the external appeal process. The Member may start the external appeal process by filing a completed application with the New York State Department of Financial Services. He/She may appoint a representative to assist him/her with his/her application; however, the Department of Financial Services may contact him/her and request that he/she confirm in writing that he/she have appointed the representative.

Under New York State law, the Member completed request for external appeal must be filed within four (4) months of either the date upon which he/she receives a final adverse determination, or the date upon which he/she receives a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

SECTION XIII - COORDINATION OF BENEFITS

This section applies when the Member also has group dental coverage with another plan. When he/she receives a Covered Service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

A. Definitions.

1. **"Allowable expense"** is the necessary, reasonable, and customary item of expense for dental care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

2. **"Plan"** is other group dental coverage with which We will coordinate benefits. The term "plan" includes:
   - Group dental benefits and blanket or group remittance dental benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
   - Dental benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type policies.
   - Dental benefits coverage of a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

3. **"Primary plan"** is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

4. **"Secondary plan"** is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment.

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.

2. If the person receiving benefits is the Member and is only covered as a Dependent under the other plan, this Policy will be primary.

3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's dental care expenses:
   - The plan of the parent who has custody will be primary;
   - If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third; and
   - If a court decree between the parents says which parent is responsible for the child's dental care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

C. Effects of Coordination.

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

D. Right to Receive and Release Necessary Information.
We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. The Member must give Us any needed information for coordination purposes, in the time frame requested.

E. Our Right to Recover Overpayment.
If We made a payment as a primary plan, the Member agrees to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and he/she agrees to sign all documents necessary to help Us recover any overpayment.

F. Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans.
We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this Policy is primary, as defined in this section, We will pay benefits first.

2. If this Policy is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer.

3. If We request information from a non-complying plan and do not receive it within 30 days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Policy provide identical benefits. When the information is received, We will make any necessary adjustments.

SECTION XIV – TERMINATION OF COVERAGE

Coverage under this Policy will automatically be terminated on the first of the following to apply:

1. The Group and/or the Subscriber has failed to pay Premiums within 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.
2. The end of the month in which the Subscriber ceases to meet the eligibility requirements as defined by the Group.
3. Upon the Subscriber's death, coverage will terminate unless he/she has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium has been paid.
4. For Spouses in case of divorce, the date of the divorce.
5. For Children, until the end of the month in which the Child turns 30 years of age.
6. For all other Dependents, the end of the month in which the Dependent ceases to be eligible.
7. The end of the month during which the Group or the Subscriber provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.
8. If the Subscriber has performed an act that constitutes fraud or made a misrepresentation of material fact in writing on his/her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber. However, if the Subscriber makes a misrepresentation of material fact in writing on his or her enrollment application We will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of his/her coverage will have a retroactive effect of up to his/her enrollment under the Policy. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.
9. The date that the Group Policy is terminated. If We terminate and/or decide to stop offering a particular class of group policies without regard to claims experience or health related status, to which this Policy belongs, We will provide the Group and the Subscriber at least 30 days prior written notice.
10. The Group has performed an act or practice that constitutes fraud or made a misrepresentation of material fact under the terms of the coverage.
11. The Group has failed to comply with a material plan provision relating to group participation rules. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.
12. The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage. We will provide written notice to the Group and the Subscriber at least 30 days prior to when the coverage will cease.

13. The date there is no longer any enrollee who lives, resides, or works in Our Service Area.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

See the Continuation of Coverage section of this Policy for his/her right to continuation of this coverage under COBRA or USERRA.

SECTION XV – EXTENSION OF BENEFITS

Upon termination of insurance, whether due to termination of eligibility, or termination of this Policy, an extension of benefits shall be provided for a period of no less than 30 days for completion of a dental procedure that was started before the Member's coverage ended.

SECTION XVI - CONTINUATION OF COVERAGE

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. Call or write the Member's employer to find out if he/she is entitled to temporary continuation of coverage under COBRA. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA.

A. Qualifying Events.

Pursuant to federal COBRA, the Subscriber, his/her Spouse and his/her Children may be able to temporarily continue coverage under this Policy in certain situations when he/she would otherwise lose coverage, known as qualifying events.

1. If the Member's coverage ends due to voluntary or involuntary termination of employment or a change in his/her employee class (e.g. a reduction in the number of hours of employment) he/she may continue coverage. Coverage may be continued for him/her, his/her Spouse and any of his/her covered Children.

