This is Your

EMBLEMHEALTH
NEW YORK STATE DENTAL PLAN CERTIFICATE OF INSURANCE
For
NEW YORK STATE POLICE BENEVOLENT ASSOCIATION OF THE NEW YORK STATE TROOPERS, INC. FOR THE UNIT OF COMMISSIONED AND NON-COMMISSIONED OFFICERS IN THE DIVISION OF STATE POLICE (PBA SUPERVISORS)

Issued by
EmblemHealth Plan, Inc.
55 Water Street
New York, New York 10041

This Certificate of Coverage ("Certificate") explains the dental benefits available to a Member (hereinafter referred to as "You" or "Your") under a Group Contract for Dental Insurance between EmblemHealth Plan, Inc. (hereinafter referred to as "EmblemHealth", "We", "Us" or "Our") and the State of New York, referred to as the "Group" in this Contract. This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

The insurance evidenced by this Certificate provides DENTAL insurance only.

This Certificate offers You the option to receive Covered Services on two benefit levels:

1. In-Network Benefits. In-network benefits are the highest level of coverage available. In-network benefits apply when Your dental care is provided by Participating Providers in the dental network named on the Attachment. You should always consider receiving health care services first through the in-network benefits portion of this Certificate.

2. Out-of-Network Benefits. The out-of-network benefits portion of this Certificate provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider's charge.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP CONTRACT. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

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

Karen Ignagni
Chief Executive Officer

If You need foreign language assistance to understand this Certificate, You may call Us at the number on Your ID card.

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SECTION ONE

DEFINITIONS

Defined terms will appear capitalized throughout this Certificate.

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 Certificate for a description of how the Allowed Amount is calculated. If Your Non-Participating Provider charges more than the Allowed Amount, You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements.

Annual Maximum: The maximum amount We will pay in benefits per Member in each Plan Year. Refer to the Attachment to see if an Annual Maximum(s) applies to Your benefits.

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

Attachment: The part of this Certificate that describes any specific benefit information for your group, including applicable Deductibles, Maximums, and certain limits on Covered Services. The Attachment also names the schedules of allowances that We use to determine payment of Covered Services received from Participating and Non-Participating Providers.

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

Certificate: This Certificate issued by EmblemHealth, including the Attachment and any riders.

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

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. Refer to the Attachment to see if Coinsurance applies to any of Your benefits.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service. Refer to the Attachment to see if a Copayment applies to any of Your benefits.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance. Refer to the Attachment to see if cost-sharing applies to any of Your benefits.

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

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Coinsurance is applied. The Deductible may not apply to all Covered Services. Refer to the Attachment to see if a deductible applies to any of Your benefits.

Dependents: The Subscriber's Spouse, domestic partner, and Children and any additional Dependents described in the Who is Covered section of this Certificate.

Emergency Dental Care: Emergency dental treatment required to alleviate pain and suffering caused by dental disease or trauma. Refer to the Dental Services section of this Certificate 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 You communicate to Us that does not involve a Utilization Review determination.

Group: The State of New York, the employer or party that has entered into an agreement with Us as a contract holder.

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

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.

In-Network Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the Covered Service that You are required to pay to a Participating

Provider. The amount can vary by the type of Covered Service. Refer to the Attachment to see if an In-Network Coinsurance applies to any of Your benefits.

In-Network Copayment: A fixed amount You pay directly to a Participating Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service. Refer to the Attachment to see if an In-Network Copayment applies to any of Your benefits.

In-Network Cost-Sharing: Amounts You must pay to a Participating Provider for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance. Refer to the Attachment to see if In-Network Cost-Sharing applies to any of Your benefits.

Lifetime Maximum: The maximum amount that We will pay in benefits per Member in the Member's Lifetime. Refer to the Attachment to see if a Lifetime Maximum applies to any of Your benefits.

Medically Necessary: See the How Your Coverage Works section of this Certificate 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 pursuant to a Grievance, "Member" also means the Member's designee.

Network: The Providers We have contracted with to provide health care services to You.

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide services to You. You will pay more to see a Non-Participating Provider.

Out-of-Network Coinsurance: Your share of the costs of a Covered Service calculated as a percent of the Allowed Amount for the service that You are required to pay to a Non-Participating Provider. The amount can vary by the type of Covered Service. Refer to the Attachment to see if Out-of-Network Coinsurance applies to any of Your benefits.

Out-of-Network Copayment: A fixed amount You pay directly to a Non-Participating Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service. Refer to the Attachment to see if an Out-of-Network Copayment applies to any of Your benefits.

Out-of-Network Cost-Sharing: Amounts You must pay to a Non-Participating Provider for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance. Refer to the Attachment to see if Out-of-Network Cost-Sharing applies to any of Your benefits.

Participating Provider: A Provider who has a contract with Us to provide services to You. A list of Participating Providers and their locations is available on Our website at www.emblemhealth.com or upon Your request to Us. The list will be revised from time to time by Us.

Plan Year: A calendar year ending on December 31 of each year.

Pre-Determination: An estimate of benefits payable that is made before You receive services. You and/or Your Provider can request a Pre-determination for certain types of services. A Pre-Determination is not a guarantee of benefits or coverage.

Premium: The amount that must be paid for Your dental insurance coverage. Premiums for Your dental insurance coverage are paid to Us by Your Group.

Primary Care Dentist ("PCD"): A participating dentist who directly provides or coordinates a range of dental services for You.

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 this Certificate.

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 Your Provider completing a paper Referral form. Referrals are not required under this Certificate.

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 the State of New York. We have Participating Providers in the State of New York and in other states.

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.

Subscriber: The person to whom this Certificate is issued.

Treatment Plan: A Treatment Plan is a detailed statement of the dental services to be rendered and the fees to be charged.

UCR (Usual, Customary and Reasonable): The amount paid for a dental service in a geographic area based on what Providers in the area usually charge for the same or similar medical service. The Schedules of Allowances used to reimburse Participating and Non-Participating Providers under this Certificate are not based on UCR.

Us, We, Our: EmblemHealth Plan, Inc. and anyone to whom We legally delegate performance, on Our behalf, under this Certificate.

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

You, Your: The Member.

SECTION TWO

HOW YOUR DENTAL COVERAGE WORKS

A. Your Coverage Under this Certificate.

Your employer (referred to as the "Group") has purchased a Group dental insurance Contract from Us. We will provide the benefits described in this Certificate to covered Members of the Group, that is, to employees of the Group and their covered Dependents. However, this Certificate is not a contract between You and Us. You should keep this Certificate with Your other important papers so that it is available for Your future reference.

B. Covered Services.

You will receive Covered Services under the terms and conditions of this Certificate only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider for in-network coverage;
- Provided by a Non-Participating Provider for out-of-network coverage;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Attachment to this Certificate; and
- Received while Your Certificate is in force.

