

This is Your

PREFERRED PROVIDER ORGANIZATION

CERTIFICATE OF COVERAGE

Issued by

MVP Health Services Corp.

This Certificate of Coverage (“Certificate”) explains the benefits available to You under a Group Contract between MVP Health Services Corp. (hereinafter referred to as “We”, “Us”, or “Our”) and the Group listed in the Group Contract. This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

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 care is provided by Participating Providers in Our Network affiliate’s Healthplex Exchange Network. You should always consider receiving dental 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.

The insurance evidenced by this Certificate provides DENTAL insurance ONLY.

By:

A handwritten signature in black ink, appearing to read "Chris Del Vecchio". The signature is written in a cursive style with a large initial "C".

Christopher Del Vecchio,
Chief Executive Officer
MVP Health Services Corp.

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SECTION I - Definitions

Defined terms will appear capitalized throughout the Certificate.

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

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

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

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 MVP Health Services Corp., including the Schedule of Benefits and any attached riders. The Certificate explains the benefits available to You under the Group Contract.

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. The amount can vary by the type of Covered Service.

Contract: The Contract entered into between MVP Health Services Corp. and the Group and any riders attached to the Contract.

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.

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

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for 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 Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service that You owe before We begin to pay for a particular Covered Service.

Dependents: The Subscriber's Spouse.

Emergency Dental Care: Emergency dental treatment required to alleviate pain and suffering caused by dental disease or trauma. Refer to the Adult Dental Care 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 employer or party that has entered into an agreement with Us as a contractholder.

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 rehabilitative 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.

In-Network Cost-Sharing: Amounts You must pay to a Participating Provider for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

In-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Participating Providers. The In-Network Deductible applies before any Copayments or Coinsurance are applied. The In-Network Deductible may not apply to all Covered Services. You may also have an In-Network Deductible that applies to a specific Covered Service that You owe before We begin to pay for a particular Covered Service.

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, "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 does not have a contract with Us to provide health care 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.

Out-of-Network Cost-Sharing: Amounts You must pay to a Non-Participating Provider for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Out-of-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Non-Participating Providers. The Out-of-Network Deductible applies before any Copayments or Coinsurance are applied. The Out-of-Network Deductible may not

apply to all Covered Services. You may also have an Out-of-Network Deductible that applies to a specific Covered Service that You owe before We begin to pay for a particular Covered Service

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

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

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

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

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

Premium: The amount that must be paid for Your dental insurance coverage.

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.

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

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of: Albany, Broome, Cayuga, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, Steuben, St. Lawrence, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Westchester, Wyoming and Yates Counties.

Specialist: A dentist who focuses on a specific area of dentistry, including oral surgery, endodontia, and periodontia, 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.

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.

Us, We, Our: MVP Health Services Corp. 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 (including treatment for a rare disease or a clinical trial).

You, Your: The Member.

SECTION II - How Your 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/or 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;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of 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 the number on Your ID card; or
- Visit Our website at mvphealthcare.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"). This Certificate requires that You select a PCD. Although You are encouraged to receive care from Your PCD, You do not need a written Referral from Your PCD before receiving Specialist care from a Participating Provider.

You may select any participating PCD who is available from the list of PCDs in the PPO Healthplex Exchange Network. Each Member may select a different PCD.

For purposes of Cost-Sharing, if You seek services from a PCD (or a dentist covering for a PCD) who has a primary or secondary specialty other than general dentistry, You must pay the specialty office visit Cost-Sharing in the Schedule of Benefits section of this Certificate when the services provided are related to specialty care.

E. Access to Providers and Changing Providers.

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

To see a Provider, call his or her office and tell the Provider that You are an MVP Health Services Corp. 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.

To contact Your Provider after normal business hours, call the Provider's office. You will be directed to Your Provider, an answering machine with directions on how to obtain services, or another Provider. If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911.

You may change Your PCD by calling the number on the back of your ID card. This can be done at any time.

If We do not have a Participating Provider for certain provider types in the county in which You live or in a bordering county that is within approved time and distance standards, We will approve a Referral to a specific Non-Participating Provider until You no longer need the care or We have a Participating Provider in Our network that meets the time and distance standards and Your care has been transitioned to that Participating Provider. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing.

