**INDIVIDUAL DENTAL BENEFITS POLICY**

**(with ESSENTIAL PEDIATRIC DENTAL BENEFITS)**

**issued by**

**INTERNATIONAL HEALTHCARE SERVICES, INC. ("IHS")**

This is Your individual Policy for coverage issued by International Healthcare Services, Inc. ("IHS"). This Policy, together with the attached Schedule of Benefits, application, and any amendment or rider amending the terms of this Policy, constitute the entire agreement between You and Us as described in paragraph "3", "Changes in Policy" Section XVI of this Policy.

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)] [thirty (30)] days from the date You receive this Policy. We will refund any Premium paid including any Policy fees or other charges.

Renewability. Refer to the Termination of Coverage section of this Policy for the renewal provisions.

**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 except in the case of the need for Emergency Dental Care. 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 wherein Emergency Dental Care is required described in the Pediatric and Adult Dental Care sections of this Policy. You will be responsible for paying the cost of all care that is provided by Non-Participating Providers except in the instances when (1) the Member requires Emergency Dental Care; or (2) the service is authorized by Us.

**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 State of New Jersey.

**The coverage evidenced by this Policy provides DENTAL coverage ONLY.**

Signed By:

President

**INTERNATIONAL HEALTHCARE SERVICES, INC.**
**333 EARLE OVINGTON BLVD., SUITE 300**
**UNIONDALE, NY 11553**

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## SECTION I - DEFINITIONS

Defined terms will appear capitalized throughout the Policy.

**Acute:** The onset of disease or injury, or a change in Your 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 again.

**Child Dependent:** Your child who is under age 19. Your "Child Dependent" includes:

a) Your biological child;
b) Your legally adopted child;
c) Your step-child;
d) The child of Your Civil Union Partner
e) The child of Your Domestic Partner; and
f) Children under a court appointed guardianship.

We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

In addition, to the Child Dependents described above, any other child over whom You have legal custody or legal guardianship or a blood relationship may be covered to the same extent as a Child Dependent under the Policy. We may require that You submit proof of: legal custody; legal guardianship; blood relationship; or legal relationship, in our discretion.

At our discretion, IHS can require proof that a person meets the definition of a Child Dependent.

**Civil Union:** a union that is either established pursuant to New Jersey law or recognized by the State of New Jersey as a Civil Union.

**Civil Union Partner:** A person who has established and is in a Civil Union with You.

**Copaymen**t: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service.

**Cost-Sharing:** Amounts You must pay for Covered Services expressed as Copayments.

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

**Dependent:** A Spouse, Civil Union Partner, Domestic Partner, or Child Dependent whom You enroll for coverage under this Policy, as described in the General Information section of this Policy. However, a Dependent is not a person who is on active duty in any armed forces of any country.

Once You enroll an eligible Dependent, the Dependent then becomes a "Member".

**Domestic Partner**: As used in this Policy and pursuant to P.L. 2003, c. 246, shall mean one of the following: (1) if the domestic partnership is entered into on or after February 19, 2007, an individual who (a) is age 62 or older; (b) is either the same or a different gender than the Employee; and (c) has established a domestic partnership with the Employee by filing an affidavit of domestic partnership and obtaining a certificate of domestic partnership from their local registrar; or (2) if the domestic partnership is entered into prior to February 19, 2007, an individual who (a) is age 18 or older; (b) is the same gender as the Employee; and (c) has established a domestic partnership with the Employee by filing an affidavit of domestic partnership and obtaining a certificate of domestic partnership from their local registrar.

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

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

**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 the State of New Jersey, 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.

**IHS:** means International Healthcare Services, Inc.

**Medically Necessary:** Medically Necessary means that a service or supply is provided by a recognized health care Provider, and We determine at our Discretion, that it is:

a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;
c) in accordance with generally accepted medical practice;
d) not for the convenience of You;
e) the most appropriate level of medical care Your needs; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that a Provider prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary.

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

**Member:** You or a covered Dependent for whom required Premiums have been paid by You

**Non-Participating Provider:** A Provider who doesn't have a contract with Us to provide services to You. You will pay more to see a Non-Participating Provider. In the instances when (1) You require Emergency Dental Care; or (2) the service is authorized by Us, the services of Non-Participating Providers are Covered.

**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 contract 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.

**Participating Specialist:** A Provider who has a contract with Us and is certified as a pediatric dentist, endodontist, periodontist, prosthodontist, oral surgeon or orthodontist.

**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 International Healthcare Services, Inc., 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 Pediatric and Adult Dental Care Sections of this Policy.

**Premium:** The amount that must be paid for Your dental coverage by You. to Us on or before the due date with such period of grace as set forth in this Policy.

**Primary Care Dentist ("PCD"):** A Participating Provider 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 the laws of the State of New Jersey 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 You. 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 as otherwise authorized by Us, a Referral will not be made to a Non-Participating Provider. In the event the required Specialist needed to provide a specific service is not available within the network, a Referral can be given to a Non-Participating Provider.

**Schedule of Benefits**: The section of this Policy that describes the Copayments, and Out-of-Pocket Limits.

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

**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 You are legally married, including a same sex Spouse, a Civil Union Partner and a Domestic Partner.

**Subscriber:** The person to whom this Policy is issued.

**Third Party Administrator:** Healthplex, Inc. is Our Third Party Administrator. They are delegated to performing the following services:

1. Customer Service
2. Provider Relations
3. Claims Adjudication
4. Utilization Review
5. Complaints and Appeals.

**Us, We, Our:** International Healthcare Services, Inc. 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. Coverage under this Policy.

You have purchased a dental coverage Policy from Us. We will provide the benefits described in this Policy to You and Your eligible 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 or Preventive Services;
- Provided by a Participating Provider except if Emergency Dental Care is required, or when there is no Provider in the network to perform the service;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Pediatric and Adult Dental Care sections of this Policy; and
- Received while You are Covered under this Plan.

### C. Participating Providers.

To find out if a Provider is a Participating Provider:

- Check Your Provider directory, available at Your request by calling Our Third Party Administrator at 888-468-5175; or
- Call Our Third Party Administrator at 888-468-5175; or
- Visit Our Third Party Administrator'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 may select any Participating PCD who is available from the list of PCDs in the Healthplex Network. You and each Dependent may select a different PCD. You need a written Referral from a PCD before receiving Specialist care from a Participating Provider. In the event the required Specialist needed to provide a specific service and is not available within the network, a Referral can be given to a Non-Participating Provider.

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 or Non-Participating Provider for Emergency 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 Pediatric and Adult Dental Care sections of this Policy for the services that require a Referral.

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

To see a PCD, call the PCD's office and tell the PCD that You are an IHS Member, and explain the reason for Your visit. Have Your ID card available. The PCD's office may ask You for Your ID number. When You go to the PCD's office, You should bring Your ID card.

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

**F. Services Subject To Preauthorization.**
Our Preauthorization is required before You receive a Covered Service procedure, treatment plan or device. The Preauthorization process is to determine whether the service procedure, treatment plan or device is Medically Necessary and therefore a Covered Service. Your PCD is responsible for requesting Preauthorization for in-network services listed in the Pediatric and Adult Dental Care sections of this Policy.

