Dental Benefits for
Cambridge Central School District
Group 992458-D4, D4A

Dental

9/2014

THIS IS YOUR EMPIRE BLUECROSS GROUP PLAN

FOR DENTAL CARE BENEFITS

Provided By

EMPIRE BLUECROSS

For Employees of

CAMBRIDGE CENTRAL SCHOOL DISTRICT

This is your Empire BlueCross Group Dental Care Plan available to you through an insurance policy issued and underwritten by Empire BlueCross. It is issued to the person named on the Identification Card. Coverage under the Plan begins on the effective date, and will continue unless it is terminated for any of the reasons described in this booklet.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripció

EMPIRE BLUECROSS
P.O. Box 11800
Albany, New York 12211

Form: **9962458-4A** **Rev:** **9/2014**

TABLE OF CONTENTS

SECTION ONE - INTRODUCTION

1. **Your Coverage Under this Plan.** The employer named on the cover page (referred to as "the group contract holder") has entered into a contract with us to provide group dental insurance benefits. Under that contract we will provide the benefits described in this booklet to members of the group, that is, to employees of the employer or to members of the organization. The benefits under that group contract which we describe in this booklet are referred to as "this Plan". However, this booklet is not a contract between you and us. You should keep this booklet with your other important papers so that it is available for your future reference.

2. **Words We Use.** Throughout this booklet, Empire BlueCross will be referred to as "we", "us" or "our". The word "you" refers to you, the employee or member of the group to whom this booklet is issued and whose name appears on the Empire BlueCross Identification Card; and to any members of your family who are also covered under this Plan.

3. **Care Must Be Medically Necessary.** We will not make payments under this Plan if the service or care was not medically necessary. Examples of this are: (1) your Dentist restores a tooth when a filling would have been appropriate because the loss of tooth structure or level of decay does not justify the restoration with a crown; (2) your Dentist performs a microscopic bacteria evaluation or a hair analysis in connection with periodontic treatment, both of which are services not clinically significant in relation to periodontic treatment. In these situations our determination of medically necessity will be made after considering the advice of trained dental professionals, including dentists. In making the determination we will examine all of the circumstances surrounding your condition and the care provided, including your Dentist's reasons for providing or prescribing the care, and any unusual circumstances. The fact that your Dentist prescribed the care does not automatically mean that the care qualifies for our payments under this Plan. Refer to the General Provisions Section of this Plan for an explanation of guidelines which we may use to determine whether a service is covered under this Plan.

4. **Your Payments Under This Plan.** Some of the benefits under this Plan require you to pay part of the cost of the benefits.

   Coinsurance. Coinsurance is a fixed percentage of the cost that you must pay each time you receive a particular benefit. For those benefits in this Plan where coinsurance applies, the amount of our payment is indicated and you must pay the remaining portion.

5. **Our Payments Under This Plan.** Benefits in this Plan are based on the maximum allowed amount for the service or item. The Maximum Allowed Amount is the maximum dollar amount of reimbursement for Covered Services. Please see the Maximum Allowed Amount Reimbursement for Covered Dental Services section for additional information.

If your Dentist participates in our program of direct payment to Dentists under our Matrix One program, our payment for dental services under this Plan will be made directly to the Dentist and you will not have to pay any fee to the Dentist for a service covered under this Plan, except a coinsurance.

If your Dentist does not participate in our program of direct payment to Dentists, we reserve the right to pay either you or the Dentist, or other provider.

The amount of our payment for a procedure includes payment for the necessary related care by the Dentist before and after the procedure. In other words, the one payment covers the dental procedure itself **and** the care before and after the procedure. The one payment also covers any material or appliances the Dentist uses.

SECTION TWO - WHO IS COVERED

1. **Who Is Covered.** You, the employee or member of the group whose name appears on the Identification Card, are covered under this Plan. In addition, if the group contract holder has requested that we cover your family, the following members of your family are also covered:

   - Your spouse - an opposite sex or same-sex spouse to a marriage that is legally recognized in the jurisdiction (State or Country) in which it is performed. Former spouses, as a result of a divorce or annulment of a marriage, are not considered eligible spouses.
   - Your children, including natural children, legally adopted children, stepchildren, and child of your domestic partner, until the end of the month in which the child turns 26 years of age. Your children need not be financially dependent upon you for support or claimed as dependents on your tax return; residents of your household; enrolled as students; or unmarried. Children-in-law (spouses of children) and grandchildren are not covered.
   - Your unmarried children, regardless of age, who are incapable of self-sustaining employment because of mental retardation, mental illness, or developmental disability as defined in the New York Mental Hygiene Law, or because of physical handicap, and who became so incapable prior to attainment of the age at which the dependent coverage would otherwise terminate.