F. Out-of-Network Services.

We Cover the services of Non-Participating Providers. See the Schedule of Benefits section of this Certificate for the Non-Participating Provider services that are Covered. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to in-network and out-of-network services.

G. Services Subject to Preauthorization.

Our Preauthorization is required before You receive certain Covered Services. You are responsible for requesting Preauthorization for the in-network and out-of-network services listed in the Schedule of Benefits section of this Certificate.

H. Preauthorization Procedure.

If You seek coverage for services that require Preauthorization, You must call Us at the number on Your ID card.

You must contact Us to request Preauthorization at least two (2) weeks prior to a planned service. If that is not possible, then contact Us as soon as reasonably possible during regular business hours prior to the service.

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources including medical policy, clinical guidelines, and therapeutic guidelines.

I. Medical Management.

The benefits available to You under this Certificate may be subject to pre-service, concurrent and retrospective reviews to determine when services should be Covered by Us. The purpose of these reviews is to promote the delivery of cost-effective medical 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.

J. Medical Necessity.

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

We may base Our decision on a review of:

- Your dental records;
- Our dental policies and clinical guidelines;
- Dental opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed dental 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;
- The opinion of health care professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your 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 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.

K. Important Telephone Numbers and Addresses.

- **CLAIMS**
Healthplex, Inc.
Attn: Claims Dept.
P.O. Box 9255
Uniondale, NY 11553-9255
(Submit claim forms to this address.)

Claims-Referrals@healthplex.com
(Submit electronic claim forms to this e-mail address.)
- **COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS**
Call the number on Your ID card

Healthplex, Inc.
Attn: Quality Management
333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553-3608
- **EMERGENCY DENTAL CARE**
Call the number on Your ID card
Monday – Friday 9:00 a.m. – 5:00 p.m.
Evenings, Weekends and Holidays

- MEMBER SERVICES
Call the number on Your ID card
(Member Services Representatives are available Monday – Friday 8:00 a.m. – 5:00 p.m.)
- PREAUTHORIZATION
Call the number on Your ID card
- OUR WEBSITE
mvphealthcare.com

SECTION III - Access to Care and Transitional Care

A. Referral to a Non-Participating Provider.

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

B. When a Specialist Can Be Your Primary Care Dentist.

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

C. Standing Referral to a Participating Specialist.

If You need ongoing specialty care, You may receive a "standing Referral" to a Specialist who is a Participating Provider. This means that You will not need a new Referral from Your PCD every time You need to see that Specialist. We will consult with the Specialist and Your PCD and decide whether You should have a standing Referral. Any Referral will be pursuant to a treatment plan approved by Us in consultation with Your PCD, the Specialist and You. The treatment plan may limit the number of visits, or the period during which the visits are authorized and may require the Specialist to provide your PCD with regular updates on the specialty care provided as well as all necessary medical information. We will not approve a standing Referral to a non-participating Specialist unless We determine that We do not have an

appropriate Provider in Our network. If We approve a standing Referral to a non-participating Specialist, Covered Services rendered by the non-participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing.

D. When Your Provider Leaves the Network.

If You are in an ongoing course of treatment when Your Provider leaves Our network, then You may continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider's contractual obligation to provide services to You terminates.

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

E. New Members In a Course of Treatment.

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

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

SECTION IV - Cost-Sharing Expenses and Allowed Amount

A. Deductible.

Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of 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, the individual Deductible applies to each person covered under this Certificate. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year. However, after Deductible payments for persons covered under this Certificate collectively total the family Deductible amount in the Schedule of Benefits section of 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 separate In-Network and Out-of-Network Deductible. Amounts You pay for out-of-network services do not apply toward Your In-Network Deductible. Copayments and Coinsurance for in-network services do not apply 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.**

B. Copayments.

There are no Copayments for Covered Services under this Certificate.

C. Coinsurance.

Except where stated otherwise, after You have satisfied the Deductible as 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 Schedule of Benefits section of this Certificate. **You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.**

D. Out-of-Pocket Limit.

This Certificate does not have an Out-of-Pocket Limit.

