THIS IS YOUR

NEW YORK STATE OF HEALTH DENTAL POLICY

issued by

HEALTHPLEX INSURANCE COMPANY

This is Your individual Policy for insurance coverage issued by Healthplex Insurance Company. ("HIC"). This Policy, together with the attached Schedule of Benefits, applications, and any amendment or rider amending the terms of this Policy, constitute the entire agreement between You and Us.

You have the right to return this Policy. Examine it carefully. If You are not satisfied, You may return this Policy to Us and ask Us to cancel it. Your request must be made in writing within ten (10) days from the date You receive this Policy. We will refund any Premium paid including any Policy fees or other charges.

Renewability. The renewal date for this Policy is January 1 of each year. This Policy will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Policy or by the Subscriber upon 30 days' prior written notice to Us. Coverage under this Policy lasts until the end of the month in which You turn 19 years of age.

In-Network Benefits. This Policy only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers in Our network. Care Covered under this Policy 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 Policy, You must contact Your Primary Care Dentist before You obtain the services except for Emergency Dental Care described in the Pediatric Dental Care Section of this Policy. Except for Emergency Dental Care described in the Pediatric Dental Care section of this Policy, You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.

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

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

The insurance evidenced by this Policy provides DENTAL insurance ONLY.

Signed By:

Sharon Zelkind

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President

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

TABLE OF CONTENTS

SECTION I – DEFINITIONS

Defined terms will appear capitalized throughout the Policy.

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

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

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

Balance Billing: When a Non-Participating Provider bills 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.

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

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

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

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

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

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

Dependents: The Subscriber's Children.

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

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

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

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

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

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

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

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

Medically Necessary: See the How Your Coverage Works section of this Policy for the definition.

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

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

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

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

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

Participating Provider: A Provider who has a Policy with Us to provide services to You. A list of Participating Providers and their locations is available on Our Third Party Administrator's 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: A calendar year ending on December 31 of each year.

Policy: This Policy issued by Healthplex Insurance Company, 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, or device that the Covered Service, procedure, treatment plan or device is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this Policy.

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

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

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

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

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCD to a Specialist) in order to arrange for additional care for a Member. A Referral can be transmitted electronically or by Your Provider completing a paper Referral form. Except as provided in the Access to Care and Transitional Care section of this Policy or otherwise authorized by Us, a Referral will not be made to a Non-Participating Provider.

Responsible Adult: The person who enters into this Policy with Us on behalf his or her Child or Children.

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

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

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

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

Subscriber: The person to whom this Policy is issued. In the case of a Policy that provides coverage for Pediatric Dental Care only, the Subscriber refers to the Responsible Adult if the Member is under 18 years of age.

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

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

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

You, Your: The Member.

SECTION II – HOW YOUR COVERAGE WORKS

A. Your Coverage under this Policy.

You have purchased a dental insurance Policy from Us. We will provide the benefits described in this Policy to You and Your covered Dependents. You should keep this Policy with Your other important papers so that it is available for Your future reference.

B. Covered Services.

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

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

C. Participating Providers.

To find out if a Provider is a Participating Provider:

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

D. The Role of Primary Care Dentists.

This Policy has a gatekeeper, usually known as a Primary Care Dentist ("PCD"). This Policy requires that you select a 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 EPO Healthplex Network. Each Member may select a different PCD.

1. **Services Not Requiring Referral from Your PCD**. 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.

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

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

   To see a Provider, call his or her office and tell the Provider that You are a HIC Member, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your Member ID number. When You go to the Provider's office, bring Your ID card with You.

   You may change Your PCD by calling Healthplex, HIC's Third Party Administrator's Customer Service number at 888-468-5175. This can be done anytime.

E. Services Subject To Preauthorization.
Our Preauthorization is required before You receive certain Covered Services. Your PCD is responsible for requesting Preauthorization for in-network services.

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

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

We may base Our decision on a review of:

- Your dental records;
- Our dental policies and clinical guidelines;
- 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 dental practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is 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.

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

H. Important Telephone Numbers and Addresses.

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

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

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

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

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

OUR WEBSITE
www.healthplex.com

SECTION III – ACCESS TO CARE AND TRANSITIONAL CARE

A. Referral to a Non-Participating Provider

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

B. When a Specialist Can Be 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.

C. Standing Referral to a Participating Specialist

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

D. When Your Provider Leaves the Network

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

In order for You to continue to receive Covered Services for up to 90 days, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to 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 Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

E. New Members In a Course of Treatment

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

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

SECTION IV – COST-SHARING EXPENSES AND ALLOWED AMOUNT

A. Deductible

Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Policy for Covered Services during each Plan Year before We provide coverage. If You have other than individual coverage, the individual Deductible applies to each person covered under this Policy.