C. Participating Providers.

To find out if a Provider is a Participating Provider:

- Check Our Provider directory, available at Your request;
- Call 1-800-947-0101 or the number on Your ID card; or
- Visit Our website www.emblemhealth.com and select Find a Doctor, then Find Care, or securely login to our member portal at www.my.emblemhealth.com.

The Provider directory will give You the following information about Our Participating Providers:

- Name, address, and telephone number;
- Specialty;
- Board certification (if applicable);
- Languages spoken; and
- Whether the Participating Provider is accepting new patients.

D. The Role of Primary Care Dentists.

This Certificate does not have a gatekeeper, usually known as a Primary Care Dentist ("PCD"). You do not need a Referral from a PCD before receiving Specialist care.

E. Access to Providers and Changing Providers.

Sometimes Providers in Our Provider directory are not available. You should call the Provider 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 You are an EmblemHealth Preferred Premier Member, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your Group or Member ID number. When You go to the Provider's office, bring Your ID card with You.

We will be responsible for negotiating single case agreements with Non-Participating Providers on a case-by-case basis when We determine that it is clinically appropriate or to address access issues. Requests for a single case agreement must be made in coordination with Our customer service center in advance. Members will only be responsible for in-network cost-sharing for services provided under such single case agreements.

F. Out-of-Network Services.

We Cover the services of Non-Participating Providers. In any case where benefits are limited to a certain number of visits or frequencies, such limits apply in the aggregate to in-network and out-of-network services. We will reimburse You for Covered Services that You receive from a Non-Participating Provider based on the Preferred schedule of allowances for the type of service You receive, subject to applicable Cost-Sharing, if any. You are responsible for any difference between Our payment and the Non-Participating Provider's billed charge. If You would like to know the Allowed Amount for a particular Non-Participating Provider service, please call the number on Your ID card. Examples of the allowances for common dental procedures received from a Non-Participating Provider may also be available on the New York State Department of Civil Service website at www.cs.ny.gov/employee-benefits.

G. Services Subject to Preauthorization.

Preauthorization is not required before You receive Covered Services.

H. Medical Management.

The benefits available to You under this Certificate are subject to retrospective review to determine whether 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 the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

I. Medical Necessity.

We Cover benefits described in this Certificate as long as the dental service, procedure, treatment, test or device (collectively, "service") is Medically Necessary. 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 base Our decision on a review of:

- Your medical and dental records;
- Our medical and dental policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians or dentists;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment; and/or
- The opinion of Health Care Professionals in the generally-recognized health specialty involved.

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 Your dental condition, illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical and dental practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is 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 You 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 Appeal sections of this Certificate for Your right to an internal Appeal and external appeal of Our determination that a service is not Medically Necessary.

J. Pre-Determination of Benefits.

You have the option to obtain a Predetermination of Benefits from Us prior to the onset of certain treatments. Predetermination of Benefits is a process by which We will review and estimate benefits before certain services are rendered.

To obtain a Predetermination of Benefits, You or Your Provider may submit a Treatment Plan to Us before receiving oral surgery, prosthetic services, appliances or orthodontic services. We will review the Treatment Plan and inform you and your Provider of the results of this review. The results of the Pre-Determination of Benefits are only an estimate. The estimate may change based on any new information received by Us after We have issued the Pre-Determination of Benefits and/or if Your coverage changes after We have issued the Pre-Determination of Benefits, but before You receive services.

If You do not take advantage of the Predetermination of Benefits service, You will not have an estimate in advance of the services and materials that We will cover or the benefits that We will provide. We reserve the right to determine Your benefits taking into account alternate procedures, services or courses of treatment. If You or Your Provider feel that the alternate procedure, service or course of treatment is not appropriate in Your case, your request will be subject to medical necessity review and internal and external utilization review appeals. (See the Sections of this Certificate entitled "Utilization Review" and "External Appeals"). Predetermination of Benefits is not available for Preventive and Diagnostic Services.

K. Important Telephone Numbers and Addresses.

- CLAIMS
  Submit out-of-network claim forms to:
  EmblemHealth, PO Box 2838, NY, NY 10116-2838

  Claim forms are available at www.emblemhealth.com or by securely logging in to our member portal at www.my.emblemhealth.com, or by calling the number on Your ID card. Claim forms may also be available on the New York State Department of Civil Service website at www.cs.ny.gov/employee-benefits.

- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
  1-800-947-0101
  Or call the number on Your ID card.

- MEMBER SERVICES
  1-800-947-0101
  Or call the number on Your ID card.

- OUR WEBSITE
  www.emblemhealth.com
  You can also securely login to our member portal at www.my.emblemhealth.com for information specific to Your plan.

- NEW YORK STATE DEPARTMENT OF CIVIL SERVICE WEBSITE
  www.cs.ny.gov/employee-benefits

SECTION THREE

COST-SHARING EXPENSES AND ALLOWED AMOUNT

A. Deductible.

Refer to the Attachment to see if a Deductible applies to any of Your benefits. If applicable, You must pay the Deductible amount set forth in the Attachment to this Certificate for Covered In-network and out-of-network Services during each Plan Year before We provide coverage. If You have other than individual coverage, You must pay the family Deductible in the Attachment to this Certificate for Covered in-network and out-of-network Services under this Certificate during each Plan Year before We provide coverage for any person covered under this Certificate. However, after Deductible payments for persons covered under this Certificate collectively total the family Deductible amount set forth in the Attachment to this Certificate in a Plan Year, no further Deductible will be required for any person covered under this Certificate for that Plan Year. You have a combined In-Network and Out-of-Network Deductible. Cost-Sharing for out-of-network services applies toward Your In-Network Deductible. Cost-Sharing for in-network services applies toward Your Out-of-Network Deductible. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Deductible.

The Deductible runs from January 1 to December 31 of each calendar year.

B. Copayments.

There are no Copayments for Covered Services under this Certificate.

C. Coinsurance.

Except where stated otherwise, after You have satisfied the Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your in-network or out-of-network benefit as shown in the Attachment to this Certificate. You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount. Refer to the Attachment to see if Coinsurance applies to any of Your benefits.

D. Your Additional Payments for Out-of-Network Benefits.

When You receive Covered Services from a Non-Participating Provider, in addition to any applicable Deductibles and Coinsurance described in the Attachment to this Certificate, You must also pay the difference between the Allowed Amount, which is based on the Preferred schedule of allowances, and the Provider's actual charge for out-of-network services. This means that the total of amount of Our payment may be less than the Non-Participating Provider's actual charge, and You will be responsible to pay the difference.

When You receive Covered Services from a Non-Participating Provider, We will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services You received. Sometimes, applying these rules will change the way that We pay for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. For example, Your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. We will make one (1) inclusive payment in that case rather than a separate payment for each billed code.

