THIS IS YOUR

NEW YORK STATE DENTAL EXCHANGE CERTIFICATE

issued by

HEALTHPLEX INSURANCE COMPANY

This Certificate of Coverage "Certificate" explains the benefits available to You under a Group Policy between Healthplex Insurance Company ("HIC") (hereinafter referred to as "We", "Us", or Our") and the Group Policyholder listed in the Group Policy.

In-Network Benefits. This Certificate only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers in our Healthplex network. Care Covered under this Certificate must be provided, arranged or authorized in advance by Your Primary Care Dentist and, when required, approved by Us. In order to receive the benefits under this Certificate, You must contact Your Primary Care Dentist before You obtain the services except for services to treat an Emergency Condition. Except for care for an Emergency Condition, You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.

Disclosure: This policy provides DENTAL insurance ONLY. This policy does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.

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

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

Signed By:

_____

President

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

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SECTION I – DEFINITIONS

Throughout this Dental Certificate, these words will mean the following:

Acute: The sudden onset of disease or injury, or a sudden 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.

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 Healthplex Insurance Company, including the Schedule of Benefits and any attached riders.

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

Coinsurance: your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider.

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 Coinsurance, Copayments, and/or Deductibles.

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

Deductible: the amount You owe before We begin to pay for Covered Services. The Deductible applies before any Coinsurance or Copayments are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (for example, a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Dental Services: (except as limited or excluded under this Certificate) means those professional services of Dentists or Other Participating Health Professionals, including surgical and preventive services approved by HIC.

Dependents: The Subscriber's Spouse.

Emergency Condition: a medical or behavioral condition, that manifests itself by Acute symptoms of sufficient severity, including severe pain that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or,
- Serious disfigurement of such person.

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

External Appeal Agent: an entity that has been certified by the 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.

Health Care Professional: An appropriately licensed, registered or certified Physician; osteopath; dentist; optometrist; chiropractor; psychologist; psychiatrist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist certified to administer immunizing agents; or any other licensed, registered or certified Health Care Professional under Title 8 of the Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Certificate.

HIC: means the Healthplex Insurance Company, dental service corporation licensed under Article 42 of the New York State Insurance Laws.

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

Identification Card: means the card that HIC issues to Members upon enrollment. When a Member arrives at a Participating Provider to receive Covered Services, the Member must show the provider his or her Identification Card to verify coverage by HIC.

Medically Necessary: See section II of this Certificate for the definition.

Member: The Subscriber and Covered Dependents for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, "Member" also means the Member's designee.

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

Out-of-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 health care services We do not Cover.

Participating Provider: means any Dentist, Other Participating Health Professional, and Other Participating Health Care Facility that We have authorized to provide Covered Services to You under this Certificate. A list of Participating Providers and their locations is available on Our website at www.healthplex.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.

Policy: The Policy issued by Healthplex Insurance Company and issued to the Policyholder including the Schedule of Benefits and any attached riders.

Preauthorization: a decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device that the Covered Service, treatment plan, 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 health 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 dentist under Title 8 of the Education Law (or other comparable state law, if applicable) that the New York Insurance law required to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be Covered under the Policy.

Referral: an authorization given to one Participating Provider from another Participating Provider (usually from a PCD to a Participating 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. Except as provided in section III of this Certificate or as otherwise authorized by Us, a Referral will not be made to a Non-Participating Provider

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

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

Specialist: A dentist who focuses on a specific area of dentistry, (including Oral Surgery, Endodontia, Periodontia, Orthodontia, and Pediatric Dentistry) or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

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

Subscriber: The person to whom this Certificate is issued.

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

Urgent Care: medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency department care. Urgent Care may be rendered in a Participating Provider's office or Urgent Care Center.

Us, We, Our: Healthplex Insurance Company and anyone to whom we legally delegate to perform, on Our behalf, under the 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 clinical trial).

You, Your: the Member.

SECTION II – HOW YOUR COVERAGE WORKS

1. **Your Coverage under this Certificate.** Your employer (referred to as the "Group Policyholder") has purchased a Group Dental Policy from Us. We will provide the benefits described in this Certificate to members of the Group, that is, to employees of the Group and their Covered Dependents. However, this Certificate is not a contract between You and Us. You should keep this Certificate with Your other important papers so that it is available for Your future reference.

2. **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;
   - Listed as a Covered Service;
   - Not in excess of any benefit limitations described in the Covered Dental Services in section VI of this Certificate; and
   - Received while Your Certificate is in force.