Adding or Removing Dependents

If you need to change coverage categories or add or remove a dependent, you should contact your Benefits Administrator for the appropriate forms. All changes to coverage must be in writing. Life events that might cause you to need to add or remove a dependent are having a baby, getting married, getting divorced, or having your children no longer meet the eligibility requirements. The following circumstances may result in changes to your coverage:

- If you failed to enroll when you became eligible, you may enroll yourself or yourself and your dependents without waiting for the open enrollment period if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption (the qualifying event), provided that you apply for such coverage within 60 days after the qualifying event.
- Your cost for coverage may change if you add a dependent midyear. Any change affecting payment of your premium should go through your employer.
- If you or your eligible dependents reject initial enrollment, you and your eligible dependents can become eligible for coverage under this program if the following enrollment conditions are met:
  - You or eligible dependent was covered under another plan at the time coverage was initially offered, and
  - Coverage was provided in accordance with continuation required by federal or state law and was exhausted, or
  - Contract holder contributions toward the payment of premium for the other plan were terminated, or
  - Coverage under the other plan was subsequently terminated as a result of loss of eligibility for one of the following:
    - Termination of employment
    - Termination of the other
    - Legal separation, divorce or annulment
    - Reduction in the number of hours of

plan

- Death of the spouse
- An employer no longer offers benefits to a class of indivuduals (i.e., part time workers)

employment

- Premium payments for the other plan were terminated
- Lifetime maximum being met under such insurance

The eligible group member, member's spouse and eligible dependents who have not been covered under other group coverage, are eligible for a special enrollment period following marriage, a birth, adoption or placement for adoption.

Coverage must be applied for within 60 days of one of the qualifying special enrollment events described above.

- If you marry and transfer to two-person /husband and wife or family coverage within 60 days of the marriage date, Empire will provide retroactive coverage during this period. Otherwise, coverage begins on the date Empire receives and accepts your completed enrollment form from your employer during the open enrollment period.

- Eligible Employees and Dependents may also enroll under two additional circumstances:
  - the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
  - the Employee or Dependent becomes eligible for a subsidy (state premium assistance program)

  The Employee or Dependent must request Special Enrollment within sixty (60) days of the loss of Medicaid/CHIP or of the eligibility determination.

- Enrolling a newborn child:
  - For a Member who has <u>individual (for self only), employee\spouse, or parent\child (two-person)</u> coverage:
    - He\she MUST notify the Company of his\her desire to switch to a parent\child, parent\children, or family contract within sixty (60) days after the date of birth.
    - He\she MUST formally add his\her **<u>eligible</u>** newborn or a proposed adopted newborn to his\her contract within sixty (60) days from the date of birth by contacting his\her Group Benefit Administrator, Broker, or Company Representative and submitting an enrollment form in order to have the newborn's enrollment retroactive to the date of birth.
    - If the Company does not receive enrollment notification within sixty (60) days, coverage will begin on the date that we receive, and accept from the Group, a completed copy of the Member enrollment form**.**
    - If you do not switch to a parent\child, parent\children, or family contract and enroll your **eligible** newborn under that contract as described above, your newborn or proposed adopted newborn will NOT be covered under your Plan
  - For a Member who has <u>family or parent\children</u> (more than two person) coverage:
    - An **eligible** newborn child, or a proposed adopted newborn, will be covered from the date of birth**.**
    - He\she MUST formally add his\her **eligible** newborn or a proposed adopted newborn to his\her contract within sixty (60) days from the date of birth by contacting his\her Group Benefit Administrator, Broker, or Company Representative as well as submitting an enrollment form.

  - Coverage will still be effective from the date of birth for an **eligible** newborn or a proposed adopted newborn if an enrollment form is received after sixty (60) days, and enrollment will still be retroactive to the date of birth.
- Any claims for an **eligible** newborn or a proposed adopted newborn received after sixty (60) days will not be processed until the newborn or proposed adopted newborn is formally enrolled.
- An adopted newborn is covered from the moment of birth if:
  - You take custody as soon as the infant is released from the hospital after birth,
  - The newborn is dependent upon you pending finalization of the adoption, and
  - You file an adoption petition within 31 days of the infant's birth.
- Adopted newborns will not be covered from the moment of birth if:
  - The infant has coverage from one of the natural parents for the newborn's initial hospital stay
  - A notice revoking the adoption has been filed
  - One of the natural parents revokes their consent to the adoption
- Qualified Medical Child Support Orders (QMCSO). A court order, judgment or decree that:
  - Provides for child support relating to health benefits with respect to the child of a group health plan participant or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law, or
  - Enforces a state medical child support law enacted under Section 1908 of the Social Security Act.