E. Annual Maximum.

This Certificate has an in-network and out-of-network annual maximum for benefits described in the Adult Dental Care section of this Certificate. When Members receiving adult dental care have met the annual maximum for Covered Services in the Schedule of Benefits section of this Certificate, no more benefits will be payable for that Member for the remainder of that Plan Year. If You have other than individual coverage, the individual annual maximum for adult dental care

benefits applies to each person covered under this Certificate. Once a person within a family meets the individual annual maximum for adult dental care, no more benefits for services will be payable for that person.

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

When You receive Covered Services from a Non-Participating Provider, in addition to the applicable Copayments, Deductible and Coinsurance described in the Schedule of Benefits section of this Certificate, You must also pay the amount, if any, by which the Non-Participating Provider's actual charge exceeds Our Allowed Amount. This means that the total of Our coverage and any Cost-Sharing amounts You pay may be less than the Non-Participating Provider's actual charge.

When You receive Covered Services from a Participating or 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.

G. Allowed Amount.

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

The Allowed Amount for Participating Providers will be the amount we have negotiated with the Participating Provider.

The Allowed Amount for Non-Participating Providers will be determined as follows:

For Providers in Our Service Area.

For Providers in Our Service Area, the Allowed Amount will be an amount based on Our Participating Provider fee schedule or rate.

Our Allowed Amount is not based on UCR. The Non-Participating Provider's actual charge may exceed Our Allowed Amount. You must pay the difference between Our Allowed

Amount and the Non-Participating Provider's charge. Contact Us at the number on Your ID card or visit Our website at mvphealthcare.com for information on Your financial responsibility when You receive services from a Non-Participating Provider.

SECTION V - Who Is Covered

A. Who is Covered Under this Certificate.

You, the Subscriber to whom this Certificate is issued, are covered under this Certificate. You must live, work, or reside in Our Service Area to be 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:

1. **Individual.** If You selected individual coverage, then You are covered.
2. **Individual and Spouse.** If You selected individual and Spouse coverage, then You and Your Spouse are covered.

C. When Coverage Begins.

Coverage under this Certificate will begin as follows:

1. If You, the Subscriber, elect coverage before becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your Group.
2. If You, the Subscriber, do not elect coverage upon becoming eligible or within 30 days of becoming eligible for other than a special enrollment period, You must wait until the Group's next open enrollment period to enroll, except as provided below.
3. If You, the Subscriber, marry while covered, and We receive notice of such marriage and Premium Payment within 30 days thereafter, coverage for Your Spouse starts on the first day of the following month after We receive Your application. If We do not receive notice within 30 days of the marriage, You must wait until the Group's next open enrollment period to add Your Spouse.

D. Special Enrollment Periods.

You or Your Spouse can also enroll for coverage within 30 days of the loss of coverage in another group dental plan if coverage was terminated because You or Your Spouse are no longer eligible for coverage under the other group dental plan due to:

1. Termination of employment;
2. Termination of the other group dental plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment; or
6. Employer contributions towards the group dental plan were terminated.

You or Your Spouse can also enroll 30 days from exhaustion of Your COBRA coverage or if You gain a Dependent or become a Dependent through marriage.

We must receive notice and Premium payment within 30 days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application.

In addition, You or Your Spouse, can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. You or Your Spouse loses eligibility for Medicaid; or
2. You or Your Spouse becomes eligible for Medicaid.

We must receive notice and Premium payment within 60 days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application.

E. Domestic Partner Coverage.

This Certificate covers domestic partners of Subscribers as Spouses. 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
 - b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
 - c. Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
 - A joint bank account;
 - A joint credit card or charge card;
 - Joint obligation on a loan;

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

SECTION VI - Adult Dental Care

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits. The following benefits are provided for those Members 19 years of age and above.