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

**H. Medically Necessary**
Medically Necessary means that a service or supply is provided by a recognized health care

Provider, and We determine at our discretion, that it is:

a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;
c) in accordance with generally accepted medical practice;
d) not for the convenience of You;
e) the most appropriate level of medical care Your or Your Covered Dependents need; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that a Provider prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary.

See the Utilization Review section of this Policy for Your right to an internal Appeal of Our determination that a service is not Medically Necessary.

## I. Important Telephone Numbers and Addresses.

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

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

MEMBER APPEALS
International Healthcare Services, 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.

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 for the provision of general/preventive dental care (i.e. special behavioral issues that may exist), 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 requested by You. If We approve the Referral, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with Your PCD, the Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be 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

Anytime You have a life-threatening dental condition or dental disease or a degenerative and disabling condition or dental 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 who is a Participating Provider

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

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. Copayments

You must pay the Copayments, or fixed amounts, in the Schedule of Benefits in sections XVI and XVII of this Policy for Covered Services.

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

When You or Your Covered Dependents have met Your Out-of-Pocket Limit in payment of Copayments 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 payment of Copayments 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. Once the Out-of-Pocket Limit has been met, there is no additional Cost-Sharing for the remainder of the Plan Year for pediatric dental Covered Services.

### C. Allowed Amount.

"Allowed Amount" means the maximum amount We will pay for the services or supplies covered under this Policy, before any applicable Copayment 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

You, the Subscriber to whom this Policy is issued, are covered under this Policy. You must live or reside in Our Service Area to be covered under this Policy. Members of Your family may also be covered depending upon the type of coverage You selected. Pediatric Benefit coverage ends when You or Your Dependent turns 19 years of age. Dependent Children shall then be covered under the Adult Benefit Care section until the end of the year in which the Child turns 30 years of age. You and Your Spouse shall be covered and receive Adult Benefits throughout the term of the Policy.

### B. Types of Coverage

We offer the following types of coverage:

1. **Individual**. If You selected individual coverage, then You are covered.
2. **Individual and Spouse.** If You selected individual and Spouse coverage, then You and Your Spouse are covered.
3. **Parent and Child(ren).** If You selected parent and child(ren) coverage, then You and Your Children, as described below, are covered.
4. **Family**. If You selected family coverage, then You, Your Spouse and Your Child or Children, as described below, are covered.

### C. Open Enrollment

[If offered Inside the FFM]

[For Plan Years beginning on or after January 1, 2016, You can enroll under this Policy during an open enrollment period that runs from November 1, 2015, through January 31, 2016. If We receive Your selection on or before December 15, 2015, Your Coverage will begin on January 1, 2016, as long as the applicable Premium payment is received by then. If We receive Your selection between the dates of December 16, 2015, through January 15, 2016, Your coverage will begin on February 1, 2016, as long as the applicable Premium payment is received by then. If We receive Your selection between the dates of January 16, 2016, through January 31, 2016, Your coverage will begin on March 1, 2016, 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.]

[If offered Outside the FFM]

[You can enroll under this Policy at any time during the calendar year]

### D. Special Enrollment Periods

[If offered Inside the FFM]

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

1. You or Your Spouse, or Child Dependent involuntarily lose minimum essential coverage including COBRA, 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, Your Spouse or Child Dependent 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, Your Spouse or Child Dependent lose eligibility for Medicaid coverage, but not including Medicaid programs that do not provide coverage for primary or specialty care.

[Outside of the annual open enrollment period, You, Your Spouse or Child can be enrolled for coverage within 60 days of the occurrence of one (1) of the following events:

1. You, Your Spouse or Child Dependent's enrollment or non-enrollment in another qualified dental plan was unintentional, inadvertent or erroneous.

2. You, Your Spouse or Child Dependent adequately demonstrate to Us that another qualified dental plan in which You were enrolled substantially violated a material provision of its policy;

3. You, Your Spouse or Child Dependent move and become eligible for new qualified dental plans;

4. You gain a Dependent or become a Dependent through marriage, birth, adoption or placement for adoption;

5. You lose a Dependent or are no longer considered a Dependent through divorce, legal separation, or upon the death of You or Your Dependents.

6. 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 qualified health plan to another one (1) time per month;

7. You, Your Spouse or Child Dependent demonstrate to Us that You meet other exceptional circumstances as We may provide;

8. You, Your Spouse or Child Dependent were not previously a citizen, national, or lawfully present individual and You gain such status;

9. You, Your Spouse or Child Dependent 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; or

We must receive notice and we must receive any premium payment within 60 days of one of these events.

If You have a newborn or adopted newborn Child and We receive notice of such birth within 60 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from

the Hospital after birth and You file a petition pursuant to the laws of the State of New Jersey within 60 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to the laws of the State of New Jersey, and consent to the adoption has not been revoked. If You have individual or individual and Spouse coverage You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any 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 We receive notice and receive the Premium payment.

If You enroll because You lost minimum essential coverage or because You got married, Your coverage will begin on the first day of the month following Your loss of coverage or marriage.

In all other cases, the effective date of Your coverage will depend on when We receive 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.]

[If offered outside the FFM]

[Outside of the annual open enroll period, You can enroll for coverage within 31 days of the date the Subscriber gains a Dependent through marriage, adoption or placement for adoption, except as otherwise specified below.

We must receive notice and any Premium payment with 60 days of one (1) of the following events:

If You have a newborn or adopted newborn child and We receive notice of such birth within 60 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to the laws of the State of New Jersey within 60 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to the laws of the State of New Jersey, and consent to the adoption has not been revoked. If You have individual or Individual an Spouse coverage You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any 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 We receive notice, provided that You pay any additional Premium when due.

We must receive notice and any Premium payment with 31 days of one (1) of these events:

In all other cases, the effective date of Your coverage will depend on when We receive 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.]

## SECTION VI - PEDIATRIC DENTAL CARE

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

### A. We cover the following Pediatric Dental Care services:

**Dental Benefits**

Subject to the limitation outlined below and the applicable Copayments shown in Section XVII Schedule of Benefits - Pediatric Dental and Section XIX Premiums, we cover, as detailed below, the diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services in the dental benefit package for Covered Persons through the age of 18 when services are provided by a Participating Provider or by a Non-Participating Provider who performs Emergency Dental Care or preauthorized services.

- Dental services are available from birth with an age one dental visit encouraged.
- A second opinion is allowed.
- Emergency treatment is available without Preauthorization. Emergency treatment includes, but may not be limited to treatment for: pain, Acute or chronic infection, facial, oral or head and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensive, abnormal bleeding, fractures of facial bones or dislocation of the mandible.
- Diagnostic and preventive services are linked to the provider, thus allowing You to transfer to a different provider/practice and receive these services. The new Provider is encouraged to request copies of diagnostic radiographs if recently provided. If they are not available radiographs needed to diagnose and treat will be allowed.
- Denials of services to the dentist shall include an explanation and identify the reviewer including their contact information.
- Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.
- Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials as needed by report.
- Services that are considered experimental in nature will not be considered.
- This Policy will not cover any charges for broken appointments.