E. Allowed Amount.

"Allowed Amount" means the maximum amount We will pay for the services or supplies Covered under this Certificate, before any applicable Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for Participating Providers will be Preferred Premier Schedule of Allowances or the Participating Provider's charge, if less, or the amount We negotiate with a Participating Provider. Our payments to Participating Providers may include financial incentives to help improve the quality or coordination of care and promote the delivery of Covered Services in a cost-efficient manner. Payments under this financial incentive program are not made as payment for a specific Covered Service provided to You. Your Cost-Sharing will not change based on any payments made to or received from Participating Providers as part of the financial incentive program.

The Allowed Amount for Non-Participating Providers will be determined based on the Preferred schedule of allowances for the type of Non-Participating Provider service rendered. Payment will be calculated based on the Preferred schedule of allowances in force on the date of service. We reserve the right to negotiate a lower rate with Non-Participating Providers. Your Cost-Sharing will not increase if We negotiate a lower rate with Your Non-Participating Provider. If You would like to know the Allowed Amount for a particular Non-Participating Provider service, please call the number on Your ID card. Examples of Allowed Amounts for common dental procedures received from Non-Participating Providers may also be available on the New York State Department of Civil Service website at www.cs.ny.gov/employee-benefits.

F. Annual Maximum.

This Certificate has an annual maximum for benefits. When a Member receiving benefits has met the annual maximum for Covered Services set forth in the Attachment to this Certificate, no more benefits will be payable for that Member for the remainder of that Plan Year. If other than individual coverage applies, the individual annual maximum applies to each person covered under this Certificate. Once a person within a family meets the individual annual maximum, no more benefits for services will be payable for that person. If other than individual coverage applies, when persons in the same family covered under this Certificate collectively meet the family annual maximum, no more benefits will be payable for the family for the rest of that Plan Year. Unless specifically provided otherwise in the Attachment, orthodontic benefits are not subject to the annual maximum.

G. Lifetime Maximum for Orthodontics.

This Certificate has a lifetime maximum for orthodontic benefits. Once Your covered child has met the lifetime maximum for orthodontics set forth in the Attachment to this Certificate, no more benefits for those services will be payable for the remainder of Your child's lifetime.

SECTION FOUR

WHO IS COVERED

A. Who is Covered Under this Certificate.

You, the Subscriber to whom this Certificate is issued, are covered under this Certificate. Members of Your family may also be covered depending on the type of coverage You selected.

B. Types of Coverage.

We offer the following types of coverage:

- Individual. If You selected individual coverage, then You are covered.
- Family. If You selected family coverage, then You and Your Spouse, domestic partner and Your Child or Children, as described below, are covered.

C. Children Covered Under this Certificate.

If You selected family coverage, Children covered under this Certificate include Your natural Children, legally adopted Children, step Children, your domestic partner's child, a child who resides with you and is financially dependent on you that you have assumed legal responsibility in place of the parent. 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 19 years of age. Any unmarried Child who is a student at an accredited institution of learning is considered a Child until age 25 and coverage will last until the end of month in which the Child turns 25 years of age. However, if the Dependent is no longer a student between the ages of 19-25, coverage ends the last day of the month following a 3-month extension of benefits after the completion of a semester. Coverage also includes Children for whom You are a permanent legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order.

For the purposes of eligibility, You may deduct from your Child's age up to four years for service in a branch of the U.S. Military for time served between the ages of 19 and 25. To be eligible, your dependent Child must be in enrolled in school on a full-time basis, be unmarried, and not eligible for other employer group coverage. You must be able to provide written documentation from the U.S. Military showing the dates of service. Proof of full-time status will be required upon verification. In no event will any person who is in the armed forces of any country, including a student in an armed forces military academy of any country, be eligible for coverage.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, intellectual disability (as defined in the New York Mental Hygiene Law), or physical disability 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 You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You must apply and submit an application to request that the Child be included in Your coverage and send proof. We have the right to check whether a Child qualifies and continues to qualify under this section.

C. Children Covered Under this Certificate. (continued)

Coverage shall continue for a Child who is a full-time student when the Child takes a medical leave of absence from school due to illness for a period of 12 months from the last day of attendance in school. However, coverage of the Child is not provided beyond the age at which coverage would otherwise terminate. To qualify for such coverage, We may require that the leave be certified as Medically Necessary by the Child's Physician who is licensed to practice in the state of New York.

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 Certificate at any time.

D. When Coverage Begins.

Coverage under this Certificate will begin as follows:

If You are a new employee eligible for coverage, your coverage will begin on the first day after you have completed Your benefit waiting period as outlined in the Attachment. Newly eligible employees have the same waiting period. ("Newly eligible employees" are employees who are not eligible for coverage under the Dental Plan when they are hired, but become eligible later. For example, their work schedule increases from 30 percent to 50 percent). However, You may have satisfied the benefit waiting period requirement while you were working in a non-eligible position. In this event, your effective date is the first day following the date you were employed in an eligible position.

E. Special Enrollment Periods.

There are no Special Enrollment Periods. If the benefit waiting period and eligibility requirements are met, coverage begins based on the date of request for You or any qualified Dependents.

F. Domestic Partner Coverage.

This Certificate covers domestic partners of Subscribers as Spouses. If You selected family coverage, Children covered under this Certificate also includes the Children of Your 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:
    a. An alternative affidavit of domestic partnership. 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 contract;
        - The partners are not related by blood in a manner that would bar marriage under the laws of the State of New York;
        - The partners have been living together on a continuous basis prior to the date of the application; and
        - Neither individual has been registered as a member of another domestic partnership within the last six (6) months

F. Domestic Partner Coverage. (continued)

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 FIVE

DENTAL SERVICES

We Cover the dental services described below. Please refer to the Attachment to this Certificate for any applicable Cost-Sharing requirements, applicable Annual and Lifetime Maximums and for special coverage limits that apply to select services. Charges for items and services used or provided by Dentists and Providers to comply with federal, state and local laws and regulations and charges for behavioral management are not covered unless specifically listed as Covered. Prescription drugs and medications are not covered. Except as specifically provided otherwise, services and appliances for the treatment of temporo-mandibular joint (TMJ) dysfunction syndrome are not covered unless dental in nature and medically necessary.

Type A - Preventive and Diagnostic Services.

Biopsy & Examination of Oral Tissue. We cover incisional biopsy and examination of oral tissue. However, We do not cover sialography, temporo-mandibular joint (TMJ) arthrogram (including injection), tomographic survey, bacteriological studies, caries susceptibility, pulp vitality test, diagnostic casts and photographs, nutritional counseling or oral hygiene instructions.

Examinations. We Cover routine examinations of the oral cavity. This includes charting of the teeth, if performed. We cover the number of examinations set forth on the Attachment per person per calendar year. Please refer to the portion of the Attachment entitled Special Benefit Limits for this information. We will only cover one (1) initial comprehensive oral evaluation per Provider per lifetime. All subsequent non-emergency examinations done by the same Provider are covered as periodic examinations.