2. If the Member is a covered Spouse, he/she may continue coverage if his/her coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Divorce or legal separation from the Subscriber; or
    - Death of the Subscriber; or.
    - The covered employee becoming entitled to Medicare.

3. If the Member has a covered Child, he/she may continue coverage if the Member's coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Loss of covered Child status under the plan rules;
    - Death of the member; or
    - The Covered employee becoming entitled to Medicare.

If the Member wants to continue coverage he/she must request continuation from the Group in writing and make the first Premium payment within the 60-day period following the later of:

1. The date coverage would otherwise terminate; or
2. The date he/she is sent notice by first class mail of the right of continuation by the Group.

The Group may charge up to 102% of the Group Premium for continued coverage.

Continued coverage under this section will terminate at the earliest of the following:

1. The date 18 months after the Subscriber's coverage would have terminated because of termination of employment; provided that the Subscriber or their dependents may continue for a total of 29 months if the Subscriber is determined to be disabled under the United States Social Security Act.
2. If the Member is a covered Spouse or Child the date 36 months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the Member's eligibility for Medicare, or the failure to qualify under the definition of "Children";
3. The date the Member becomes covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
4. The date the Member becomes entitled to Medicare;
5. The date to which Premiums are paid if the Member fails to make a timely payment; or
6. The date the Group Policy terminates. However, if the Group Policy is replaced with similar coverage, the Member has the right to become covered under the new Group Policy for the balance of the period remaining for his/her continued coverage.

Continuation Rights During Active Duty

Under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end due to service in the uniformed services or upon becoming eligible for medical and dental care under federal health insurance by reason of their service. Call or write the Member's Group to find out if the Subscriber is entitled to temporary continuation of coverage under USERRA.

The Group may charge up to 102% of the Group Premium for continued coverage. This does not apply if the Subscriber or his/her dependents serve less than 31 days.

Continued coverage under this section will terminate at the earliest of the following:

1. The 24-month period beginning on the date on which the absence begins; or
2. The day after the date on which the Subscriber or his /her Dependent fail to apply for or return to a position of employment.

An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment unless an exclusion or waiting period would have been imposed under the health plan had coverage not been terminated.

1. This shall not apply to the coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.
2. If the Subscriber or his/her Dependent's coverage under a health plan is terminated by reason of the person having become eligible for federal health insurance for former

members of the uniformed services and their dependents, but subsequently do not commence a period of active duty under the order to active duty that established such eligibility because the order is canceled before such active duty commences, any exclusion or waiting period in connection with the reinstatement of coverage shall apply to the continued employment in the same manner as if the Subscriber or his/her Dependents had become reemployed upon such termination of eligibility.

SECTION XVII – GENERAL PROVISIONS

1. Agreements between Us and Participating Providers.

Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Policy does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any dental benefits program.

2. Assignment.

The Member cannot assign any benefits or monies due under this Policy or legal claims based on a denial of benefits to any person, corporation, or other organization. Any assignment of benefits or legal claims based on a denial of benefits by him/her will be void. Assignment means the transfer to another person or to an organization of his/her rights to the services provided under this Policy or the Member's right to collect money from Us for those services. Nothing in this paragraph shall affect the Member's right to appoint a designee or representative as otherwise permitted by applicable law.

3. Changes in This Policy.

We may unilaterally change this Policy upon renewal, if We give the Group 45 days' prior written notice.

4. Choice of Law.

This Policy shall be governed by the laws of the State of New York.

5. Clerical Error.

Clerical error, whether by the Group or Us, with respect to this Policy, or any other documentation issued by Us in connection with this Policy, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

6. Conformity with Law.

Any term of this Policy which is in conflict with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

7. Continuation of Benefit Limitations.

Some of the benefits in this Policy may be limited to a specific number of visits, a benefit maximum and/or subject to a Deductible. The Member will not be entitled to any additional benefits if his/her coverage status should change during the Year. For example, if his/her coverage status changes from covered family member to him/her, all benefits previously utilized when he/she were a covered family member will be applied toward his/her new status as a Subscriber.

8. Enrollment ERISA.

The Group will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages, and social security numbers of all Group Members covered under this Policy, and any other information required to confirm their eligibility for coverage.