**Diagnostic Services**

* Indicated diagnostic services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

*a) Clinical oral evaluations once every 6 months **

1. Comprehensive oral evaluation– complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and

development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation

2. Periodic oral evaluation – subsequent thorough evaluation of an established patient*
3. Oral evaluation for patient under the age of 3 and counseling with primary caregiver*
4. Limited oral evaluations that are problem focused
5. Detailed oral evaluations that are problem focused

b) Diagnostic Imaging with interpretation
   1. A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views.
   2. An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
   3. Additional films/views needed for diagnosing can be provided as needed.
   4. Bitewings, periapicals, panoramic and cephlometric radiographic images
   5. Intraoral and extraoral radiographic images
   6. Oral/facial photographic images
   7. Maxillofacial MRI, ultrasound
   8. Cone beam image capture
c) Tests and Examinations
d) Viral culture
e) Collection and preparation of saliva sample for laboratory diagnostic testing
f) Diagnostic casts – for diagnostic purposes only and not in conjunction with other services
g) Oral pathology laboratory
   1. Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
   2. Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
   3. Other oral pathology procedures, by report

**Preventive Services**

* Indicates preventive services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

a) Dental prophylaxis once every 6 months*
b) Topical fluoride treatment once every 6 months – in conjunction with prophylaxis as a separate service*
c) Fluoride varnish once every 3 months for children under the age of 6
d) Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars. Replacement of sealants can be considered with Preauthorization.
e) Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal
   1. fixed – unilateral and bilateral
   2. removable – bilateral only
   3. recementation of fixed space maintainer

4. removal of fixed space maintainer – considered for provider that did not place appliance

**Restorative Services**

- There are no frequency limits on replacing restorations (fillings) or crowns.
- Request for replacement due to failure soon after insertion, may require documentation
- To demonstrate material failure as the cause.
- Reimbursement will include the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia.
- The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.
- Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth.
- Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal, facial or lingual surface(s) of the tooth.
- Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered).

Restorative service to include:

a) Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, pulp cap (direct or indirect) polishing and adjusting occlusion.

b) Gold foil - . Service includes local anesthesia, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program

c) Inlay/onlay restorations – metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program.

d) Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function.
   1. Service requires Preauthorization and will not be considered for cosmetic reasons, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor long term prognosis
   2. Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion.
   3. Provisional crowns are not covered.

e) Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown,

f) Prefabricated stainless steel, stainless steel crown with resin window and resin crowns. Service includes local anesthesia, insertion with cementation and adjusting occlusion.

g) Core buildup including pins

h) Pin retention

i) Indirectly fabricated (custom fabricated/cast) and prefabricated post and core
j) Additional fabricated ( custom fabricated/cast) and prefabricated post
k) Post removal
l) Temporary crown (fractured tooth)
m) Additional procedures to construct new crown under existing partial denture
n) Coping
o) Crown repair
p) Protective restoration/sedative filling

**Endodontic Services**

- Services require Preauthorization with submission of diagnostic materials and documentation of need and will not be considered for teeth that are not in occlusion or function and have poor long term prognosis. The condition of the rest of the Member's oral cavity, including missing teeth, untreated decay, and periodondic condition, will be considered when determining the long-term prognosis of the tooth.
- Teeth must be in occlusion, periodontally sound, needed for function and have good long term prognosis.
- Service includes all necessary radiographs or views needed for endodontic treatment.
- Emergency services for pain do not require Preauthorization

Endodontic services, subject to the limitations above, shall include:

a) Therapeutic pulpotomy for primary and permanent teeth
b) Pulpal debridement for primary and permanent teeth
c) Partial pulpotomy for apexogensis
d) Pulpal therapy for anterior and posterior primary teeth
e) Endodontic therapy and retreatment
f) Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
g) Apexification: initial, interim and final visits
h) Pulpal regeneration
i) Apicoectomy/Periradicular Surgery
j) Retrograde filling
k) Root amputation
l) Surgical procedure for isolation of tooth with rubber dam
m) Hemisection
n) Canal preparation and fitting of preformed dowel or post
o) Post removal

**Periodontal Services**

Services require Preauthorization with submission of diagnostic materials and documentation of need.

a) Surgical services
    1. Gingivectomy and gingivoplasty
    2. Gingival flap including root planning
    3. Apically positioned flap

4. Clinical crown lengthening
5. Osseous surgery
6. Bone replacement graft – first site and additional sites
7. Biologic materials to aid soft and osseous tissue regeneration
8. Guided tissue regeneration
9. Surgical revision
10. Pedicle and free soft tissue graft
11. Subepithelial connective tissue graft
12. Distal or proximal wedge
13. Soft tissue allograft
14. Combined connective tissue and double pedicle graft

b) Non-Surgical Periodontal Service
1. Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma
2. Periodontal root planing and scaling – with Preauthorization can be considered every 6 months for individuals with special healthcare needs
3. Full mouth debridement to enable comprehensive evaluation
4. Localized delivery of antimicrobial agents

c) Periodontal maintenance

**Prosthodontic Services**

- All dentures and maxillofacial prosthetics require Preauthorization.
- Fixed prosthodontics (fixed bridges) will normally only be considered if extenuating circumstances exist. A Preauthorization shall be submitted to an IHS dental consultant with recent diagnostic full mouth radiographs and written documentation of the circumstances.
- New dentures or replacement dentures may be considered every 7 $^{1}/_{2}$ years unless dentures become obsolete due to additional extractions or are damaged beyond repair.
- All needed dental treatment must be completed prior to denture fabrication.
- Patient identification must be placed in dentures in accordance with State Board regulation.
- Insertion of dentures includes adjustments for 6 months post insertion.
- Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

Prosthodontic services to include:

a) Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature

b) Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion.
1. Resin base and cast frame dentures including any conventional clasps, rests and teeth
2. Flexible base denture including any clasps, rests and teeth

3. Removable unilateral partial dentures or dentures without clasps are not considered

c) Overdenture – complete and partial

d) Denture adjustments –6 months after insertion or repair

e) Denture repairs – includes adjustments for first 6 months following service

f) Denture rebase – following 12 months post denture insertion and subject to Preauthorization denture rebase is covered and includes adjustments for first 6 months following service

g) Denture relines – following 12 months post denture insertion denture relines are covered once a year without Preauthorization and includes adjustments for first 6 months following service

h) Precision attachment, by report

i) Maxillofacial prosthetics - includes adjustments for first 6 months following service

1. Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
2. Obturator prosthesis: surgical, definitive and modifications
3. Mandibular resection prosthesis with and without guide flange
4. Feeding aid
5. Surgical stents
6. Radiation carrier
7. Fluoride gel carrier
8. Commissure splint
9. Surgical splint
10. Topical medicament carrier
11. Adjustments, modification and repair to a maxillofacial prosthesis
12. Maintenance and cleaning of maxillofacial prosthesis

j) Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years.

1. Covered Services, subject to the limitations above, include: implant body, abutment and crown.

k) Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists.

1. The replacement of an existing defective fixed bridge is also allowed when noted criteria are met.
2. A Member with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge.
3. Considerations and requirements noted for single crowns apply
4. Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth.