Fluoride Treatments. We cover fluoride treatment for dependent covered children. We will cover one (1) fluoride treatment per child per calendar year. Coverage is available for this service until the end of the month in which the child reaches age nineteen (19).

Mouth Guards. We will cover one (1) athletic mouth guard per lifetime for each covered dependent child. The mouth guard must be for use in athletic activity. A Dentist must also prescribe it. We will cover this protective appliance only until the end of the month in which the child reaches age nineteen (19).

Palliative Services (Emergency Dental Care). We will cover one (1) palliative service for each Member in each calendar year. This is a service for the relief of pain. You must have made an emergency visit to your Provider. This includes an adjustment of a prosthetic appliance that must have been installed for over one (1) year.

Prophylaxes. We Cover prophylaxes. Prophylaxis is the scaling, cleaning and polishing of the teeth. We will cover only the number of prophylaxes set forth on the Attachment per Member per calendar year. Please refer to the portion of the Attachment entitled Special Coverage Limits for this number.

Sealants. We will cover sealants for each covered dependent child from age 6 through end of the month in which the child reaches age 14. We will only cover sealants applied to the occlusal (biting) surface of the first and second permanent molars and bicuspids. We will not cover sealants applied to other surfaces or teeth. Benefits are available once per covered tooth every three (3) calendar years.

Space Maintainers. We will cover one (1) space maintainer per quadrant per covered dependent child per lifetime. We cover the treatment and the appliance. We will cover space maintainers only until the end of the month in which the child reaches age nineteen (19). If the insertion of a space maintainer is performed in conjunction with the re-cementation of a space maintainer, Our allowance will be the scheduled amount for insertion of the space maintainer. We will not provide a separate allowance for the re-cementation.

X-Rays. We cover the taking of x-ray films of the teeth, mouth or jaw. We will cover four (4) bitewing x-rays for each Member in each calendar year. We will cover the taking of fourteen (14) standard periapical x-ray films or one (1) panoramic film once every three (3) years. We will also cover two (2) occlusal intra-oral x-ray films within a three (3) year period. Individual periapical x-rays performed on the same day as a full mouth series are not covered. Duplication of x-rays is not covered.

Type B – Basic Services.

Anesthesia & IV Sedation/Analgesia. We will cover deep sedation/general anesthesia and IV moderate sedation/anesthesia when rendered in connection with a Covered Service. As with all Covered Services, the services must be consistent with accepted standards of dental practice as well as Our criteria for medical necessity, and the services must be performed by a licensed provider certified to provide the anesthesia or IV sedation/analgesia by the state in which the services are rendered. Local anesthesia is included in the allowance for the procedure being performed. Inhalation of Nitrous oxide/analgesia and non-intravenous conscious sedation are not covered and are considered inclusive when rendered with deep sedation/general anesthesia and IV moderate sedation/anesthesia.

Basic Restorations. We will Cover basic restorations. Basic restorations are fillings. We will not cover temporary fillings, sedative fillings, and tissue conditioning. Benefits are subject to the terms set forth below.

- The Schedule of Allowances imposes a maximum benefit for fillings done on the same tooth by the same Dentist or Provider within a six (6) month period. We will not pay more than this maximum benefit for fillings for each Member in any six (6) month period.
- If two (2) fillings are done on the same tooth on the same day, Our allowance will be up to the Allowed amount for a three (3) surface filling.
- If a three (3) surface inlay, crown or abutment is done on a tooth that has been filled within the last six (6) month period, We will deduct the Scheduled or Allowed amount for the filling from its payment for the inlay, crown or abutment.
- The charge for cementation for a crown/inlay is included in the allowance for the crown/inlay.
- Composite fillings on anterior, premolar, and molar teeth are reimbursed at the composite rate for services rendered by Preferred Premier Participating Providers.
- Composite fillings on anterior and premolar teeth are reimbursed at the composite rate and molar teeth are reimbursed at the amalgam rate for services rendered by Non-Participating Providers.

Bedside Calls. We will cover bedside calls. The call must be made due to an emergency.

Consultations. We will Cover a consultation with a specialist in the field of oral surgery, orthodontics, periodontics, prosthodontics, endodontics, and pedodontics One (1) consultation is Covered per each specialty field per twelve (12) months. We will Cover the consultation if there is no other service rendered by the specialist on that date. If the dental provider is not a specialist, the consultation will be Covered as a routine examination and will count as an examination toward the examination maximum per person per calendar year set forth on the Attachment. The report of the specialist must be submitted with your claim form.

Endodontics (Non-Surgical). We will Cover non-surgical endodontics. The guidelines below apply to your coverage for these services.

- Therapeutic Pulpotomy or Pulpal Debridement are Covered once per tooth per lifetime. If root canal therapy is done on a tooth that has had a Therapeutic Pulpotomy or Pulpal Debridement in last three-month period by the same Provider, We will deduct the Scheduled or Allowed amount for the Therapeutic Pulpotomy or Pulpal Debridement from its payment for the root canal therapy.
- Pulp capping is not covered.
- Surgical Placement of rubber dam, recalcification of perforation, preparation of canal for posts or dowels, and bleaching of discolored teeth are not covered.
- Inter-operative radiographs are considered part of non-surgical endodontic therapy and are included in the allowance for non-surgical endodontic therapy. No separate allowance is provided for intra-operative radiographs.

Extractions. We will cover the routine removal of a tooth or teeth. Pre-operative x-rays taken for diagnostic purposes are separately reimbursed. X-rays taken solely for your extraction, local anesthesia, and post-operative care are not separately covered. They are included in Our allowance for extractions.

Surgical Endodontics (Root Canal Therapy). We will Cover surgical endodontics. You may obtain a Predetermination of Benefits for certain surgical endodontics. The guidelines below apply to your coverage for this service.

- If any combination of apicoectomy, root end amalgam and apical curettage is done on the same tooth by the same Provider within a three (3) month period of root canal therapy, We will not apply the Scheduled or Allowed amounts for these services. We will apply a combined allowance for these services.
- The allowance for incision and drainage done within two (2) weeks of root canal therapy or periodontal surgery on the same tooth by the same Provider will be deducted from the allowance for the root canal therapy or periodontal surgery.
- Intra-operative radiographs are considered part of surgical endodontic therapy and are included in the allowance for surgical endodontic therapy. No separate allowance is provided for intra-operative radiographs.

Oral Surgery. We will Cover oral surgery. You may obtain a Predetermination of Benefits for oral surgery. We will Cover the surgical removal of an erupted tooth. You are Covered for surgical procedures in or about the oral cavity. Pre-operative x-rays taken for diagnostic purposes are separately reimbursed. X-rays taken solely for your surgery, local anesthesia, and post-operative care are not separately Covered. They are included in Our allowance for oral surgery. The guidelines below apply to your coverage for this service.