3. **Participating Providers.** To find out if a Provider is a Participating Provider:
   - Check Your Provider directory, available at Your request. Call Healthplex, Inc. our dental administrator, at 888-468-5175
   - Visit Healthplex's website at www.healthplex.com.

4. **The Role of Primary Care Dentists.** This Certificate has a gatekeeper, usually known as a Primary Care Dentist (PCD). You need a written Referral from a 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 Healthplex Network. .

   Your PCD is responsible for determining the most appropriate treatment for Your dental care needs. You do not need a Referral from Your PCD to a Participating Provider for the following services:
   - Emergency Dental Care
   - Preventive Dental Care; and
   - Routine Dental Care;

   provided that the Participating Provider discusses the services and treatment plan with Your PCD; agrees to follow Our policies and procedures including any procedures regarding Referrals or Preauthorization for services rendered by such Participating Provider; and agrees to provide services pursuant to a treatment plan (if any) approved by Us.

5. **Services Subject To Preauthorization.** Our Preauthorization is required before You receive certain Covered Dental Services. Your PCD is responsible for requesting Preauthorization for in-network services listed in the Covered Dental Services of this Certificate.

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

7. **Care Must Be Medically Necessary.** We Cover benefits described in this Certificate as long as the dental care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

   We may base Our decision on a review of: Your medical records; Our medical policies and clinical guidelines; medical opinions of a professional society, peer review committee or other groups of Physicians; reports in peer-reviewed medical literature; reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data; professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment; the opinion of Health Care Professionals in the generally-recognized health specialty involved; and the opinion of the attending Providers, which have credence but do not overrule contrary opinions.

   Services will be deemed Medically Necessary only if:
   - They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for 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 medical practice;
   - They are not primarily for the convenience of You, Your family, or Your Dental Provider;
   - They are not more costly than an alternative service or sequence of services, that is they are at least as likely to produce equivalent therapeutic or diagnostic results.

   When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example we will not provide coverage for an inpatient admission for dental surgery if the surgery could have been performed on an outpatient basis.

See section IX of this Certificate for Your right to an internal appeal and external appeal of our determination that a service is not Medically Necessary.

8. Important Telephone Numbers and Addresses.

CLAIMS
Healthplex, Inc.
333 Earle Ovington Blvd.
Uniondale, NY 11553
*Submit claim forms to this address.

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

MEDICAL EMERGENCIES AND URGENT CARE
888-468-5175
24-hour/7 day coverage

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

PREAUTHORIZATION
Healthplex, Inc.
333 Earle Ovington Blvd.
Uniondale, NY 11553
888-468-5175

OUR WEBSITE
www.healthplex.com

SECTION III – ACCESS TO CARE AND TRANSITIONAL CARE

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. Approvals of Referrals to Non-Participating Providers will not be made for the convenience of You or another treating Provider. Your Participating Provider must request prior approval of the Referral to a specific Non-Participating Provider. 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, Your Non-Participating Provider and You. Covered Dental 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.

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 be responsible only for any applicable In-Network Cost-Sharing.

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 Dental 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.

When Your Provider Leaves the Network

If You are in an ongoing course of treatment when Your Provider leaves Our Network, then You may be able to continue to receive Covered Dental Services for the ongoing treatment from the

former Participating Provider for up to ninety (90) days from the date Your Provider's contractual obligation to provide services to You terminates.

In order for You to continue to receive Covered Dental Services for up to ninety (90) days with a former Participating Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to 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. If the Provider agrees to these conditions, You will receive the Covered Dental 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.

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 sixty (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 sixty (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 be responsible only for any applicable In-Network Cost-Sharing.

SECTION IV – COST-SHARING EXPENSES AND ALLOWED AMOUNT

1. Deductible. Except where stated otherwise, You must pay the amount in the Schedule of Benefits in Sections XIV and XV of this Certificate for Covered Dental Services during each Plan Year before We provide coverage. Once a person meets the individual Deductible, no further Deductible is required for that Plan Year.

2. Copayments. Except where stated otherwise, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits in Sections XIV and XV of this Certificate for Covered Dental Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

3. Coinsurance. Except where stated otherwise, after You have satisfied the annual Deductible described above, You must pay a percentage of the Allowed Amount for Covered Dental Services. We will pay the remaining percentage of the Allowed Amount as shown in the Schedule of Benefits in Sections XIV and XV of this Certificate.

SECTION V – WHO IS COVERED

Who is Covered Under this Certificate. You the Member 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 Policy. If You selected one of the following types of coverage, members of Your family may also be covered.