5. Abutment teeth must be periodontally sound and have a good long term prognosis
6. Repair and recementation

l) Pediatric partial denture – for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth, subject to Preauthorization.

**Oral and Maxillofacial Surgical Services**

Local anesthesia, suturing and routine post op visit for suture removal are included with service.

a) Extraction of teeth:
   1. Extraction of coronal remnants – deciduous tooth,
   2. Extraction, erupted tooth or exposed root
   3. Surgical removal of erupted tooth or residual root
   4. Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications

b) Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.

c) Other surgical Procedures
   1. Oroantral fistula
   2. Primary closure of sinus perforation and sinus repairs
   3. Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
   4. Surgical access of an unerupted tooth
   5. Mobilization of erupted or malpositioned tooth to aid eruption
   6. Placement of device to aid eruption
   7. Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
   8. Surgical repositioning of tooth/teeth
   9. Transseptal fiberotomy/supra crestal fiberotomy
   10. Surgical placement of anchorage device with or without flap
   11. Harvesting bone for use in graft(s)

d) Alveoloplasty in conjunction or not in conjunction with extractions

e) Vestibuloplasty

f) Excision of benign and malignant tumors/lesions

g) Removal of cysts (odontogenic and nonodontogenic) and foreign bodies

h) Destruction of lesions by electrosurgery

i) Removal of lateral exostosis, torus palatinus or torus madibularis

j) Surgical reduction of osseous tuberosity

k) Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same Provider.

l) Surgical Incision
   1. Incision and drainage of abscess - intraoral and extraoral
   2. Removal of foreign body
   3. Partial ostectomy/sequestrectomy
   4. Maxillary sinusotomy

m) Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same Provider.

n) Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same Provider.
   1. Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same Provider.
   2. Manipulation under anesthesia
   3. Condylectomy, discectomy, synovectomy
   4. Joint reconstruction
   5. Services associated with TMJD treatment require Preauthorization

o) Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage

p) Arthroscopy

q) Occlusal orthotic device – includes placement and removal to same Provider

r) Surgical and other repairs
   1. Repair of traumatic wounds – small and complicated
   2. Skin and bone graft and synthetic graft
   3. Collection and application of autologous blood concentrate
   4. Osteoplasty and osteotomy
   5. LeFort I, II, III with or without bone graft
   6. Graft of the mandible or maxilla – autogenous or nonautogenous
   7. Sinus augmentations
   8. Repair of maxillofacial soft and hard tissue defects
   9. Frenectomy and frenoplasty
   10. Excision of hyperplastic tissue and pericoronal gingiva
   11. Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
   12. Emergency tracheotomy
   13. Coronoidectomy
   14. Implant – mandibular augmentation purposes
   15. Appliance removal – "by report" for Provider that did not place appliance, splint or hardware

**Orthodontic Services**

Medical necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health Provider that orthodontic treatment will improve the mental/psychological condition of the Member.

- Orthodontic treatment requires Preauthorization and is not considered for cosmetic purposes.
- Orthodontic consultation can be provided once annually as needed by the same Provider.
- Pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services.

- Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with Referral to oral surgeon or dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service.
- Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to the Member's 19th birthday.
- Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
- The placement of the appliance represents the treatment start date.
- Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for Provider that did not start case and requires Preauthorization.
- Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

Orthodontic services, subject to the limitations above, shall include:

a) Limited treatment for the primary, transitional and adult dentition
b) Interceptive treatment for the primary and transitional dentition
c) Minor treatment to control harmful habits
d) Continuation of transfer cases or cases started outside of the program
e) Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.
f) Orthognathic Surgical Cases with comprehensive orthodontic treatment
g) Repairs to orthodontic appliances
h) Replacement of lost or broken retainer
i) Rebonding or recementing of brackets and/or bands

Request for treatment must include diagnostic materials to demonstrate need, the completed HDL (NJ-Mod2) form and documentation that all needed dental preventive and treatment services have been completed.

Approval for comprehensive treatment is for up to 12 visits at a time with request for continuation to include the previously mentioned documentation and most recent diagnostic tools to demonstrate progression of treatment.

**Adjunctive General Services**

a) Palliative treatment for emergency treatment – per visit
b) Anesthesia
    1. Local anesthesia NOT in conjunction with operative or surgical procedures.
    2. Regional block
    3. Trigeminal division block.

4. Deep sedation/general anesthesia provided by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires Hospitalization or general anesthesia. 2 hour maximum time
5. Intravenous conscious sedation/analgesia – 2 hour maximum time
6. Nitrous oxide/analgesia
7. Non-intravenous conscious sedation – to include oral medications

c) Behavior management – for additional time required to provide services to a Member with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.

- One unit equals 15 minutes of additional time
- Utilization thresholds are based on place of service as follows. Preauthorization is required when thresholds are exceeded.
    - Office or Clinic maximum – 2 units
    - Inpatient/Outpatient Hospital – 4 units
    - Skilled Nursing/Long Term Care – 2 units

d) Consultation by Specialist or non-primary care provider

e) Professional visits

- House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
- Hospital or ambulatory surgical center call
    - For cases that are treated in a facility.
    - For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Preauthorization is required.
    - General anesthesia and outpatient facility charges for dental services are covered
    - Dental services rendered in these settings by a dentist not on staff are considered separately
- Office visit for observation – (during regular hours) no other service performed

f) Drugs

- Therapeutic parenteral drug
    - Single administration
    - Two or more administrations - not to be combined with single administration
- Other drugs and/or medicaments – by report

g) Application of desensitizing medicament – per visit

h) Occlusal guard – for treatment of bruxism, clenching or grinding

i) Athletic mouthguard covered once per year

j) Occlusal adjustment

- Limited - (per visit)
- Complete (regardless of the number of visits), once in a lifetime

k) Odontoplasty

l) Internal bleaching

## SECTION VII - ADULT DENTAL CARE

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

**We cover the following Adult Dental Care services:**

**Dental Benefits**

Subject to the limitations outlined below and the applicable Copayments shown in the Section XVIII Schedule of Benefits – Adult Dental and Section XIX Premiums and as set forth in the Exclusion and Limitations section located at the end of this section, We cover, as detailed below, the diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, and certain adjunctive services in the dental benefit package for Covered Adults when services are provided by a Participating Provider or by a Non-Participating Provider who performs Emergency Dental Care or preauthorized services.

- A second opinion is allowed.
- Emergency treatment is available without Preauthorization. Emergency treatment includes, but may not be limited to treatment for: pain, Acute or chronic infection, facial, oral or head and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensive, abnormal bleeding, fractures of facial bones or dislocation of the mandible.
- Diagnostic and preventive services are linked to the Provider, thus allowing You to transfer to a different Provider/practice and receive these services. The new Provider is encouraged to request copies of diagnostic radiographs if recently provided. If they are not available radiographs needed to diagnose and treat will be allowed.
- Denials of services to the dentist shall include an explanation and identify the reviewer including their contact information.
- Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.
- Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials as needed by report.
- Services that are considered experimental in nature will not be considered.
- This Policy will not cover any charges for broken appointments.