- The Schedule of Allowances imposes an annual maximum benefit per arch for alveolectomy and alveoplasty. We will not pay more than that maximum benefit per arch for each Member in each calendar year for these services.
- Alveolectomy done in conjunction with a surgical extraction is not covered.
- Surgery on fractured jaws, impactions, and lesions in and around the mouth is Covered. Orthognathic surgery and surgery relating to accidental injury are not covered.
- Transplantations are not covered. Reimplantations of natural teeth are Covered.
- Reimplantation of an implant is not covered.

Periodontal Surgery. We will Cover periodontal surgery, including soft tissue and osseous surgery. You may obtain a Predetermination of Benefits for certain periodontics. We will Cover five (5) periodontal treatments in each calendar year. We will Cover one (1) type of periodontal surgery and/or one (1) graft per quadrant. Five (5) single tooth periodontal surgeries or grafts are considered to be a quadrant. Periodontal appliances are not covered.

- Repeated periodontal surgeries or grafts will not be covered for a period of three (3) years from the date of the original surgery or graft.
- You are Covered for guided tissue regeneration if performed in conjunction with a Covered periodontal surgery.
- Periodontal services associated with implants are not covered.

Periodontal Treatment (Non-surgical). We will Cover non-surgical periodontics. Non-surgical periodontics is the treatment of diseases of the gums and the long structure of the jaw, including subgingival scaling, periodontal maintenance and minor bite correction (occlusal adjustment). You are Covered for five (5) periodontal treatments in each calendar year. The guidelines below apply to your coverage.

- We will Cover two (2) periodontal maintenance procedures per calendar year in lieu of prophylaxis.
- Occlusal adjustments done on the same tooth and in conjunction with fillings, prosthetic services, root canal therapy or repairs, inlays and crowns are not covered.
- Splints are covered only in connection with the replacement of a missing tooth. We will Cover only that portion of the splint replacing the missing tooth.
- Unscheduled dressing changes are not separately covered. They are included in the allowance for the procedure performed.

We will Cover antimicrobial medications via controlled release delivery into diseased tissue, per tooth. This must be performed in conjunction with periodontal scaling and root planning or periodontal maintenance. We will Cover two (2) teeth per quadrant, eight (8) teeth per mouth in each twenty-four (24) month period.

Repair of Prosthetic Appliances. We will Cover the repair of dentures, the replacement of broken teeth or clasps in a denture, re-cementation of inlays, crowns, bridges and space maintainers, repair of inlays and veneers, and the replacement of broken facings. The Schedule of Allowances imposes an annual maximum benefit for all repairs. We will not pay more than the maximum benefit for each member in each calendar year for repairs.

- We will Cover the replacement of broken teeth or clasps in a denture. We will also Cover the re-cementation of bridges and the replacement of broken facings. The Schedule of Allowances imposes an annual maximum benefit for all repairs. We will not pay more than that maximum benefit for each Member in each calendar year for repairs.
- Duplication (Jump), rebase, or chairside reline to a denture is limited to one (1) per denture in a five (5) year period. This applies to both partial and full dentures.
- Rebase or repair of new dentures are covered only after six (6) months have passed after the date of the insertion of the denture.

Type C- Major Services.

Fixed & Removable Prosthodontics. We will Cover removable and fixed prosthodontic services as set forth below. You may obtain a Predetermination of Benefits for prosthetic services and appliances. Note that there is no separate allowance for a temporary service or appliance. The allowance for a temporary service or appliance is included in the allowance for the completed, permanent service or appliance.

- We will Cover dentures that are constructed prior to the removal of teeth. These are known as immediate dentures. The dentures must be put in the same day the teeth are removed.
- We will Cover permanent dentures. These may be full or partial.
- We will Cover fixed and removable partial dentures.

Fixed & Removable Prosthodontics coverage is subject to the guidelines below.

- If the repair of a partial denture is done in conjunction with the insertion of a new denture in the same area of the mouth, Our allowance will be the Allowed amount for the insertion of the new denture.
- If a denture adjustment is performed in conjunction with palliative treatment, Our allowance will be the Allowed amount for the palliative treatment.
- There will be no benefits for any treatment of the abutment tooth or attachment tooth.
- Replacement or the substitution of appliances is Covered only after five (5) years have passed since the appliance was inserted.
- When a fixed bridge and a partial denture are inserted in the same arch, only the partial denture is Covered unless five (5) years have passed since the prior insertion of the fixed bridge or partial denture.
- We will cover crowns or pontics for attachment or clasp purposes only if the tooth is so broken down that it cannot be restored by fillings.
- We will cover splints only when a missing tooth is being replaced. Only that portion replacing the missing tooth is covered.
- We will Cover crowns and inlays used as abutments only when they are used as primary support for fixed appliances.
- We will Cover adjustment of appliances only after one (1) year of insertion.
- Precious metal material or porcelain/ceramic substrate used in abutment crowns is reimbursed at the base metal rate for services rendered by Non-Participating Providers and at the full cast high noble metal rate for services rendered by Preferred Premier Participating Providers.
- There is not a separate allowance for a temporary service or appliance. The allowance for a temporary service or appliance is included in the allowance for the completed, permanent service or appliance.

The procedures below are excluded from coverage under Fixed & Removable Prosthodontics.

- A cantilever pontic, when used for attachment purposes, is not covered.
- Double or multiple abutments.
- Crowns used in splints for periodontal conditions.
- Crown build-ups done in connection with abutment crowns.
- Services or appliances used solely as an adjunct to periodontal care.

- Precision attachment, metal coping, tissue conditioning and stress breakers.
- Cosmetic surgery and/or treatment unless otherwise medically necessary.

Implant Services. We will Cover Implant Services as described in this paragraph. Benefits are subject to the per implant dollar cap set forth in the Attachment.

- We will Cover surgical placement of the implant body; endosteal implant, or mini implant once per tooth per lifetime if included in a type of dental service that is listed as "covered" on the Attachment.
- We will Cover crowns and fixed partial dentures over implants.
- We will Cover replacement or substitution of crowns, implant supported only after five (5) years have passed since the appliance was inserted.
- We will not cover implant services for wisdom teeth (i.e. tooth numbers 1, 16, 17 and 32).
- There is no separate benefit and/or payment allowance for temporary service.
- We will not cover periodontal services for implants.
- We will not cover the removal of an implant body or any implant services other than outlined in this certificate.

You may request a pre-determination of benefits for implant services.

Major Restorative Services. We will Cover major restorative services. These services include: crowns; inlays; prosthetic services; removable, complete and partial dentures; fixed bridges; crowns or inlays used as abutments. You may obtain a Predetermination of Benefits for Major Restorative Services. The following guidelines apply to Your coverage for Major Restorative Services.