The Group will provide Us with this information upon request. The Group may also have additional responsibilities as the "plan administrator" as defined by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The "plan administrator" is the Group, or a third party appointed by the Group. We are not the ERISA plan administrator.

9. Entire Agreement.
This Policy, including any endorsements, riders and the attached applications, if any, constitutes the entire Policy.

10. Fraud and Abusive Billing.
We have processes to review claims before and after payment to detect fraud and abusive billing. Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

11. Furnishing Information and Audit.
The Group and all persons covered under this Policy will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Policy. The Member must provide Us with information over the telephone for reasons such as the following: to allow Us to determine the level of care he/she needs; so that We may certify care authorized by his/her Provider; or to make decisions regarding the medical necessity of his/her care. The Group will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to group enrollment at the Group's New York office.

12. Identification Cards.
Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Policy. To be entitled to such services or benefits, the Member's Premiums must be paid in full at the time that the services are sought to be received.

13. Incontestability.
No statement made by the Member will be the basis for avoiding or reducing coverage unless it is in writing and signed by him/her. All statements contained in any such written instrument shall be deemed representations and not warranties.

14. Independent Contractors.
Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by the Member, his/her covered Spouse or his/her Children while receiving care from any Participating Provider or in any Participating Provider's facility.

15. Material Accessibility.
We will give the Group, and the Group will give the Member; ID cards Certificates, riders and other necessary materials.

16. More Information about the Member's Dental Plan.

The Member can request additional information about his/her coverage under this Policy. Upon his/her request, We will provide the following information:

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or utilization review guidelines.
- Written application procedures and minimum qualification requirements for Providers.

17. Notice.

Any notice that We give to the Member under this Policy will be mailed to his/her address as it appears in Our records or to the address of the Group. He/She agrees to provide Us with notice of any change of his/her address. If he/she has to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to:

Healthplex Insurance Company
333 Earle Ovington Blvd., Suite 300
Uniondale, New York 11553

18. Premium Refund.

We will give any refund of Premiums, if due, to the Group.

19. Recovery of Overpayments.

On occasion a payment will be made to the Member when he/she are not covered, for a service that is not Covered, or which is more than is proper. When this happens We will explain the problem to him/her and he/she must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

20. Renewal Date.

The renewal date for this Policy is the anniversary of the effective date of the Group Policy of each year. This Policy will automatically renew each year on the renewal date unless otherwise terminated by Us, as permitted by this Policy or by the Group upon 30 days prior written notice to Us.

21. Right to Develop Guidelines and Administrative Rules.

We may develop or adopt standards that describe in more detail when We will or will not make payments under this Policy. Those standards will not be contrary to the descriptions in this Policy. If the Member has a question about the standards that apply to a particular benefit, he/she may contact Us and We will explain the standards or send him/her a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Policy.

22. Right to Offset.

If We make a claim payment to the Member on his/her behalf in error or he/she owes Us any money, he/she must repay the amount he/she owes Us. Except as otherwise required by law, if We owe him/her a payment for other claims received, We have the right to subtract any amount he/she owes Us from any payment We owe him/her.

23. Severability.

The unenforceability or invalidity of any provision of this Policy shall not affect the validity and enforceability of the remainder of this Policy.

24. Significant Change in Circumstances.

If We are unable to arrange for Covered Services as provided under this Policy as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

25. Subrogation and Reimbursement.

These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for the Member's injury, illness or other condition and We have provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including his/her own insurance carrier) for the benefits We have provided to him/her under this Policy. Subrogation means that We have the right, independently of him/her, to proceed directly against the other party to recover the benefits that We have provided.

Subject to applicable state law, unless preempted by federal law, We may have a right of reimbursement if the Member or anyone on his/her behalf receives payment from any responsible party (including his/her own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness, or condition for which We provided benefits. Under Section 5-335 of the New York General Obligations Law, Our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a

statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that he/she did not take any action against Our rights or violate any policy between he/she and us. The law presumes that the settlement between him/her and the responsible party does not include compensation for the cost of dental care services for which We provided benefits.

We request that the Member notifies Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of his/her intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by him/her for which we have provided benefits. He/She must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

26. Third Party Beneficiaries.

No third party beneficiaries are intended to be created by this Policy and nothing in the Policy shall confer upon any person or entity other than the Member or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Policy. No other party can enforce this Policy's provisions or seek any remedy arising out of either Our or his/her performance or failure to perform any portion of this Policy, or to bring an action or pursuit for the breach of any terms of this Policy.