**Diagnostic Services**

* Indicated diagnostic services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

*a)* *Clinical oral evaluations twice in a 12 month period**

1. Comprehensive oral evaluation– complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and

development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation

2. Periodic oral evaluation – subsequent thorough evaluation of an established patient*
3. Limited oral evaluations that are problem focused
4. Detailed oral evaluations that are problem focused

b) Diagnostic Imaging with interpretation
   1. A full mouth series can be provided every 3 years.
   2. An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
   3. Additional films/views needed for diagnosing can be provided as needed.
   4. Bitewings, periapicals, panoramic and cephlometric radiographic images
   5. Intraoral and extraoral radiographic images
   6. Oral/facial photographic images
   7. Maxillofacial MRI, ultrasound
   8. Cone beam image capture

c) Tests and Examinations

d) Viral culture

e) Collection and preparation of saliva sample for laboratory diagnostic testing

f) Diagnostic casts – for diagnostic purposes only and not in conjunction with other services

g) Oral pathology laboratory
   1. Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
   2. Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
   3. Other oral pathology procedures, by report

**Preventive Services**

Dental prophylaxis twice every 12 months. This service can be considered every 3 months for individuals with special healthcare needs.

**Restorative Services**

- There are no frequency limits on replacing restorations (fillings).
- Preauthorization is required for all crowns and shall be based on substantial loss of tooth structure and the condition of the remaining teeth and supporting tissue.
- Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause.
- Reimbursement will include the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia.
- The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.
- Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth.

- Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal, facial or lingual surface(s) of the tooth.
- Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered).

Restorative service to include:

a) Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, pulp cap (direct or indirect) polishing and adjusting occlusion.
b) Gold foil - . Service includes local anesthesia, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
c) Inlay/onlay restorations – metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
d) Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function. (Preauthorization required)
    1. Service requires Preauthorization and will not be considered for cosmetic reasons, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor long term prognosis
    2. Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion.
    3. Provisional crowns are not covered.
e) Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown,
f) Core buildup including pins
g) Pin retention
h) Indirectly fabricated (custom fabricated/cast) and prefabricated post and core (Preauthorization required)
i) Additional fabricated ( custom fabricated/cast) and prefabricated post (Preauthorization required)
j) Post removal
k) Temporary crown (fractured tooth)
l) Additional procedures to construct new crown under existing partial denture (Preauthorization required)
m) Coping
n) Crown repair
o) Protective restoration/sedative filling

**Endodontic Services**

- Services require Preauthorization with submission of diagnostic materials and documentation of need and will not be considered for teeth that are not in occlusion or function and have poor long term prognosis. The condition of the rest of Your oral cavity, including missing teeth, untreated decay, and periodondic condition, will be considered when determining the long-term prognosis of the tooth.

- Teeth must be in occlusion, periodontally sound, needed for function and have good long term prognosis.
- Service includes all necessary radiographs or views needed for endodontic treatment.
- Emergency services for pain do not require Preauthorization.

Endodontic services, subject to the limitations above, shall include:

a) Therapeutic pulpotomy for primary and permanent teeth
b) Pulpal debridement for primary and permanent teeth
c) Partial pulpotomy for apexogensis
d) Pulpal therapy for anterior and posterior primary teeth
e) Endodontic therapy and retreatment
f) Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
g) Apexification: initial, interim and final visits
h) Pulpal regeneration
i) Apicoectomy/Periradicular Surgery
j) Retrograde filling
k) Root amputation
l) Surgical procedure for isolation of tooth with rubber dam
m) Hemisection
n) Canal preparation and fitting of preformed dowel or post
o) Post removal

**Periodontal Services**

Services require Preauthorization with submission of diagnostic materials and documentation of need.

a) Surgical services
    1. Gingivectomy and gingivoplasty
    2. Gingival flap including root planning
    3. Apically positioned flap
    4. Clinical crown lengthening
    5. Osseous surgery
    6. Bone replacement graft – first site and additional sites
    7. Biologic materials to aid soft and osseous tissue regeneration
    8. Guided tissue regeneration
    9. Surgical revision
    10. Pedicle and free soft tissue graft
    11. Subepithelial connective tissue graft
    12. Distal or proximal wedge
    13. Soft tissue allograft
    14. Combined connective tissue and double pedicle graft
b) Non-Surgical Periodontal Service
    1. Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma

2. Periodontal root planing and scaling – can be considered for up to 4 quadrants every 12 months without Preauthorization. Preauthorization shall be obtain for additional quadrants.
3. Full mouth debridement to enable comprehensive evaluation
4. Localized delivery of antimicrobial agents

c) Periodontal maintenance

**Prosthodontic Services**

Services require Preauthorization with submission of diagnostic materials and documentation of need.

- All dentures and maxillofacial prosthetics require Preauthorization.
- Fixed prosthodontics (fixed bridges) will normally only be considered if extenuating circumstances exist. A Preauthorization shall be submitted to an IHS dental consultant with recent diagnostic full mouth radiographs and written documentation of the circumstances.
- New dentures or replacement dentures may be considered every 7 $^{1}/_{2}$ years unless dentures become obsolete due to additional extractions or are damaged beyond repair.
- All needed dental treatment must be completed prior to denture fabrication.
- Patient identification must be placed in dentures in accordance with State Board regulation.
- Insertion of dentures includes adjustments for 6 months post insertion.
- Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

Prosthodontic services to include:

a) Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature

b) Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion.
   1. Resin base and cast frame dentures including any conventional clasps, rests and teeth
   2. Flexible base denture including any clasps, rests and teeth
   3. Removable unilateral partial dentures or dentures without clasps are not considered

c) Overdenture – complete and partial

d) Denture adjustments –6 months after insertion or repair

e) Denture repairs – includes adjustments for first 6 months following service

f) Denture rebase – following 12 months post denture insertion and subject to Preauthorization denture rebase is covered and includes adjustments for first 6 months following service

g) Denture relines – following 12 months post denture insertion denture relines are covered once a year without Preauthorization and includes adjustments for first 6 months following service

h) Precision attachment, by report

i) Maxillofacial prosthetics - includes adjustments for first 6 months following service
   1. Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
   2. Obturator prosthesis: surgical, definitive and modifications
   3. Mandibular resection prosthesis with and without guide flange
   4. Feeding aid
   5. Surgical stents
   6. Radiation carrier
   7. Fluoride gel carrier
   8. Commissure splint
   9. Surgical splint
   10. Topical medicament carrier (Preauthorization required)
   11. Adjustments, modification and repair to a maxillofacial prosthesis
   12. Maintenance and cleaning of maxillofacial prosthesis

j) Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years.
   1. Covered Services, subject to the limitations above, include: implant body, abutment and crown.

k) Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists.
   1. The replacement of an existing defective fixed bridge is also allowed when noted criteria are met.
   2. Considerations and requirements noted for single crowns apply
   3. Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth.
   4. Abutment teeth must be periodontally sound and have a good long term prognosis
   5. Repair and recementation

**Oral and Maxillofacial Surgical Services**

Services require Preauthorization with submission of diagnostic materials and documentation of need.