  A Qualified Medical Child Support Order is usually issued when a parent receiving post-divorce custody of the child is not an employee.

  You may request, without charge, the procedures governing the administration of a Qualified Medical Child Support Order determination from your Plan Administrator. Your Plan Administrator will notify Empire to process the enrollment for the covered person.

If you need to change coverage categories or add or remove a dependent, you should contact your Benefits Administrator for the appropriate forms. All changes to coverage must be in writing. Life events that might cause you to need to add or remove a dependent are:

- Having a baby
- Getting married
- Getting divorced (Spousal coverage ends on the last day of the month following a divorce or annulment.)
- Having your children reach the age limit for coverage, cease to be dependent on you or get married.

Our Role in Notifying You

There may be times when benefits and/or procedures may change. We or your employer will notify you of any change in writing. Announcements will go directly to you at the address that appears on our records or to your group benefits office.

SECTION THREE - DENTAL BENEFITS

1. **Treatment Plan.** After the Dentist's initial examination, the Dentist must prepare a written Treatment Plan if the cost of the dental care to be provided will exceed $300. We will review the Treatment Plan and inform you which procedures are covered under the Treatment Plan and we will inform you and your Dentist how much we will pay for the treatment described. This method assures that you know how much we will pay for the dental care and how much you will be responsible for. If the Dentist provides more expensive care than we approved in the Treatment Plan, we will not pay for the excess portion.

   Regardless of whether or not you submit a proposed treatment plan, we will not pay for more expensive procedures if an alternative, less expensive, procedure would produce a professionally satisfactory result. If you and your Dentist agree to a more expensive method of treatment, you must pay the excess portion attributable to the more expensive procedure.

2. **Preventive Services.** We will pay for the following preventive and diagnostic dental services:

A. Oral Examinations. Oral examinations include:

(1) examinations when the Dentist first examines you to determine if further dental care is required. We will not pay for more than two routine oral examinations during any twelve month period;

(2) emergency palliative treatments for the purpose of removing or alleviating pain and sedative fillings. If additional dental services are provided (other than x-rays) on the same day, we will not make a separate payment for the oral examination.

B. Dental X-rays. Dental x-rays include:

(1) periapical x-rays, only when used for diagnostic purposes.

(2) bitewing x-rays. We will not pay for bitewing x-rays more than twice during any twelve month period.

(3) occlusal and extra-oral x-rays. We will not pay for more than a total of 2 films in any 12-month period.

(4) panoramic or full mouth x-rays.

C. Fluoride Applications. We will only pay for fluoride applications for children age 18 and younger. We will not pay for more than two fluoride applications in any twelve month period.

D. Prophylaxis. Prophylaxis includes polishing and scaling. We will not pay for more than two prophylaxes during any twelve month period. For persons over age 18, the prophylaxis may include periodontic prophylaxis.

Payments for Preventive Services.

Deductible. You must pay the first $25 of charges in each year.

Our Payments. After you have met the deductible, we will pay 80% of the maximum allowed amount of each procedure.

3. **Basic Restorative Dental Services.** We will pay for the following basic restorative dental services:

   A. Repair of Dentures and Bridges. We will pay for repairs to full or partial dentures or to bridges. The repair must take place more than 12 months after the denture or bridge was first inserted.]

   B. Fillings. The fillings may consist of silver amalgam and/or tooth color restorations using synthetic materials. Our payment for the filling includes payment for local anesthesia or direct pulp capping on the same date as the filling.

   C. Tooth Extractions. We will pay for the extraction of teeth, including extractions by surgical methods.]

   D. Endodontics. For children age 14 or less, we will pay for pulpotomy, including localanesthesia, x-rays, pulp capping, temporary fillings and post-operative care. For persons of all ages, we will pay for root canal therapy, including local anesthesia, x-rays, pulpotomy, temporary fillings and post-operative care. We will only pay for root canal therapy if you were covered under this Plan on the later of the date the pulp chamber is opened or the date the canals are explored to the apex.

   E. Periodontics. The periodontic care may consist of a surgical periodontic examination; gingival curettage; gingivectomy and gingivoplasty; osseous surgery including flap entry and enclosure; mucogingivoplastic surgery; and management of acute infections and oral lesions.

   F. Oral Surgery. The oral surgery may consist of treatment of fractures and dislocations, and diagnosis and treatment of cysts, abscesses and impaction.

   G. Apicoectomy. The apicoectomy may include flap surgery, apical curettage, local anesthesia, x-rays and post-operative care. We will not pay for more than one time per root.

Payments for Basic Restorative Dental Services.

Deductible. You must pay the first $25 of charges in each year.

Our Payments. After you have met the deductible, we will pay 80% of the maximum allowed amount of each procedure, except that we will pay only 50% of the maximum allowed amount for endodontic and periodontic procedures.