B. Copayments

There are no Copayments for Covered Services under this Policy.

C. Coinsurance

There is no Coinsurance for Covered Services under this Policy.

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

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

E. Allowed Amount.

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

SECTION V – WHO IS COVERED

A. Who is Covered Under this Policy

This Policy is issued to cover the Members (known as "You") who are under 19 years of age. Coverage lasts until the end of the month in which You turn 19 years of age.

B. Children Covered Under This Policy

Children covered under this Policy include the Subscriber's natural Children, legally adopted Children, step Children, and for Children for whom the Subscriber is the proposed adopted parent without regard to financial dependence, residency with the Subscriber, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption.

Coverage also includes Children for whom the Subscriber is a legal guardian if the Children are chiefly dependent upon the Subscriber for support and the Subscriber has been appointed the legal guardian by a court order. Foster Children of the Subscriber are covered.

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

C. Open Enrollment

You can enroll under this Contract during an open enrollment period that runs from November 1 of the prior calendar year through January 31 of the following calendar year. If the NYSOH receives Your selection on or before December 15 of the prior calendar year, Your coverage will begin on January 1 as long as the applicable Premium payment is received by then. If the NYSOH receives Your selection between December 16 of the prior calendar year through January 15 of the following calendar year, Your coverage will begin on February 1, as long as the applicable premium payment is received by then. If the NYSOH receives Your selection between January 16 through January 31, Your coverage will begin on March 1 as long as the applicable premium payment is received by then.

If You do not enroll during open enrollment, or during a special enrollment period as described below, You must wait until the next annual open enrollment period to enroll.

D. Special Enrollment Periods

Outside of the annual open enrollment period, You can enroll for coverage within 60 days prior to or after the occurrence of one (1) of the following events:

1. You involuntarily lose minimum essential coverage, including COBRA and state continuation coverage, including if You are enrolled in a non-calendar year group health plan or individual health insurance coverage, even if You have the option to renew the coverage;
2. You are determined newly eligible for advance payments of the Premium Tax Credit because coverage You are enrolled in will no longer be employer-sponsored minimum essential coverage, including as a result of Your employer discontinuing or changing available coverage within the next 60 days, provided that You are allowed to terminate

existing coverage; or

3. You lose eligibility for Medicaid coverage, including Medicaid coverage for pregnancy-related services and Medicaid coverage for the medically needy, but not including other Medicaid programs that do not provide coverage for primary or specialty care; or
4. You move and become eligible for new qualified dental plans because of a permanent move and You either had minimum essential coverage for one (1) or more days during the 60 days before the move or were living outside the United States or a United States territory at the time of the move.

Outside of the annual open enrollment period, You can enroll for coverage within 60 days after the occurrence of one (1) of the following events:

1. Your enrollment or non-enrollment in another qualified dental plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the NYSOH, or a non-NYSOH entity providing enrollment assistance or conducting enrollment activities, as evaluated and determined by the NYSOH;
2. You adequately demonstrate to the NYSOH that another qualified dental plan in which You were enrolled substantially violated a material provision of its contract;
3. You gain a Dependent or become a Dependent through marriage, birth, adoption or placement for adoption, or placement in foster care or through a child support order or other court order, however, foster children and Children for whom You are a legal guardian are not covered under this Policy;
4. You lose a Dependent or are no longer considered a Dependent through divorce, legal separation, or upon the death of You or Your Dependents;
5. If You are an Indian, as defined in 25 U.S.C. 450b(d), You may enroll in a qualified dental plan or change from one (1) qualified dental plan to another one (1) time per month;
6. You demonstrate to the NYSOH that You meet other exceptional circumstances as the NYSOH may provide;
7. You were not previously a citizen, national, or lawfully present individual and You gain such status; or
8. You are determined newly eligible or newly ineligible for advance payments of the Premium Tax Credit or have a change in eligibility for cost-sharing reductions.

The NYSOH must receive notice and We must receive any Premium payment within 60 days of one (1) of these events.

If You enroll because You are losing minimum essential coverage within the next 60 days, or You are determined newly eligible for advance payments of the Premium Tax Credit because the coverage You are enrolled in will no longer be employer-sponsored minimum essential coverage; or You gain access to new qualified dental plans because You are moving, and Your selection is made on or before the triggering event, then Your coverage will begin on the first day of the month following Your loss of coverage.