Types of Coverage

In addition to Individual coverage, We offer the following types of coverage:

Individual and Spouse - If You selected Individual and Spouse coverage, then You and Your Spouse are covered.

When Coverage Begins

Coverage under this Certificate will begin as follows:

1. If You, the Member 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. Groups cannot impose waiting periods that exceed 90 days.
2. If You, the Member 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 Member, marry while covered, and We receive notice of such marriage within 30 days thereafter, coverage for Your Spouse starts on the first day of the month following such marriage. 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.

Special Enrollment Periods

You or Your Spouse can also enroll for coverage within 30 days of the occurrence of one of the following events:

1. You or Your Spouse loses minimum essential coverage.
2. Your enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange as evaluated and determined by the Exchange.
3. You adequately demonstrate to the Exchange that another qualified health plan in which You were enrolled substantially violated a material provision of its contract.
4. You move and become eligible for new qualified health plans.

5. If You are an Indian, as defined in 25 U.S.C. 450b(d), You may enroll in a qualified health plan or change from one qualified health plan to another one time per month.
6. You demonstrate to the Exchange that You meet other exceptional circumstances as the Exchange may provide.

We must receive notice and premium payment within 30 days of one of these events. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month. But, if You enroll because You lost minimum essential coverage, Your coverage will begin on the first day of the month following Your loss of coverage

In addition, You or Your Spouse, can also enroll for coverage within 30 days of the occurrence of one of the following events:

1. You or Your Spouse loses eligibility for Medicaid or a state child health plan.
2. You or Your Spouse becomes eligible for Medicaid or a state child health plan.

We must receive notice and premium payment within 30 days of one of these events. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

Domestic Partner Coverage

This Certificate covers domestic partners of Members 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 months, where such registry exists, or

2. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.

a. The affidavit must be notarized and must contain the following:
   - The partners are both eighteen 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 laws of the State of New York
   - The partners have been living together on a continuous basis prior to the date of the application;
   - Neither individual has been registered as a member of another domestic partnership within the last six months; and

b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and

c. Proof that the partners are financially interdependent. Two 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 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
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

SECTION VI – COVERED SERVICES

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

A. Pediatric Dental Care

We Cover the following dental care services for Adults under the age of 19:

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

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

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

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

- Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
- X-ray, full mouth x-rays at thirty-six (36) month intervals, bitewing x-rays at six (6) to twelve (12) month intervals, or panoramic x-rays at thirty-six (36) 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 General Anesthesia;
- Amalgam, composite restorations and stainless steel crowns; and
- Other restorative materials appropriate for children.

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

Prosthodontics: We Cover prosthodontic services as follows:

- Removable complete or partial dentures, including six (6) months follow-up care; and
- Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate.

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.

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

Procedures include but are not limited to:

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

B. Adult Dental Care

We Cover the following dental care services for Adults age 19 and over:

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

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

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

- Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);

- X-ray, full mouth x-rays at thirty-six (36) month intervals, bitewing x-rays at six (6) to twelve (12) month intervals, or panoramic x-rays at thirty-six (36) 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 General Anesthesia;
- Amalgam, composite restorations and stainless steel crowns; and
- Other restorative materials appropriate for Adults.

Endodontics: We Cover endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required. Please note that in most cases molar root canals are not covered services for Adults.

Prosthodontics: We Cover prosthodontic services as follows:

- Removable complete or partial dentures, including six (6) months follow-up care; and
- Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate.

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.

SECTION VII – EXCLUSIONS

No Coverage is available under this Certificate for the following:

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

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

Cosmetic Services. We do not Cover cosmetic services, Prescription Drugs, or surgery except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (for example, 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 section IX of this Certificate.

Coverage Outside of the United States, Canada or Mexico. We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services to treat Your Emergency Condition.

Experimental or Investigational Treatment. We do not Cover any health care service, procedure, treatment, device, or Prescription Drug 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 the Certificate for non-investigational treatments. See section IX of this Certificate for a further explanation of Your Appeal rights.

Felony Participation. We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence.

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 unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

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

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).

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

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.

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

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

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

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

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.

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

SECTION VIII - CLAIM DETERMINATIONS

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.

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. Completed claim forms should be sent to the address in Section II of this Certificate.

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.

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 N.Y. Public Health Law § 238-a(1).

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 Referrals and contractual benefit denials. If You disagree with Our claim determination you may submit a Grievance pursuant to section IX of this Certificate.