Local anesthesia, suturing and routine post op visit for suture removal are included with service.

a) Extraction of teeth:
   1. Extraction of coronal remnants – deciduous tooth,
   2. Extraction, erupted tooth or exposed root
   3. Surgical removal of erupted tooth or residual root

4. Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications

b) Other surgical Procedures
   1. Oroantral fistula
   2. Primary closure of sinus perforation and sinus repairs
   3. Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
   4. Surgical access of an unerupted tooth
   5. Mobilization of erupted or malpositioned tooth to aid eruption
   6. Placement of device to aid eruption
   7. Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
   8. Surgical repositioning of tooth/teeth
   9. Transseptal fiberotomy/supra crestal fiberotomy
   10. Surgical placement of anchorage device with or without flap
   11. Harvesting bone for use in graft(s)

c) Alveoloplasty in conjunction or not in conjunction with extractions
d) Vestibuloplasty
e) Excision of benign and malignant tumors/lesions
f) Removal of cysts (odontogenic and nonodontogenic) and foreign bodies
g) Destruction of lesions by electrosurgery
h) Removal of lateral exostosis, torus palatinus or torus madibularis
i) Surgical reduction of osseous tuberosity
j) Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.
k) Surgical Incision
   1. Incision and drainage of abscess - intraoral and extraoral
   2. Removal of foreign body
   3. Partial ostectomy/sequestrectomy
   4. Maxillary sinusotomy
l) Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.
m) Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider.
   1. Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
   2. Manipulation under anesthesia
   3. Condylectomy, discectomy, synovectomy
   4. Joint reconstruction
   5. Services associated with TMJD treatment require Preauthorization
n) Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage
o) Arthroscopy
p) Occlusal orthotic device – includes placement and removal to same provider
q) Surgical and other repairs

1. Repair of traumatic wounds – small and complicated
2. Skin and bone graft and synthetic graft
3. Collection and application of autologous blood concentrate
4. Osteoplasty and osteotomy
5. LeFort I, II, III with or without bone graft
6. Graft of the mandible or maxilla – autogenous or nonautogenous
7. Sinus augmentations
8. Repair of maxillofacial soft and hard tissue defects
9. Frenectomy and frenoplasty
10. Excision of hyperplastic tissue and pericoronal gingiva
11. Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
12. Emergency tracheotomy
13. Coronoidectomy
14. Implant – mandibular augmentation purposes
15. Appliance removal – "by report" for provider that did not place appliance, splint or hardware

**Adjunctive General Services**

a) Palliative treatment for emergency treatment – per visit

b) Anesthesia
   1. Local anesthesia NOT in conjunction with operative or surgical procedures.
   2. Regional block
   3. Trigeminal division block.
   4. Deep sedation/general anesthesia provided by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires Hospitalization or general anesthesia. 2 hour maximum time
   5. Intravenous conscious sedation/analgesia – 2 hour maximum time
   6. Nitrous oxide/analgesia
   7. Non-intravenous conscious sedation – to include oral medications

c) Behavior management – for additional time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.
   - One unit equals 15 minutes of additional time
   - Utilization thresholds are based on place of service as follows. Preauthorization is required when thresholds are exceeded.
     - Office or Clinic maximum – 2 units
     - Inpatient/Outpatient Hospital – 4 units
     - Skilled Nursing/Long Term Care – 2 units

d) Consultation by Specialist or non-primary care Provider

e) Professional visits
   - House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
   - Hospital or ambulatory surgical center call
     - For cases that are treated in a facility.

- For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Preauthorization is required.
- General anesthesia and outpatient facility charges for dental services are covered
- Dental services rendered in these settings by a dentist not on staff are considered separately

- Office visit for observation – (during regular hours) no other service performed

f) Drugs
- Therapeutic parenteral drug
  - Single administration
  - Two or more administrations - not to be combined with single administration
- Other drugs and/or medicaments – by report

g) Application of desensitizing medicament – per visit
h) Occlusal guard – for treatment of bruxism, clenching or grinding
i) Athletic mouthguard covered once per year
j) Occlusal adjustment
- Limited - (per visit)
- Complete (regardless of the number of visits), once in a lifetime

k) Odontoplasty
l) Internal bleaching

**Exclusions and Limitations**

**Non-covered services**
A non-covered service is that procedure which is primarily for cosmetic purposes, for which dental necessity cannot be demonstrated, or which is determined to be beyond the scope of the program by an IHS dental consultant as specified in this chapter.

Preauthorization is required for all crowns and shall be based on substantial loss of tooth structure and the condition of the remaining teeth and supporting tissue to justify this treatment.

**Removable prosthodontic services shall be provided as follows:**

Dentures, both partial and complete, may be prior authorized when submitted evidence indicates masticatory deficiencies likely to impair the general health of the beneficiary.

The following factors should also be considered when requesting Preauthorization for dentures (including immediate dentures):

Employment status and rehabilitative potential of the beneficiary (for example, provision of dentures will enhance vocational placement);

Medical status of beneficiary (nature and severity of disease or impairment) and psychological predisposition;

Condition of the oral cavity, including abnormal soft tissue or osseous conditions; Condition of present dentures, if applicable.

Generally, Preauthorization for partial dentures to replace posterior teeth will not be granted if there are at least eight posterior teeth which in the opinion of an IHS dental consultant are in reasonably good periodontal condition, occlusion and position, or where a prosthesis in one arch will produce equivalent dentition.

**Fixed prosthodontic** services shall be provided as follows:

Fixed bridges will not normally be reimbursed. If extenuating circumstances exist, a Preauthorization request shall be submitted to an IHS dental consultant with recent diagnostic full mouth radiographs and written documentation of the circumstances.

In extenuating circumstances, if a patient is mentally or physically compromised to the extent that a removable prosthesis cannot be tolerated, a request accompanied by documentation from the Physician should be submitted.

Replacement of an existing defective fixed bridge will only be considered for reimbursement if there are no other missing teeth in that arch, there is no radiographic evidence of a periodontal pathology present on recent radiographs and the abutment teeth have a favorable long term prognosis.

If there are fewer than eight posterior teeth in reasonably good occlusion and periodontal condition, a partial denture will be recommended by an IHS dental consultant.

**Implant services** shall be provided as follows:

Implants will not normally be considered for reimbursement. Preauthorization for implants will be limited to requests that demonstrate that a beneficiary has a facial anomaly, deformity or has been unable to function with a complete denture for at least two years and other oral surgical corrections have been unsuccessful in improving the retention of the denture.

**Periodontal services**

Reimbursement shall be provided for periodontal scaling and root planing for four quadrants annually without Preauthorization. Preauthorization shall be obtained for additional quadrants of periodontal scaling and root planing, and all other periodontal services.

Additional periodontal services may be prior authorized by the Division on a very selective basis.

When requesting periodontal surgery, consideration should be given to the age and health of the beneficiary, the amount of bone loss, the condition of the remaining dentition, the desire, ability, and

motivation of the beneficiary to follow through with necessary home and follow-up care, and the prognosis for the remaining teeth.

## SECTION VIII - EXCLUSIONS AND LIMITATIONS

No Coverage is available under this Policy for the following:

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

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

**C. Cosmetic Services.**
We do not cover cosmetic services or surgery unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a newly-born Child Dependent 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.