We Cover the following dental care services:

- A. Emergency Dental Care.** We Cover Emergency Dental Care, which includes emergency dental treatment required to alleviate pain and suffering caused by dental disease or trauma. Emergency Dental Care is not subject to Our Preauthorization.
- B. Preventive Dental Care.** We Cover preventive dental care that includes procedures which help to prevent oral disease from occurring, including:
- Prophylaxis (scaling and polishing the teeth) at six (6) month intervals;
- C. Routine Dental Care.** We Cover routine dental care provided in the office of a dentist, including:
- Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
 - X-rays, full mouth x-rays or panoramic x-rays at 36-month intervals, bitewing x-rays at six (6) month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
 - Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
 - In-office conscious sedation; and
 - Amalgam, composite restorations and stainless-steel crowns;
- D. Endodontics.** We Cover routine endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required. In those members age 21 and over, molar endodontic therapy will be considered only in those instances where the tooth in question is a critical abutment for an existing functional prosthesis and when the tooth cannot be extracted and replaced with a new prosthesis, or, where there is a documented medical condition which precludes extraction.
- E. Periodontics.** We Cover limited periodontic services. We Cover non-surgical periodontic services. We Cover periodontic surgical services necessary for treatment related to hormonal disturbances, drug therapy, or congenital defects.
- F. Prosthodontics.** We Cover prosthodontic services as follows:
- Removable complete or partial dentures, for Members 19 years of age and above, including six (6) months follow-up care; and

- Additional services including insertion of identification slips, repairs, relines and rebases and treatment of cleft palate.

We do not Cover implants or implant related services.

Fixed bridges are not Covered unless they are required:

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

G. Oral Surgery. We Cover non-routine oral surgery, such as partial and complete bony extractions, tooth re-implantation, tooth transplantation, surgical access of an unerupted tooth, mobilization of erupted or malpositioned tooth to aid eruption, and placement of device to facilitate eruption of an impacted tooth.

SECTION VII - 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. 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. Coverage Outside of the United States, Canada or Mexico.

We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico.

D. 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.

E. Felony Participation.

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

F. Foot Care.

We do not Cover foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.

G. Government Facility.

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

H. Medical Services.

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

I. Medically Necessary.

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

J. Medicare or Other Governmental Program.

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

K. Military Service.

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

L. No-Fault Automobile Insurance.

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

M. Services Not Listed.

We do not Cover services that are not listed in this Certificate as being Covered.

N. Services Provided by a Family Member.

We do not Cover services performed by a covered person's immediate family member. "Immediate family member" means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, child-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild, or grandchild's spouse.

O. Services Separately Billed by Hospital Employees.

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

P. Services with No Charge.

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

Q. Vision Services.

We do not Cover the examination or fitting of eyeglasses or contact lenses.

R. War.

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

S. 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 VIII - 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 the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us. See the Coordination of Benefits section of this Certificate for information on how We coordinate benefit payments when You also have group health coverage with another plan.

B. Notice of Claim.

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

C. Timeframe for Filing Claims.

Claims for services must be submitted to Us for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120-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 clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by New York Public Health Law Section 238-a (1).

E. Claim Determinations.

Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our Claim determination procedure applies to contractual benefit denials and Referrals. If 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 or Referral), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

If We need additional information, We will request it within 15 days from receipt of the claim. 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.

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 deny the claim in whole or in part. 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 if We deny the claim in whole or in part.

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 IX - 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 phone at the number on Your ID card or in writing to file a Grievance. 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 800-777-4793 or visit Our website at mvphealthcare.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 two (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: 30 business days of receipt of all necessary
(That are not in relation to a claim or request information to make a determination.
for a service or treatment.)

E. Assistance.

If You remain dissatisfied with Our 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 them at:

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

If You need assistance filing a Grievance, You may also contact the state independent Consumer Assistance Program at:

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

SECTION X - 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 Physicians; or 2) licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical 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 **mvphhealthcare.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 800-777-4793 or visit Our website at **mvphhealthcare.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 earlier of the receipt of part of the requested information or 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. 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.

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), 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), 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 the earlier of 15 calendar days of receipt of part of the requested information or 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) 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) within the earlier of 72 hours or of one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. 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) 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 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 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.

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.

1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, You, or Your designee, must submit:
 - A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
 - Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

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

- Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

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 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, 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.