For a description of the Utilization Review procedures and Appeal process for Medical Necessity or experimental or investigational determinations, see section IX of this Certificate.

A pre-service claim is a request that a service or treatment be approved before it has been received. A post-service claim is a request for a service or treatment that You have already received.

Pre-service Claim Determinations.
If We have all the information necessary to make a determination regarding a pre-service claim (for example a Referral or a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

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.

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 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 time period. Written notice will follow within three calendar days of the decision.

Post-service Claim Determinations.
If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period.

SECTION IX – GRIEVANCE, UTILIZATION REVIEW & EXTERNAL APPEALS

I. GRIEVANCES

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.

Filing a Grievance. You can contact Us by phone at 888-468-5175 or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a referral or a Covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when you received the decision you are asking Us to review to file the Grievance.

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

We keep all requests and discussions confidential and We'll 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.

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 the 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 a 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 service.)	In writing, within 45 calendar days of receipt of all necessary information.

Grievance Appeals. If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone, in person, or in writing. However, Urgent Appeals may be filed by phone. You have up to [60] business days from receipt of the Grievance determination to file an Appeal.

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

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

Expedited/Urgent Grievances:	The earlier of 2 business days of receipt of the 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 a treatment that has already been provided.)	30 calendar days of receipt of Your Appeal.
All Other Grievances: that are not in relation to a claim or request for service.)	30 business days of receipt of all necessary information to make a determination.

If You remain dissatisfied with Our Grievance determination or at any other time You are dissatisfied, You may:

Call the New York State Department of Health at
1-800-206-8125 or write them at:
New York State Department of Health
Bureau of Certification and Surveillance
Corning Tower
Empire State Plaza
Albany, NY 12237
www.health.ny.gov

Call the New York State Department of Financial Services
1-800-342-3736 or write them at:
New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov

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

Community Health Advocates
105 East 22nd Street
New York, NY. 10010
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org

II. UTILIZATION REVIEW

We review health services to determine whether the services are or were Medically Necessary or experimental or investigational. This process is called Utilization Review (UR). 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 888-468-5175.

All determinations that services are not Medically Necessary will be made by licensed Physicians or by licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the health care 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 or were 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, You can contact Us.

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 business days of receipt of the request.

If We need additional information, We will request it within 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 business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

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 follow within one calendar day of the decision. 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 and Your Provider by telephone and in writing within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour time period.

Concurrent Reviews

Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one business day of receipt of all necessary information. If We need additional information, We will request it within one business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one business of Our receipt of the information or, if We do not receive the information, within 15 calendar days of the end of the 45-day time period.

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 and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one business day of receipt of the request for coverage if all necessary information was included or three calendar days from the verbal notification if all necessary information was not included. If the request for coverage is not made at least 24 hours prior to

the expiration of a previously approved treatment, the Urgent Preauthorization Review timeframes apply.

Retrospective Reviews
If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period.

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

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.

Reconsideration
If We did not attempt to consult with Your Provider before making an adverse determination, Your Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For Preauthorization and concurrent reviews, the reconsideration will take place within one 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.

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, in person, 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 include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before

a decision can be made. A clinical peer reviewer who is a Physician or a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the Appeal.

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 business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

If Your Appeal relates to a retrospective claim, We will decide the Appeal within 60 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

Expedited Appeals. Appeals of reviews 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. Expedited Appeals are not available for retrospective reviews. For expedited Appeals, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited Appeals will be determined within the lesser of 72 hours from receipt of the Appeal or two 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 60 calendar days of receipt of the necessary information for a standard Appeal or within two business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

If you need Assistance filing an Appeal You may contact the state independent Consumer Assistance Program at:

Community Health Advocates
105 East 22nd Street
New York, NY. 10010
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org

III. External Appeal

I. YOUR RIGHT TO AN EXTERNAL APPEAL

In some cases, You have a right to an external appeal of a denial of coverage. Specifically, if We have denied coverage on the basis that a service does not meet Our requirements for Medical Necessity (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 requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under the 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).

II. YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS NOT MEDICALLY NECESSARY

If We have denied coverage on the basis that the service does not meet Our requirements for Medical Necessity, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in I above.

III. 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, You must satisfy the two requirements for an external appeal in I above and Your attending Physician must certify that: (1) Your condition or disease is one for which standard health services are ineffective or medically inappropriate; **or** (2) one for which there does not exist a more beneficial standard service or procedure covered by Us; **or** (3) one for which there exists a clinical trial or rare disease treatment (as defined by law).