- Replacement or the substitution of inlays and single crowns is Covered only after five (5) years have passed since the appliance was inserted.
- Posts are Covered only if there is evidence of root canal therapy on the tooth.
- Pins are Covered once every six (6) months. However, pins are not covered if they are inserted in conjunction with a prosthetic service.
- Core buildups including pins are not Covered, unless done on a root canal tooth in lieu of a post/core subject to a limit of one (1) per tooth every five (5) years.
- Acrylic crowns are only Covered on the six (6) anterior teeth. They must be laboratory processed and permanent.
- If a three (3) surface inlay, crown or abutment is done on a tooth that has been filled within the last six (6) month period, We will deduct the Allowed amount for the filling from its payment for the inlay, crown or abutment.
- The charge for cementation for a crown/inlay is included in the allowance for the crown/inlay.
- We will Cover splints only when a missing tooth is being replaced. Only that portion replacing the missing tooth is Covered.
- Precious metal material or porcelain/ceramic substrate used in fixed and removable prosthodontics, is reimbursed at the base metal rate for services rendered by Non-Participating Providers and at the full cast high noble metal rate for services rendered by Preferred Premier Participating Providers.
- There is no separate allowance for a temporary service or appliance. The allowance for a temporary service or appliance is included in the allowance for the completed, permanent service or appliance.

The procedures listed below are not Covered Services.

- Crowns used in splints for periodontal conditions.
- Crown build-ups done in connection with individual crowns and abutments.
- Services or appliances used solely as an adjunct to periodontal care.
- Tissue conditioning and stress breakers.
- Precision and semi precision attachments and metal coping.
- Cosmetic surgery and/or treatment unless otherwise medically necessary.

Type D – Orthodontia Services.

Orthodontia. Orthodontia is commonly known as the straightening of teeth. Orthodontia benefits are available only to enrolled dependent children under nineteen (19) years of age, regardless of when treatment begins. Comprehensive Orthodontic Treatment may incorporate multiple treatment phases. Benefits for single or multiphase orthodontic treatment consist of initial appliance placement, active treatment visits and retention as outlined. Construction of retainers are not covered. You may obtain a Predetermination of Benefits for all phases of orthodontia. Please refer to the Attachment for the amount of Your orthodontia Lifetime Maximum and the orthodontic appliance limit and the orthodontic passive retention limit.

- We will issue payment for twenty (20) months of the active phase of orthodontic treatment. This includes initial appliance placement (which represents reimbursement for the appliance fee and diagnostic work-up), and active orthodontic treatment visits. There is no limit on the total number of months required for the completion of a full course of orthodontic treatment..
- The allowance for the initial appliance placement and active orthodontic treatment does not include charges such as missed appointments, additional cosmetic banding options, or clear aligners. Charges for these items are Your responsibility and reflect the dentist's standard charges.
- When received from a Participating Provider, We consider the following services inclusive if done during the course of active comprehensive orthodontic treatment: photos, diagnostic casts, panorex, cephalometrics, cephalometric analysis, and additional orthodontic consultations. These services may not be billed to You.
- We will not cover any appliance that was installed during a period when the child was not covered under this Certificate.
- We will not pay for the orthodontics unless it is medically necessary. The teeth must also be correctable.
- If We covered a preliminary appliance in any phase of orthodontic treatment, that payment will be deducted from the total payment for the insertion of a permanent appliance. If the appliance was inserted before you became covered under this Certificate, We will not cover the appliance.
- There is no separate allowance for a temporary service or appliance. The allowance for a temporary service or appliance is included in the allowance for the completed, permanent service or appliance.
- We provide a one-time benefit for retention, the passive phase of orthodontic treatment. Construction of retainers is not covered.

SECTION SIX

EXCLUSIONS AND LIMITATIONS

No coverage is available under this Certificate for the following:

A. Convalescent and Custodial Care.

We do not Cover services related to rest cures, custodial care or 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.

B. 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, and except for orthodontics as described in the Dental Care section of this Certificate. 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 Appeal sections of this Certificate unless medical information is submitted.

C. 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 Your rare disease or patient costs for Your 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 You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

D. Felony Participation.

We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection.

E. 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.

F. Medical Services.

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

G. 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).

H. Military Service.

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

I. 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 You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

J. Not Medically Necessary.

In general, We will not Cover any dental care service, procedure, treatment, test, device or drug 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, device or drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or drug is otherwise Covered under the terms of this Certificate.

K. Services Not Listed.

We do not Cover services that are not specifically listed in the Dental Care section of this Certificate as being Covered.

L. 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, stepchild, spouse, domestic partner, child(ren) of domestic partner, parent, stepparent, sibling, stepsibling, parent-in-law, child-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild, or grandchild's spouse.

M. Services Separately Billed by Hospital Employees.

We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

N. Services with No Charge.

We do not Cover services for which no charge is normally made.

O. Temporomandibular Joint Dysfunction (TMJ).

This Certificate excludes coverage for treatment of temporomandibular joint dysfunction (TMJ) that is medical in nature.

P. War.

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

Q. 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 SEVEN

CLAIM DETERMINATIONS

A. Claims.

A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider, either You or Your Provider will need to file a claim form in order to request benefits.

See the Coordination of Benefits section of this Certificate for information on how We coordinate benefit payments when You also have group dental 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 Your ID card or securely logging in to Our member portal at www.my.emblemhealth.com. Claim forms may also be available on the New York State Department of Civil Service website at www.cs.ny.gov/employee-benefits.

Submit completed claims for services received from Non-Participating Providers to: EmblemHealth, PO Box 2838, NY, NY 10116-2838

You may also submit a claim to Us electronically by sending it to the following e-mail address: ppoemblemhealthclaim@emblemhealth.com.

C. Timeframe for Filing Claims.

Claims for services must be submitted to Us for payment within 180 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 180-day period, You must submit it as soon as reasonably possible.

D. Claims for Prohibited Referrals.

We are not required to pay any claim, bill or other demand or request by a Provider for x-ray or imaging services or other 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. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Certificate.

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 Certificate.

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 covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

    a. If We need additional information, We will request it within 15 days from receipt of the claim. You 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 You (or Your 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 You (or Your 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. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your 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.

Pre-Service Claim Determinations and Urgent Pre-Service Reviews are not required under this Certificate.

G. Post-Service Claim Determinations.

A post-service claim is a request for a service or treatment that You 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 You (or Your designee) within 30 calendar days of the receipt of the claim. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period.

H. Payment of Claims.

Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 15 days of Our determination that payment is due, but no later than 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

SECTION EIGHT

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 You have regarding Our administrative policies or access to Providers.