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

**E. Experimental or Investigational Treatment.**
We do not cover any health care service, procedure, treatment or device that is experimental or investigational. 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 specifically, including any Hospital charges or prescription drug charge except for services set forth in the Pediatric Dental Care section Pages 16-25 and the Adult Dental Care section, Pages 31 and 32 of this Policy under the section titled "Adjunctive General Services".

**I. 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 New Jersey FamilyCare).

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

**K. Services not Listed.**
We do not cover services that are not listed in this Policy as being Covered.

**L. Services Provided by a Family Member.**
We do not cover services performed by a Member's immediate family.

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

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

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

## SECTION IX - CLAIM DETERMINATIONS

### A. Claims.

A claim is a request that benefits or services be provided or paid according to the terms of this Policy. When You receive services from a Participating Provider You will not need to submit a claim form. Notwithstanding the foregoing, You may, at Your option, file the claim for payment to Us. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If Emergency Dental Care is provided outside the State of New Jersey and the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us.

### B. Notice of Claim.

In the event You elect to file a 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 one (1) year after You receive the services for which payment is being requested. Failure to furnish proof within one (1) year shall not invalidate or reduce any claim if You can show that it was not reasonably possible to produce the information within one (1) year and proof of claim was furnished as soon as reasonably possible.

### D. 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 an Appeal pursuant to the Member Appeal Process 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 section of this Policy.

### E. Pre-service Claim Determinations.

**1.** A pre-service claim is a request from Your PCD or the Participating Specialist 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 (for example a Referral or a covered benefit determination), We will make a determination and provide notice to You within three (3) business from receipt of the claim. If We need additional information, We will request the information from Your Provider within three (3) business from receipt of the claim. You will have ten (10) calendar days to submit the

information. If We receive the information within ten (10) calendar days, We will make a determination and provide notice to You in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within ten (10) calendar days, We will make a determination within ten (10) business days of receipt of request for service

**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 by telephone, within 24 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 the information from Your Provider within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You by telephone within 48 hours of the earlier of Our receipt of the information within 48 hours from the receipt of the request for service. 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 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 in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period.

## SECTION X - 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 dentists or; 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your 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. 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 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 ten (10) calendar days to submit the information. If We receive the requested information within ten (10) calendar days, We will make a determination and provide notice to You 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 ten (10) calendar days, We will make a determination within ten (10) business days of receipt of request for service.

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 and Your Provider, by telephone, within 24 hours of receipt of the request or as fast as the member's condition requires. 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 24 hours to submit the information. We will make a determination and provide notice to You and Your Provider by telephone and in writing within 48 hours of the earlier of

Our receipt of the information or within 48 hours from the receipt of the request for service.

## C. Concurrent Reviews

1. Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You and Your Provider, by telephone and in writing, within three (3) business day of receipt of all necessary information. If We need additional information, We will request it within three (3) business day. You or Your Provider will then have ten (10) calendar days to submit the information. We will make a determination and provide notice to You and Your Provider, by telephone and in writing, within three (3) business day of Our receipt of the information or, if We do not receive the information, within ten (10) business days of receipt of request for service.

4. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within three (3) 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 and Your Provider within the earlier of 24 hours of receipt of the request or as fast as Your condition requires. If We need additional information, We will request it within 24 hours. We will make a determination and provide written notice to You and Your Provider within 24 hours of Our receipt of the information or, within 48 hours from the receipt of the request for service.

## 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 before making an adverse determination, Your Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For Preauthorization and concurrent reviews, the reconsideration will take place within one (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.

## SECTION XI - MEMBER APPEAL PROCESS

In any case where You, or Your Provider acting on behalf of You, with Your consent, is not satisfied with the denial termination or limitation of a dental service, as determined by Healthplex, You may file an Appeal. Neither You nor Your Provider who files an Appeal to a denial, termination or limitation of a dental service with Healthplex will be discriminated against and Healthplex will take no retaliation response to the filing of an Appeal to a denial, termination or limitation of a dental service.

Appeals may be oral (followed up in writing) or written to:

International Healthcare Services, Inc.
Complaints and Appeals
333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553
Member Services at 1-888-468-2183

**Level 1 Appeal**

1. You and/or the Provider acting on behalf of You with Your consent can initiate an Appeal to Healthplex verbally or in writing within one hundred and eighty (180) days of the date of the Denial of Service.

2. To submit an Appeal, You or the Provider on behalf of You must include the following information:
   a. the name and address of You or the Provider involved;
   b. Your ID number;
   c. the date of service(s);
   d. the nature of and reason behind the Appeal;
   e. the remedy sought; and
   f. the documentation to support the Appeal.

2. You, or any Provider acting on behalf of You and with Your consent, who is dissatisfied with any Healthplex utilization management determination, will have the opportunity to speak and Appeal that determination with the Healthplex Dental Director and/or the dentist designee who rendered the determination. A dentist who was not involved in the initial determination and is not a subordinate of the original reviewer will make the decision regarding the first level Appeal.

3. Level 1 Appeals shall be resolved as soon as possible in accordance with the medical exigencies of the case. For emergent and urgent Appeals, see "Expedited Appeals" section set forth herein. All other Level 1 Appeals shall be resolved within five (5) business days from date of receipt of Appeal. In the event a Level 1 Appeal is denied, the denial letter shall include the following information:

   A. Statement of action being taken by Healthplex;
   B. Explanation of reasons for action;

C. Right of You to initiate a Level 2 Appeal; and
D. Notification that You and/or the Provider acting on behalf of You, with Your consent, can file a request for a Level 2 Appeal within sixty (60) days from the receipt of the written determination of the Level 1 Appeal.

4. Upon request, You and/or the Provider, acting on behalf of You with Your consent, will be provided with the clinical criteria relied upon to make the determination.

**Level 2 Appeal**

1. You and/or the Provider acting on behalf of You with Your consent may initiate a Level 2 Appeal verbally or in writing within sixty (60) days of Your receipt of the Level 1 Appeal denial letter. You, or the Provider acting on behalf of You, who is dissatisfied with the results of the Level 1 Appeal, will have the opportunity to pursue Your Appeal before a panel of Physicians and/or other healthcare professionals. Healthplex will select the panel.

2. The Appeal panel will include at least one consultant practitioner who is trained or practices in the same specialty as would typically mange the case at issue or such other licensed healthcare professionals as mutually agreed upon by the parties. Panel Members will not have been previously involved in the utilization management determination.

3. You have a right to appear before the panel. If unable or unwilling to appear before the panel in person, You have the right to communicate by conference call or other available appropriate technology.

4. Level 2 Appeals will be acknowledged in writing to You or the Provider who is filing the Appeal within ten (10) business days of receipt.

5. Level 2 Appeals will be resolved as soon as possible in accordance with the medical exigencies of the case. For emergent and urgent Appeals, see "Expedited Appeals" section set forth herein. All other Level 2 Appeals will be resolved within twenty (20) business days.

6. Healthplex may request an extension of twenty (20) additional business days when it can be demonstrated that a reasonable cause for the delay was beyond Healthplex's control and where a written progress report and explanation for the delay has been approved to the satisfaction of the Department of Banking and Insurance. A written explanation of the delay and the reason for the request for an extension will be sent to You and/or the Provider within the original 20 business day review period.