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 Ave., 10th Floor

New York, NY 10017

Or call toll free: 1-888-614-5400, or email **cha@cssny.org**

Website: **communityhealthadvocates.org**

SECTION XI - 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 clinical trials and treatments for rare diseases), 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 clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph "A" above and Your attending Physician 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).

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

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which Your attending Physician 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 Physician 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 Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

D. Your Right to Appeal a Determination that a Service is Out-of-Network.

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

In addition, Your attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

E. Your Right to Appeal an Out-of-Network Referral Denial to a Non-Participating Provider.

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

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

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

F. 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.

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 Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician 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 Physician 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, 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.

G. 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 XII - 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 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 a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.
3. **“Primary plan”** is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).
4. **“Secondary plan”** is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules 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 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, and is also covered under another plan as a laid-off or retired employee or as the spouse of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse 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.
4. 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.

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 non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

SECTION XIII - 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. The end of the month in which the Subscriber ceases to meet the eligibility requirements as defined by the Group.
3. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium has been paid.
4. For Spouses in cases of divorce, the date of the divorce.
5. For all other Dependents, the day the Dependent ceases to be eligible.
6. 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.
7. 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. 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.
8. 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.
9. 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.

10. 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.
11. 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.
12. The date there is no longer any enrollee who lives, resides, or works in Our Service Area.

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

See the Continuation of Coverage section of this Certificate for Your right to continuation of this coverage under COBRA or USERRA.

SECTION XIV - 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 30 days for completion of a dental procedure that was started before Your coverage ended.

SECTION XV - Continuation of Coverage

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

Qualifying Events.

Pursuant to federal COBRA, You, the Subscriber and Your Spouse 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.
2. If You are a covered Spouse, 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;
 - Death of the Subscriber; or
 - The covered employee becoming entitled to Medicare.

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.

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

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

1. The date 18 months after the Subscriber's coverage would have terminated because of termination of employment; provided that the Subscriber or their dependents may continue for a total of 29 months if the Member is determined to be disabled under the United States Social Security Act;

2. If You are a covered Spouse the date 36 months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the Subscriber's eligibility for Medicare;
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.

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

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

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

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

1. This shall not apply to the coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.
2. If You or Your Dependent's coverage under a health plan is terminated by reason of the person having become eligible for federal health insurance for former members of the uniformed services and their dependents, but subsequently do not commence a period of active duty under the order to active duty that established such eligibility because the order is canceled before such active duty commences, any exclusion or waiting period in connection with the reinstatement of coverage shall apply to the continued employment in the same manner as if You or Your Dependents had become reemployed upon such termination of eligibility.

SECTION XVI - 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 or any dental benefits program.

2. Assignment.

You cannot assign any benefits under this Certificate to any person, corporation, or other organization and any such assignment will be void and unenforceable.

Assignment means the transfer to another person, corporation or organization of Your right to the services provided under this Certificate.

3. Changes in This Certificate.

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

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 conflicts 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, a benefit maximum, and/or subject to a Deductible. 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 ERISA.

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

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

9. Entire Agreement.

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

10. 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 certain information over the telephone for reasons such as the following: to determine the level of care You need; so that We may certify care authorized by Your Provider; or 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.

11. 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. To be entitled to such services or benefits, Your Premiums must be paid in full at the time that the services are sought to be received.

12. 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.

13. Input in Developing Our Policies.

Subscribers may participate in the development of Our policies by calling the number on the back of your ID card.

14. Material Accessibility.

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

15. 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.

16. Notice.

Any notice that We give You under this Certificate will be mailed to Your address as it appears in Our records or to the address of the Group. 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.

17. Premium Refund.

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

18. Recovery of Overpayments.

On occasion a payment may 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.

19. 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.

20. 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. Those standards 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 may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate.

21. 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.

22. Severability.

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

23. Third Party Beneficiaries.

No third party beneficiaries are intended to be created by this Certificate and nothing in the 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.

24. 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.

25. Translation Services.

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

26. 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.

27. Who May Change this Certificate.

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

28. 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, We reserve the right to pay either the Subscriber or the Provider regardless of whether an assignment has been made.

29. 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.

30. 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.