If You enroll because You gain a Dependent through adoption or placement for adoption, Your coverage will begin on the date of the adoption or placement for adoption. If You enroll because of a court order, Your coverage will begin on the date the court order is effective.

If You enroll because You or Your Dependents die, Your coverage will begin on the first day of the month following Your selection.

If the Subscriber has a newborn or adopted newborn Child and the NYSOH receives notice of such birth within 60 days thereafter, coverage for the newborn starts at the moment of birth; otherwise coverage begins on the date on which the NYSOH receives notice. The adopted newborn Child will be covered from the moment of birth if the Subscriber takes physical custody of the infant as soon as the infant is released from the Hospital after birth and the Subscriber files a petition pursuant to Section 115-c of the New York Domestic Relations Law within 60 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. The Subscriber must also pay any applicable additional Premium within 60 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise coverage begins on the date on which the NYSOH receives notice, provided that the Subscriber pays any additional Premium when due.

Advance payments of any Premium Tax Credit are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month.

In all other cases, the effective date of Your coverage will depend on when the NYSOH receives Your selection. If Your selection is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month, as long as Your applicable Premium payment is received by then. If Your selection 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, as long as Your applicable Premium payment is received by then.

E. Coverage of Children of Domestic Partners

Children covered under this Policy also include the Children of the Subscriber's domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists, or
2. For partners residing where registration does not exist, by an alternate affidavit of domestic partnership.
    a. The affidavit must be notarized and must contain the following:
        - The partners are both 18 years of age or older and are mentally competent to consent to contract;
        - The partners are not related by blood in a manner that would bar marriage under the laws of the State of New York;

- The partners have been living together on a continuous basis prior to the date of the application;
- Neither individual has been registered as a member of another domestic partnership within the last six (6) months; and

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

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

SECTION VI –PEDIATRIC DENTAL CARE

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

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

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

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

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

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

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

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

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

F. Prosthodontics. We Cover prosthodontic services as follows:

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

Fixed bridges are not Covered unless they are required:

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

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

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

Procedures include but are not limited to:

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

SECTION VII – EXCLUSIONS AND LIMITATIONS

No Coverage is available under this Policy for the following:

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

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

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

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

E. Experimental or Investigational Treatment.
We do not Cover any health care service, procedure, treatment or device that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for 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 Policy for non-investigational treatments. See the Utilization Review and External Appeal sections of this Policy for a further explanation of Your Appeal rights.

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION VIII – CLAIM DETERMINATIONS

A. Claims.

A claim is a request that benefits or services be provided or paid according to the terms of this Policy. When 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.

B. Notice of Claim.

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

C. Timeframe for Filing Claims.

Claims for services must be submitted to Us for payment within 120 days after 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. In no event, except in the absence of legal capacity, may a claim be filed more than one (1) year from the time the claim was required to be filed.

D. Claims for Prohibited Referrals.

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

E. Claim Determinations.

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

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

F. Pre-service Claim Determinations.

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

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

2. Urgent Pre-service Reviews.

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

G. Post-service Claim Determinations.

A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim. If We 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 PROCEDURES

A. Grievances

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

B. Filing a Grievance

You can contact Us by phone at 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 will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

C. Grievance Determination.

Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered health care professional will look into it. We will decide the Grievance and notify You within the following timeframes:

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

D. Grievance Appeals.
If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at 888-468-5175; 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 two (2) business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.
Pre-Service Grievances: (A request for a service or a 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 a service or treatment.)	30 business days of receipt of all necessary information to make a determination.

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

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

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

SECTION X - UTILIZATION REVIEW

A. Utilization review.

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

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

B. Preauthorization Reviews

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

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

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

C. Concurrent Reviews

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

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

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

D. Retrospective Reviews

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

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

E. Retrospective Review of Preauthorized Services

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

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

F. Reconsideration

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

G. Utilization Review Internal Appeals

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

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will 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.

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

available from a Participating Provider that We approved to treat Your condition; and

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

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

H. Standard Appeal

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

2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 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 (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

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

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

If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal appeal or an external appeal.

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

I. Appeal Assistance.

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

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

SECTION XI - EXTERNAL APPEAL

A. Your Right to an External Appeal.

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

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

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

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

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

B. Your Right to Appeal A Determination that A Service is Not Medically Necessary.

If We have denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph “A” above.