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

- 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);
- A clinical trial for which You are eligible (only certain clinical trials can be considered); or
- 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.

IV. 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 requirements for an external appeal in I 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.

You do not have a right to an external appeal for a denial of a Referral to an Out-of-Network provider on the basis that a health care provider is available In-Network to provide the particular health service requested by You.

V. 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 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 seventy-two (72) hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must try to 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 costs 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 research, or costs which would not be Covered under this Certificate for non-experimental or non-investigational treatments provided in the clinical trial.

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

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

VI. 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 X – COORDINATION OF BENEFITS

This section applies when you also have group health 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 prevents duplicate payments and overpayments.

Definitions

"Allowable expense" is the necessary, reasonable, and customary item of expense for health 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.

"Plan" is other group health coverage with which We will coordinate benefits. The term "plan" includes:

1. Group health benefits and group blanket or group remittance health 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.

2. Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.

3. Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

"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).

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

Rules to Determine Order of Payment

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

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

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

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

4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:

    a. The plan of the parent who has custody will be primary;

    b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.

    c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

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

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

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.

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.

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.

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 XI – TERMINATION OF COVERAGE

Coverage under this Certificate will automatically be terminated on the first of the following to apply. In all cases of termination, unless otherwise noted below, We will provide at least 30 days prior written notice to the Group.

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 You have coverage for Dependents. If You have 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. The end of the month during which the Subscriber provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.

6. If a Subscriber has performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on his/her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber. However, if a Subscriber makes an intentional misrepresentation of material fact in writing on his/her enrollment application we will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Certificate

7. The date that the Group Policy is terminated. If We terminate and/or 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 90 days prior written notice.

8. 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.

9. The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage.

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

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

See sections XII of this Certificate for Your right to continuation of this coverage.

SECTION XII – WHAT HAPPENS IF YOU LOSE COVERAGE

EXTENSION OF BENEFITS

When Your coverage under this Policy ends, benefits stop. Upon termination of insurance, whether due to termination of Your employment, termination of Your eligibility, or termination of the policy, there will be an extension of benefits for a period of no less than 30 days for completion of a dental procedure that was started before your coverage ended.

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.

Pursuant to federal COBRA continuation coverage laws, 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 and Your Spouse.

2. If You are a Covered Spouse, You may continue coverage if Your coverage ends due to:
    a. Voluntary or involuntary termination of the Covered employee's employment;
    b. Reduction in the hours worked by the Covered employee or other change in the employee's class;
    c. Divorce or legal separation of the Covered employee;
    d. Death of the Covered employee; or
    e. The Covered employee becoming entitled to Medicare.

If You want to continue coverage You must request continuation from Your employer 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 Policyholder.

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

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

1. The date 36 months after Your coverage would have terminated because of termination of employment;

2. If You are a Covered Spouse the date 36 months after coverage would have terminated due to the death of the employee, divorce or legal separation, the employee's eligibility for Medicare, or the failure to qualify under the definition of "Children";
3. The date You become Covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
4. The date You become entitled to Medicare;
5. The date to which Premiums are paid if You fail to make a timely payment; or
6. The date the Group Policy terminates. However, if the Group Policy is replaced with similar coverage, You have the right to become covered under the new Group Policy for the balance of the period remaining for Your continued coverage.

Supplementary Continuation and Temporary Suspension Rights During Active Duty.

If You, the Subscriber are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to continuation, or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if Your Group does not voluntarily maintain Your coverage and if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government, and

2. You serve no more than four years of active duty.

When Your Group does not voluntarily maintain Your coverage during active duty, coverage under this Certificate will be suspended unless You elect to continue coverage in writing within 60 days of being ordered to active duty and You pay the Group Policyholder the required Premium payment but not more frequently than on a monthly basis in advance. This right of continuation extends to You and Your eligible Dependents. Continuation of coverage is not available for any person who is eligible to be covered under Medicare; or any person who is covered as an employee, member or dependent under any other insured or uninsured arrangement which provides group hospital, surgical or medical coverage, except for coverage available to active duty members of the uniformed services and their family members.

Upon completion of active duty:

1. Your coverage under this Certificate may be resumed as long as You are reemployed or restored to participation in the Group upon return to civilian status. The right of resumption extends to coverage for Your Covered Dependents. For coverage that was suspended while on active duty, coverage under the Group plan will be retroactive to the date on which active duty terminated.