B. Filing a Grievance.

You can contact Us by calling the number on Your ID card or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your 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 Your 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 Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

You may ask that We send You electronic notification of a Grievance or Grievance Appeal determination instead of notice in writing or by telephone. You must tell Us in advance if You want to receive electronic notifications. To opt into electronic notifications, call the number on Your ID card or securely login to our member portal at www.my.emblemhealth.com. You can opt out of electronic notifications at any time.

C. Grievance Determination.

Qualified personnel will review Your 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 You 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 Your Grievance. Written notice will be provided within 72 hours of receipt of Your 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 Your Grievance.

Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 45 calendar days of receipt of all necessary information.

D. Grievance Appeals.

If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at the number on Your ID card or in writing. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

When We receive Your 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 Your 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 You in writing within the following timeframes:

Expedited/Urgent Grievances:	The earlier of 2 business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	15 calendar days of receipt of Your Appeal.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	30 calendar days of receipt of Your 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 You remain dissatisfied with Our Grievance Appeal determination, or at any other time You are dissatisfied, You may:

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

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov

If You need assistance filing a Grievance or Appeal, You 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 NINE

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 You have any questions about the Utilization Review process, please call the number on Your ID card. 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 dentists; 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 Your 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 Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your ID card or visit Our website at www.emblemhealth.com.

You may ask that We send You electronic notification of a Utilization Review determination instead of notice in writing or by telephone. You must tell Us in advance if You want to receive electronic notifications. To opt into electronic notifications, call the number on Your ID card or visit Our website at www.emblemhealth.com. You can opt out of electronic notifications at any time.

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 You (or Your designee) and Your 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. You or Your 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 You (or Your designee) and Your 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 You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information.

B. Preauthorization Reviews. (continued)

We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48 hour period. Written notification will be provided within the earlier of three (3) business days of Our receipt of the information or three (3) calendar days after the verbal notification.

Pre-authorization reviews are not required under this Certificate.

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 You (or Your designee) and Your 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. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day 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 You (or Your designee) and Your 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 You (or Your designee) and Your Provider within the earlier of 72 hours or one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your 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 You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of all or part of the requested 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. Note that a Pre-Determination is not a Preauthorization. A Pre-Determination is simply an estimate of benefits.

F. Reconsideration.

If We did not attempt to consult with Your 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 You and Your Provider, by telephone and in writing.

G. Utilization Review Internal Appeals.

You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will, if necessary, inform You of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

H. Standard Appeal.

1. **Preauthorization Appeal.** If Your 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 You (or Your designee), and where appropriate, Your 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 Your Appeal relates to a retrospective claim, We will decide the Appeal within the earlier of 30 calendar days of receipt of the information necessary to conduct the Appeal or 60 calendar days of receipt of the Appeal. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your 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 Appeal.** 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, mental health and/or substance use disorder services that may be subject to a court order, 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, Your 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. Your 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. Written notice of the determination will be provided to You (or Your designee) within 24 hours after the determination is made, but no later than 72 hours after receipt of the Appeal request.

If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal Appeal or an external appeal. Our failure to render a determination of Your Appeal within 30 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. Full and Fair Review of an Appeal.

We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connection with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

J. Appeal Assistance.

If You need Assistance filing an Appeal, You 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 TEN

EXTERNAL APPEAL

A. Your Right to an External Appeal.

In some cases, You have 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 treatments for rare diseases); or is an out-of-network treatment, You or Your 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 You to be eligible for an external appeal You must meet the following two (2) requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under this Certificate; and
- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have 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 Your request to waive the internal Appeal; or
    - You file an external appeal at the same time as You apply 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 You, 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 You and Us).

B. Your 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, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph "A" above.

C. Your 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 treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph "A" above and Your attending Provider must certify that Your 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).

C. Your Right to Appeal a Determination that a Service is Experimental or Investigational. (continued)

In addition, Your attending Provider 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 You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Provider should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which Your attending Provider certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Provider must certify that Your 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, Your attending Provider must be a licensed, board-certified or board eligible Provider qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Provider may not be Your treating Provider.

D. The External Appeal Process.

You have 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 You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have 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. You 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 You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit 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 external appeal (described below), We do not have a right to reconsider Our decision.

D. The External Appeal Process. (continued)

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Provider, 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 You in writing of its decision within two (2) business days.

If Your attending Provider certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Provider certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You 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 Certificate. 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 cost of services required to provide treatment to You 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 the research, or costs that would not be Covered under this Certificate for non-investigational treatments provided in the clinical trial.

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

We will charge You a fee of $25 for each external appeal, not to exceed $75 in a single Plan Year. The external appeal application will explain how to submit the fee. We will waive the fee if We determine that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

E. Your Responsibilities.

It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive 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 ELEVEN

COORDINATION OF BENEFITS

This section applies when You also have group dental coverage with another plan. When You receive 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 group 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 contracts.
    - Dental, benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private insurance 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 decides 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 Subscriber and is only covered as a Dependent under the other plan, this Certificate 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 will 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. You 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, You agree 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 You agree to sign all documents necessary to help Us recover any overpayment.

F. Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans.

Except as described below, 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 Certificate is primary, as defined in this section, We will pay benefits first.
2. If this Certificate 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 noncomplying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

SECTION TWELVE

TERMINATION OF COVERAGE AND EXTENSION OF BENEFITS

A. Termination of Coverage.

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

1. The Group and/or 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. Twenty-eight (28) days after the last day of the last payroll period for which the Subscriber was paid.

3. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, coverage for Dependents will be extended an additional 28-days beyond the last day of the pay period in which the employee passes.

4. For Spouses in cases of divorce, the date of the divorce. For domestic partners the date the partnership terminated or when they no longer meet the eligibility requirements

5. For Children, until the end of the month in which the Child turns 19 years of age. For unmarried Children who are students at an accredited institution of learning, until age 25; coverage will last until the end of month in which the Child turns 25 years of age. If the Child is no longer a student between the ages of 19-25, coverage ends the last day of the month following a 3-month extension of benefits after the completion of a semester.

6. For all other Dependents, the end of the month in which the Dependent ceases to be eligible.

7. The end of the month following the 30th day after the Group's provision of written notice of termination of coverage to Us; or such later termination date requested by the Group's notice.

8. If the Subscriber has performed an act that constitutes fraud or made an intentional 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 an intentional 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 Your coverage will have a retroactive effect of up to Your enrollment under the Certificate. 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 Contract is terminated. If We decide to stop offering a particular class of group contracts, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Group and Subscribers at least 30 days' prior written notice.

10. The Group has performed an act or practice that constitutes fraud or made an intentional 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 Subscriber at least 30 days prior to when the coverage will cease.

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 Certificate for Your right to continuation of this coverage under COBRA or USERRA.

B. Extension of Benefits.

Upon termination of insurance, whether due to termination of eligibility, or termination of the Certificate, an extension of benefits shall be provided for a period of no less than 60 days for completion of a dental procedure that was started before Your coverage ended.