C. Your Right to Appeal A Determination that A Service is Experimental or Investigational.
If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph "A" above and Your attending Physician must certify that Your condition or disease is one for which:

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

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

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

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

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

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

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

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

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

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

F. The External Appeal Process.
You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

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

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited appeal (described below), We do not have a right to reconsider Our decision.

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

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must 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 or an out-of-network treatment, We will provide coverage subject to the other terms and conditions of this Policy. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the costs of services required to provide treatment to 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 Policy 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.

G. Your Responsibilities

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

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

SECTION XII – TERMINATION OF COVERAGE

This Policy may be terminated as follows:

A. Automatic Termination of this Policy.
This Policy shall automatically terminate upon the death of the Subscriber, unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, this Policy will terminate as of the last day of the month for which the Premium has been paid.

B. Automatic Termination of Your Coverage.
Coverage under this Policy shall automatically terminate for Member(s) the end of the month in which the Member turns 19 years of age.

C. Termination by You.
The Subscriber may terminate this Policy at any time by giving the NYSOH at least 14 days prior written notice.

D. Termination by Us.
We may terminate this Policy with 30 days written notice as follows:

1. For Non-payment of Premiums.
   Premiums are to be paid by the Subscriber to Us on each Premium due date. While each Premium is due by the due date, there is a grace period for each Premium payment. If the Premium payment is not received by the end of the grace period, coverage will terminate as follows:

   - If the Subscriber does not receive advanced payments of the Premium Tax Credits for coverage in the NYSOH and fails to pay the required Premium within a 30-day grace period, this Policy will terminate retroactively back to the last day Premiums were paid. The Subscriber will be responsible for paying any claims submitted during the grace period if this Policy terminates.

   - If the Subscriber receives advanced payments of the Premium Tax Credits and has paid at least one (1) full month's Premium, this Policy will terminate one month after the last day Premiums were paid. That is, retroactive termination will not exceed 61 days. We may pend claims incurred during the 61-day grace period. The Subscriber will be responsible for paying any claims incurred during the 61-day grace period if this Policy coverage terminates.

2. Fraud or Misrepresentation of Material Fact.
   If the Subscriber has performed an act that constitutes fraud or made a misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, this Policy will terminate immediately upon a written notice to the Subscriber from the NYSOH. However, if the Subscriber makes a misrepresentation of material fact in writing on his or her enrollment application We will rescind coverage if the facts misrepresented would have led Us to refuse to issue this Policy and the application is attached to this Policy. Rescission means that the termination of Your coverage will have a retroactive effect of up to the issuance of this

Policy. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

3. If the Subscriber no longer lives, or resides in Our Service Area.

4. The date the Policy is terminated because We stop offering the class of contracts to which this Policy belongs, without regard to claims experience or health related status of this Policy. We will provide the Subscriber with at least thirty (30) days prior written notice.

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

SECTION XIII – EXTENSION OF BENEFITS

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

SECTION XIV - TEMPORARY SUSPENSION RIGHTS FOR MEMBERS OF THE ARMED FORCES

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 temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty 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 five (5) years of active duty.

You must make a written request to Us to have Your coverage suspended during a period of active duty. Your unearned Premiums will be refunded during the period of such suspension.

Upon completion of active duty, Your coverage may be resumed as long as You:

1. Make written application to Us; and
2. Remit the Premium within 60 days of the termination of active duty.

The right of resumption extends to coverage for Your Dependents. For coverage that was suspended while on active duty, coverage will be retroactive to the date on which active duty terminated.

SECTION XV – GENERAL PROVISIONS

1. Agreements between Us and Participating Providers.

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

2. Assignment.

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

3. Changes in This Policy.

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

4. Choice of Law.

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

5. Clerical Error.

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

6. Conformity with Law.

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

7. Continuation of Benefit Limitations.

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

8. Entire Agreement.

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

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

10. Furnishing Information and Audit.
All persons covered under this Policy will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Policy. You must provide Us with information over the telephone for reasons such as the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Provider; or to make decisions regarding the medical necessity of Your care.

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

12. Incontestability.
No statement made by the Subscriber in an application for coverage under this Policy shall avoid the Policy or be used in any legal proceeding unless the application or an exact copy is attached to this Policy. After two years from the date of issue of this Policy, no misstatements, except for fraudulent misstatements made by the Subscriber in the application for coverage, shall be used to void the Policy or deny a claim.