2. If You are not reemployed or restored to participation in Your Group upon return to civilian status, You will be eligible for continuation as long as You apply to Us for coverage within 31 days of the termination of active duty or discharge from a Hospitalization resulting from active duty as long as the Hospitalization was not in excess of one year.

SECTION XIII – 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 health benefits program.

2. **Assignment.** You cannot assign any benefits under this Certificate to any person, corporation, or other organization. Any assignment by You will be void. Assignment means the transfer to another person or to an 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 Policyholder 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 Group Policyholder 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. **Continuation of Benefit Limitations.** Some of the benefits under this Certificate may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the Year.

7. **Entire Agreement.** This Certificate, including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.

8. **Enrollment ERISA.** The Group Policyholder 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 Policyholder will provide Us with this information upon request.

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

9. **Furnishing Information and Audit.** The Group Policyholder and all persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with information over the telephone for reasons like the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care. The Group Policyholder 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 Policyholder 's New York office.

10. **Identification Cards.** Identification cards are issued by Us for identification only. Possession of any identification 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.

11. **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.

12. **Material Accessibility.** We will give Policyholder, and the Policyholder will give You identification cards, Certificates, riders, and other necessary materials.

13. **More Information about Your Health 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 copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Certificate.
    - 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.
    - Provider affiliations with Participating Hospitals.

- A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or utilization review guidelines.

14. **Notice.** Any notice that We give to You under this Certificate will be mailed to Your address as it appears on our records. 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:

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

15. **Premium Refund.** We will give any refund of Premiums, if due, to the Group Policyholder upon the death of You.

16. **Recovery of Overpayments.** On occasion a payment will be made to You when You are not covered, for a service that is not covered, or which is more than is proper. When this happens We will explain the problem to You 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.

17. **Renewal Date.** The renewal date for the Certificate is the anniversary of the effective date of the Group Policy in each Year. This Certificate will automatically renew each year on the renewal date unless otherwise terminated by Us or the Group Policyholder as permitted by the Certificate, or by You upon 30 days' prior written notice to the Group Policyholder.

18. **Right to Develop Guidelines and Administrative Rules.** We may develop or adopt standards that describe in more detail when We will make or will not make payments under 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.

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

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

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

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

    Subject to applicable state law, unless preempted by federal law, We may have a right of reimbursement if you or anyone on your behalf receives payment from any responsible party (including Your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness, or condition for which We provided benefits. Under New York General Obligations Law 5-335, Our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that You did not take any action against Our rights or violate any contract between You and us. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

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

23. **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 2 years from the date the claim was required to be filed.

24. **Translation Services.** Translation services are available under this Certificate for non-English speaking Members. Please contact us at 888-468-5175 to access these services.

25. **Waiver.** The waiver by any party of any breach of any provision of the 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.

26. **Who May Change This Certificate.** The Certificate may not be modified, amended, or changed, except in writing and signed by Our President or a person designated by the President. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change the 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 President or person designated by the President.

27. **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.

28. **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.

29. **Your Medical Records and Reports.** In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your medical 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, You automatically give Us or our designee permission to obtain and use Your medical 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 medical, dental, or mental health 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 medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
    - Permit copying of Your medical records by Us.

    We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, 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.

SECTION XIV
HEALTHPLEX INSURANCE COMPANY
SCHEDULE OF BENEFITS – PEDIATRIC SHOP DENTAL

COST-SHARING	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	$75 None		
Out-of-Pocket Limit • Individual • Family	$700 $1,400	Non-Participating Provider services are not Covered except as required for Emergency Care.	
PEDIATRIC DENTAL CARE	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care			
• Preventive/Routine Dental Care	0% Coinsurance after Deductible		One Dental Exam & Cleaning Per 6-Month Period
• Major Dental (Endodontics & Prosthodontics	0% Coinsurance after Deductible		
• Orthodontia	0% Coinsurance after Deductible		
Orthodontia & Major Dental Require Preauthorization			

SECTION XV
HEALTHPLEX INSURANCE COMPANY
SCHEDULE OF BENEFITS – ADULT SHOP DENTAL

COST-SHARING	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	None None		
Out-of-Pocket Limit • Individual • Family	$700 $1,400	Non-Participating Provider services are not Covered except as required for Emergency Care.	
ADULT DENTAL CARE	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Adult Dental Care			
• Preventive/Routine Dental Care	$48 Copayment		One Dental Exam & Cleaning Per 6-Month Period
• Major Dental (Endodontics & Prosthodontics	$48 Copayment		