27. Time to Sue.

No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Policy. The Member must start any lawsuit against Us under this Policy within two (2) years from the date the claim was required to be filed.

28. Translation Services.

Translation services are available under this Policy for non-English speaking Members. Please contact Us at 888-468-5175 to access these services.

29. Venue for Legal Action.

If a dispute arises under this Policy it must be resolved in a court located in the State of New York. The Subscriber agrees not to start a lawsuit against Us in a court anywhere else. The Member also consent to New York State courts having personal jurisdiction over him/her. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order the Subscriber to defend any action We bring against him/her.

30. Waiver.

The waiver by any party of any breach of any provision of this Policy will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

31. Who May Change This Policy.

This Policy may not be modified, amended, or changed, except in writing and signed by Our President or a person designated by the President. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Policy in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the President or person designated by the President.

32 Who Receives Payment under This Policy.

Payments under this Policy for services provided by a Participating Provider will be made directly by Us to the Provider. If the Member receives services from a Non-Participating Provider, We reserve the right to pay either him/her or the Provider regardless of whether an assignment has been made.

33. Workers' Compensation Not Affected.

The coverage provided under this Policy is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

34. The Member's Dental Records and Reports.

In order to provide the Member's coverage under this Policy, it may be necessary for Us to obtain his/her dental records and information from Providers who treated his/her. Our actions to provide that coverage include processing his/her claims, reviewing Grievances, Appeals, or complaints involving his/her care, and quality assurance reviews of his/her care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Policy, he/she automatically gives Us or our designee permission to obtain and use his/her dental records for those purposes and he/she authorizes each and every Provider who renders services to him/her to:

- Disclose all facts pertaining to his/her care, treatment, and physical condition to Us or to a dental professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to his/her care, treatment, and physical condition to Us, or to a dental professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of his/her dental records by Us.

We agree to maintain the Member's dental information in accordance with state and federal confidentiality requirements. However, he/she automatically gives Us permission to share his/her information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Policy, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

SECTION XVIII
HEALTHPLEX INSURANCE COMPANY
SCHEDULE OF BENEFITS - PEDIATRIC GROUP DENTAL

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Deductible • One (1) Member under Age 19 • Two (2) or More Members under Age 19	$75 $75 each	Non-Participating Provider services are not Covered except as required for Emergency Care.	
Out-of-Pocket Limit • One (1) Member under Age 19 • Two (2) or More Members under Age 19	$350 $700		
PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFIT & CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care	**Copayments**		
• Emergency Dental Care	$0	$0	One dental exam and cleaning per 6 month period
• Preventive Dental Care	$0	Non-Participating Provider services are not Covered except as required for Emergency Care.	Full mouth X-rays or panoramic X-Rays at 36 month intervals and bitewing X-rays at 6 month intervals
• Routine Dental Care	$0		
• Endodontics	$0		
• Periodontics	$0		
• Prosthodontics	$0		
• Oral Surgery	$0		
• Orthodontics	$0		
Orthodontia & Major Dental Require Preauthorization; Referral	**Orthodontia & Major Dental Require Preauthorization; Referral**		

SECTION XIX
HEALTHPLEX INSURANCE COMPANY
SCHEDULE OF BENEFITS - ADULT/FAMILY GROUP DENTAL

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	None None	Non-Participating Provider services are not Covered except as required for Emergency Care.	
Out-of-Pocket Limit • Individual • Family	$350 $700		
ADULT DENTAL CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Adult Dental Care	**Copayments**		
• Emergency Dental Care	$36	$36	One dental exam and cleaning per 6 month period Full mouth X-rays or panoramic X-Rays at 36 month intervals and bitewing X-rays at 6 to 12 month intervals
• Preventive Dental Care	$36	Non-Participating Provider services are not Covered except as required for Emergency Care.	
• Routine Dental Care	$36		
• Endodontics	$36		
• Periodontics	$36		
• Prosthodontics	$36		
• Oral Surgery	$36		

All in-network Preauthorization requests are the responsibility of the Member's Participating Provider. The Member will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not covered under this Policy, the Member will be responsible for the full cost of the services.