SECTION THIRTEEN

CONTINUATION OF COVERAGE/COBRA

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. Plans may also allow for New York State's mini-COBRA continuation of coverage provisions which would extend coverage up to 36 months, regardless of the reason that the employee became ineligible for coverage. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA and/or mini-COBRA. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA and/or mini-COBRA.

Qualifying Events.

Pursuant to federal COBRA, You, the Subscriber, Your Spouse, domestic partner and Your Children may be able to temporarily continue coverage under this Certificate in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g., a reduction in the number of hours of employment) You may continue coverage. Coverage may be continued for You, Your Spouse, domestic partner and any of Your covered Children.

2. If You are a covered Spouse or domestic partner, You may continue coverage if Your 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;
    - Ending of a domestic partnership with the Subscriber or no longer meeting domestic partner eligibility requirements;
    - Death of the Subscriber; or

3. If You are a covered Child, You may continue coverage if Your 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 Subscriber; or

If You want to continue coverage You 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 You are sent notice by first class mail of the right of continuation by the Group.

Qualifying Events. (continued)

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 36 months after the Subscriber's coverage would have terminated because of termination of employment.
2. If You are a covered Spouse, domestic partner or Child the date 36 months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, or the failure to qualify under the definition of "Children";
3. The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
4. The date You become entitled to Medicare;
5. The date to which Premiums are paid if You fail to make a timely payment; or
6. The date the Group Contract terminates. However, if the Group Contract is replaced with similar coverage, You have the right to become covered under the new Group Contract for the balance of the period remaining for Your 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 Your Group to find out if You are entitled to temporary continuation of coverage under USERRA. In most scenarios, benefits will continue to be provided at no additional cost.

SECTION FOURTEEN

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 Certificate does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider.

2. Assignment.

You cannot assign any benefits or monies due under this Certificate or legal claims based on a denial of benefits or request for plan documents to any person, corporation or other organization. Any assignment of benefits or legal claims based on a denial of benefits or request for plan documents by You will be void and unenforceable. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Certificate or Your right to collect money from Us for those services or Your right to sue based on a denial of benefits or request for plan documents. Nothing in this paragraph shall affect Your right to appoint a designee or representative as otherwise permitted by applicable law.

3. Changes in this Certificate.

We may unilaterally change this Certificate upon renewal to make changes required by applicable law or regulation or to make changes that do not substantively modify Covered Services, benefits or member eligibility, if We give the Group 30 days' prior written notice. Any other changes must be mutually agreed upon in writing between Us and Your Group in conjunction with the State's Joint Labor Management Committee.

4. Choice of Law.

This Certificate 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 Certificate, or any other documentation issued by Us in connection with this Certificate, 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 Certificate 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 Certificate may be limited to a specific number of visits, and/or subject to a Deductible, if applicable. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

8. Enrollment.

The Group will provide Us with an enrollment file that will include Your name, address, age, and social security number and advise Us when You are to be added to or subtracted from Our list of covered persons on a weekly basis. If the Group fails to so advise Us, the Group will be responsible for the cost of any claims paid by Us as a result of such failure. In no event will retroactive additions to or deletions from coverage be made for periods in excess of thirty (30) days.

9. Entire Agreement.

This Certificate, including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.

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 Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with information over the telephone for reasons such as the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Provider ; or to make decisions regarding the Medical Necessity of Your 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 Certificate.

13. Incontestability.

No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. 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 You while receiving care from any Participating Provider or in any Participating Provider's office or facility.

15. Material Accessibility.

We will give You ID cards, Certificates, riders and other necessary materials.

16. More Information about Your Dental Plan.

You can request additional information about Your coverage under this Certificate. Upon Your 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 (e.g. Medical Necessity 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. Non-Vesting.

Under no circumstances do you acquire a vested interest in continued receipt of a particular benefit or level of benefits. Benefits shall be determined according to the Group Contract terms in effect when an expense is incurred. Benefits may be amended at any time in accordance with applicable provisions of this Certificate and the Group Contract.

18. Notice.

Any notice that We give You under this Certificate will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery or to the address of the Group. If notice is delivered to You electronically, You may also request a copy of the notice from Us. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. mail, first class, postage prepaid to: the address on Your ID card.

19. Premium Refund.

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

20. Recovery of Overpayments.

On occasion, a payment will be made to You when You 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 You and You 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.

21. Renewal Date.

The renewal date for this Certificate is the anniversary of the effective date of the Group Contract of each year. This Certificate will automatically renew each year on the renewal date, unless otherwise terminated by Us or the Group as permitted by this Certificate.

22. 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 Certificate. We may also develop or adopt administrative rules pertaining to administrative matters. Those standards and rules will not be contrary to the descriptions in this Certificate. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate.

23. Right to Offset.

If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

24. Severability.

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

25. Significant Change in Circumstances.

If We are unable to arrange for Covered Services as provided under this Certificate 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.

26. Subrogation and Reimbursement.

These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for Your 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 Your own insurance carrier) for the benefits We have provided to You under this Certificate. Subrogation means that We have the right, independently of You, 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 You or anyone on Your behalf receives payment from any responsible party (including Your 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 You did not take any action against Our rights or violate any contract between You and Us. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

We request that You notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by You for which We have provided benefits. You 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.

27. Third Party Beneficiaries.

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

28. 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 Certificate. You must start any lawsuit against Us under this Certificate within two (2) years from the date the claim was required to be filed.

29. Translation Services.

Translation services are available under this Certificate for non-English speaking Members. Please contact Us at the number on Your ID card to access these services.

30. Venue for Legal Action.

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

31. Waiver.

The waiver by any party of any breach of any provision of this Certificate 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.

32. Who May Change this Certificate.

The policies and benefits described in this booklet are established by Us in conjunction with the State of New York through negotiations with State employee unions and administratively for unrepresented groups. Policies and benefits may also be affected by federal and state legislation and court decisions. Except as specifically provided otherwise, no employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Certificate on Our behalf in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation. Changes to this Certificate may be made upon written agreement between Us and the Group in conjunction with the State's Joint Labor Management Committee, and signed by Our Chief Executive Officer ("CEO") and/or President or a person designated by the CEO and/or President.

33. Who Receives Payment under this Certificate.

Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider and those services are covered under this Certificate, We reserve the right to pay either the Subscriber or the Provider.

34. Workers' Compensation Not Affected.

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

35. Your Dental Records and Reports.

In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your dental records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals, or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate, except as prohibited by state or federal law, You automatically give Us or Our designee permission to obtain and use Your dental records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your 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 Your 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 Your dental records by Us.

We agree to maintain Your dental information in accordance with state and federal confidentiality requirements. However, to the extent permitted under state or federal law, You automatically give Us permission to share Your 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 Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.