7. Healthplex will provide You and/or the Provider with written notification of the appeal determination and the reasons for the decision.

8. In the event a Level 2 Appeal is denied, the denial letter shall include the following information:

   A. Statement of action being taken by Healthplex and;
   B. Explanation of reasons for action.

Upon request, You and/or the Provider acting on behalf of You with Your consent will be provided with the clinical criteria relied upon to make the determination.

**Expedited Appeal**

1. Level 1 and Level 2 Appeals shall be resolved as soon as possible in accordance with the medical exigencies of the case, which in no event shall exceed 72 hours from receipt of an Appeal in the case of Appeals from determinations regarding urgent or emergent care (including all situations in which You are confined as an inpatient).

2. Investigation and resolution of Level 1 and Level 2 Appeals involving emergent care will be concluded within 24 hours of receipt of an Appeal. Investigation and resolution of Level 1 and Level 2 Appeals involving urgent care will be concluded within two (2) calendar days of receipt.

3. Initial notice of the decision to You and the Provider will be delivered orally by a Member of Healthplex's Utilization Management department within 24 hours for emergent care and within two calendar days for urgent care. Written notice of the determination will be given to You and/or the Provider acting on behalf of You with Your consent within two business days of the decision.

4. Upon request, You/Provider acting on behalf of You with Your consent will be provided with the clinical criteria relied upon to make the determination.

## SECTION XII - COMPLAINTS

You may file a complaint to the Department of Banking and Insurance (DOBI) or the Office of Insurance Claims Ombudsman (OICO). Complaints shall be limited to denials based on the nature of the benefits that are described in this Policy, such as procedures that are covered or not covered, frequency limits, timely Premium payments and eligibility. Any issues pertaining to denials based upon medical judgement such as medical necessity or experimental and investigational may not be filed with DOBI or OICO.

Complaints may be sent to:

New Jersey Department of Banking and Insurance
*Consumer Protection Services*
P.O. Box 329
Trenton, NJ 08625-0329

OR

Office of Insurance Claims Ombudsman
20 West State Street
P.O. Box 472
Trenton, NJ 08625-0472
Phone: 800-446-7467
(outside of NJ call 609-292-5316 & ask for the Ombudsman's Office)
Fax: 609-292-2431
Email ombudsman@dobi.state.nj.us

## SECTION XIII - 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:

1. For Spouses in cases of divorce, the date of the divorce or dissolution of Domestic Partnership or Civil Union; or

2. For Children, until the end of the year in which the Child turns 30 years of age.

**C. Termination by You.**
The end of the month during which You provide written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.

**D. Termination by Us.**
We may terminate coverage of this Policy with 31 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 and fails to pay the required Premium within a 31-day grace period, this Policy will terminate retroactively back to the last date 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 credit and has paid at least one 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. 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.

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

4. The date the Policy is terminated because We stop offering the class of policies 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 31 days prior written notice.

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

## SECTION XIV - EXTENSION OF BENEFITS

Upon termination of coverage, whether due to termination of eligibility, or termination of the 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 XV - 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 XVI - GENERAL PROVISIONS

**1. Agreements between Us and Participating Providers.**
Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Policy does not require any Provider to accept You as a patient. We do not guarantee Your admission to any Participating Provider or any health benefits program.

**2. Assignment.**
You cannot assign any benefits under this Policy to any person, corporation, or other organization. Any assignment by You will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Policy.

**3. Changes in This Policy.**
No agent has authority to change this Policy or to waive any of its provisions and that no change in this Policy shall be valid unless approved by an officer of Us and evidenced by endorsement on the Policy, or by amendment to the Policy signed by You and Us.

**4. Choice of Law.**
This Policy shall be governed by the laws of the State of New Jersey.

**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 Jersey State law or with any applicable federal law that imposes additional requirements from what is required under New Jersey 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 or a benefit maximum. 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, amendments, riders and the attached applications, if any, constitutes the entire Policy.

**9. 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 like 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.

**10. Identification Cards.**
Identification cards ("ID") are issued by Us for identification purposes only. Possession of any identification 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.

**11. Incontestability.**
No statement made by the Subscriber in an application for coverage under this Policy shall void 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.

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

**13. 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 Your 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.

**14. 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:

International Healthcare Services, Inc.
333 Earle Ovington Blvd., Suite 300
Uniondale, New York 11553

**15. Premium Refund.**
We will give any refund of Premiums, if due, to Subscriber.

**16. Recovery of Overpayments.**
On occasion a payment will be made to You when You are not covered, for a service that is not covered, or which is more than is proper. When this happens We will explain the problem to You and You must return the amount of the overpayment to Us within 45 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 18 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct. In the event You dispute the recoupment of overpayment, You are entitled to an internal appeal as fully described in section XI.

**17. Renewal Date.**
The renewal date for the 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 upon Us

**18. 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.

**19. 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.

**20. 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.

**21. Severability.**

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

**22. 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.

**23. 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.

**24. Time to Sue.**

No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this 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.

**25. 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.

**26. 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.

**27. 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 You or the Provider regardless of whether an assignment has been made. In the event You assign over to Your Non-Participating Provider a dental benefit payment, and the payment made by Us to the Non-Participating Provider is less than the amount of the dental benefit payment, You shall pay the Non-Participating Provider the balance owed to the Non-Participating Provider.

**28. 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.

**29. 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 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.

**SECTION XVII -**
**INTERNATIONAL HEALTHCARE SERVICES**
**SCHEDULE OF BENEFITS - PEDIATRIC INDIVIDUAL DENTAL**

| **COST-SHARING** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** |
|---|---|---|
| **Out-of-Pocket Limit**<br>• One (1) Member under Age 19<br>• Two (2) or More Members under Age 19 | $350<br>$700 | Non-Participating Provider services are not Covered except as required for Emergency Dental Care and if there is no available Participating Provider to perform the service. |
| **PEDIATRIC DENTAL CARE** | **COPAYMENTS** | |
| • Preventive Dental Care | $48 | |
| • Routine Dental Care | $48 | |
| • Endodontics | $48 | |
| • Periodontics | $48 | |
| • Prosthodontics | $48 | |
| • Orthodontics | $48 | |

All in-network Preauthorizations 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 the Policy, you will be responsible for the full cost of the services.

**SECTION XVIII -**
**INTERNATIONAL HEALTHCARE SERVICE**
**SCHEDULE OF BENEFITS - ADULT INDIVIDUAL DENTAL**

| **COST-SHARING** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing**<br><br>Non-Participating Provider services are not Covered except as required for Emergency Dental Care and if there is no available Participating Provider to perform the service. |
|---|---|---|
| **ADULT DENTAL CARE** | **COPAYMENTS** | |
| • Preventive Dental Care | $48 | |
| • Routine Dental Care | $48 | |
| • Endodontics | $48 | |
| • Periodontics | $48 | |
| • Prosthodontics | $48 | |

All in-network Preauthorizations 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 the Policy, you will be responsible for the full cost of the services.

## SECTION XIX - PREMIUMS

**Premium Rates**

**Individual**

**Individual and Spouse**

**Parent & Child(ren)**

**Family**

**Rates are guaranteed for a one year period.**