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

14 Material Accessibility.
We will give You ID cards, Policies, riders and other necessary materials.

15. More Information about Your Dental Plan.
You can request additional information about Your coverage under this Policy. Upon Your request, We will provide the following information:

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.

- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or utilization review guidelines.
- Written application procedures and minimum qualification requirements for Providers.

16. Notice.
Any notice that We give to You under this Policy will be mailed to Your address as it appears in 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

17. Premium Refund.
We will give any refund of Premiums, if due, to the Subscriber.

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

19. Renewal Date.
The renewal date for this Policy is January 1 of each Year. This Policy will automatically renew each year on the renewal date unless otherwise terminated by Us, as permitted by this Policy or by the Subscriber upon 30 days' prior written notice to Us

20. Reinstatement After Default.
If the Subscriber defaults in making any payment under this Policy, the subsequent acceptance of payment by Us or by one of Our authorized agents or brokers shall reinstate the Policy, but with respect to sickness and injury, only to Cover such sickness as may be first manifested more than 10 days after the date of such acceptance.

21 Right to Develop Guidelines and Administrative Rules.
We may develop or adopt standards that describe in more detail when We will or will not make payments under this Policy. Those standards will not be contrary to the descriptions in this Policy. If 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 Policy.

22. 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 Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

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

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

25. Subrogation and Reimbursement.
These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for 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 Policy. Subrogation means that We have the right, independently of you, to proceed directly against the other party to recover the benefits that We have provided.

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

26. Third Party Beneficiaries.

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

27. Time to Sue.

No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Policy. You must start any lawsuit against Us under this Policy within three (3) years from the date the claim was required to be filed.

28. Translation Services.

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

29. Venue for Legal Action.

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

30. Waiver.

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

31. Who May Change This Policy.

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

32. Who Receives Payment under This Policy.

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

33. Workers' Compensation Not Affected.

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

34. Your Dental Records and Reports.

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

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

We agree to maintain Your dental information in accordance with state and federal confidentiality requirements. However, 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 Policy, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

SECTION XVI
HEALTHPLEX INSURANCE COMPANY
SCHEDULE OF BENEFITS - PEDIATRIC INDIVIDUAL DENTAL

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

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

LANGUAGE ASSISTANCE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-468-9868 (TTY: 1-800-662-1220).	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-468-9868 (TTY: 1-800-662-1220).	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。 請致電 1-800-468-9868(TTY: 1-800-662-1220).	Chinese
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-468-9868 (رقم هاتف الصم والبكم: 1-800-662-1220).	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-800-468-9868 (TTY: 1-800-662-1220) 번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-468-9868 (телетайп: 1-800-662-1220).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-468-9868 (TTY: 1-800-662-1220).	Italian
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-468-9868 (ATS : 1-800-662-1220).	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-468-9868 (TTY: 1-800-662-1220).	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-800-468-9868 (TTY: 1-800-662-1220).	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-468-9868 (TTY: 1-800-662-1220).	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-468-9868 (TTY: 1-800-662-1220).	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-800-468-9868 (TTY: ১-800-662-1220)।	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-468-9868 (TTY: 1-800-662-1220).	Albanian
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-468-9868 (TTY: 1-800-662-1220).	Vietnamese
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-468-9868 (TTY: 1-800-662-1220).	Gujarati
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-468-9868 (TTY: 1-800-662-1220).	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں 1-800-468-9868 (TTY: 1-800-662-1220).	Urdu
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-468-9868 (TTY: 1-800-662-1220).	Portuguese
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-468-9868 (TTY: 1-800-662-1220).	Thai
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-468-9868 (TTY:1-800-662-1220) पर कॉल करें।	Hindi
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-468-9868 (TTY: 1-800-662-1220).	German

NOTICE OF NON-DISCRIMINATION

Healthplex, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Healthplex, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Healthplex, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:

  ○ Qualified sign language interpreters
  ○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:

  ○ Qualified interpreters
  ○ Information written in other languages

If you need these services, contact Healthplex Customer Service at: 1-800-468-9868

If you believe that Healthplex, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Mr. Arthur Cook, Director of Quality Management and Compliance, 333 Earle Ovington Boulevard, Suite 300, Uniondale, NY 11553, Telephone Number: 1-855-784-8891, TTY/TDD: 1-800-662-1220, Fax: 1-516-542-2227 or Email: QM@healthplex.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Mr. Arthur Cook, Director of Quality Management and Compliance, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.