4. Prosthetic Services. We will pay for the following prosthetic services:

A. Full and Partial Dentures. We will pay for full or partial dentures, including all adjustments, realigns and rebases required during the first 12 months following insertion. We will not pay for replacement of full or partial dentures which have been lost or stolen. We only pay for replacement of full or partial dentures for other reasons once every five years. We will only pay for construction of standard dentures; if you select special or personalized procedures we will only pay the amount we would have paid for standard dentures.

B. Fixed and Removable Bridges. We will pay for bridges on vital teeth for persons over 15 years of age. We will pay for the bridges, including local anesthesia, bases, pulp capping performed on the same date as cementation, gum preparation, pins, lab charges, crowns which are part of the bridges, and adjustments. We will only pay for replacement of a fixed or removable bridge once every five years.

C. Inlays. We will only pay for inlays when the teeth cannot be restored by filling. We will pay for local anesthesia, direct pulp capping on the same date as cementation, indirect pulp capping, lab charges, base, pins, gum preparation and temporary restoration. We will only pay for replacement of inlays once every five years.]

D. Crowns. We will only pay for crowns when the teeth cannot be restored by other means and when the crown is not part of a bridge. We will not pay for crowns for the purpose of periodontal splinting. We will pay for local anesthesia, direct pulp capping on the same date as cementation, indirect pulp capping, lab charges, base, pins, gum preparation and temporary restoration. We will only pay for replacement of crowns once every five years.

For children 14 years of age and younger, coverage is limited to plastic or stainless steel crowns for vital teeth.

We will not pay for the initial replacement of a tooth missing at the time your coverage under this Plan begins.

Payments for Prosthetic Services.

Deductible. You must pay the first $25 of charges in each year.

Our Payments. After you have met the deductible, we will pay 50% of the maximum allowed amount of each procedure.

5. **Orthodontics**. The orthodontics must be for care of a handicapping malocclusion through the use of orthodontic appliances or other orthodontic treatments. We will only make payments for orthodontic services when the services begin within 90 days after we approve the Treatment Plan. If the orthodontic treatments do not begin within 90 days after we approved the Treatment Plan, a new Treatment Plan must be submitted. We will not pay for further orthodontic services, meaning those not included in the original Treatment Plan, until five years after the prior orthodontic services were completed.

   If the Dentist submits a single bill for all the orthodontic services at the time the services begin, we will make one payment every three months during the course of treatment towards the bill for the orthodontic services.]

   Payments for Orthodontics.

   Deductible. You must pay the first $25 of charges in each year.

   Our Payments. After you have met the deductible, we will pay 50% of the maximum allowed amount of each procedure.

SECTION FOUR - EXCLUSIONS

In addition to certain exclusions and limitations already described above, we will not make any payments under this Plan when any of the following apply to you:

1. **Workers' Compensation.** We will not pay for any care for any injury, condition or disease if payment is available to you under a Workers' Compensation Law or similar legislation. We will not make any payments even if you do not claim the benefits you are entitled to receive under the Workers' Compensation Law. Also, we will not make any payments even if you bring a lawsuit against the person who caused your injury or condition and even if you received money from that lawsuit and you have repaid the hospital and other medical expenses you received payment for under the Workers' Compensation Law or similar legislation.

2. **Free Care.** We will not pay for any care if the care is furnished to you without charge or would normally be furnished to you without charge. This exclusion will also apply if the care would have been furnished to you without charge if you were not covered under this Plan or under any other insurance.

3. **Government Programs.** We will reduce our payment under this Plan by the amount you are eligible to receive for the same service under Medicare or under any other federal, state or local government programs, except that we will pay even though you are eligible for Medicaid. However, we will not reduce our payment if under the Tax Equity and Fiscal Responsibility Act of 1982 you have an option to either remain covered by this Plan or be covered by Medicare, and you choose to remain covered by this Plan. In order to know what you are entitled to receive under Medicare, you should read your Medicare handbook which is available at your local Social Security office.

4. **Hospital Care.** This Plan does not provide any benefits for hospital charges or other institutional charges for room, board or supportive care provided while you are a patient in a hospital in order to receive dental care.

5. **Unnecessary Care.** We will not pay for care under this Plan which we determine was not medically necessary for your proper medical care or treatment.

6. **Cosmetic Surgery.** We will not pay for services in connection with elective cosmetic dental care which is primarily intended to improve your appearance. We will, however, pay for services in connection with reconstructive surgery when such service is incidental to or follows dental care resulting from trauma, disease or infection.

7. **Services Maintained by an Employer.** We will not pay for any service or care furnished by a dental department, clinic, or other similar service maintained by your employer.

8. **Treatments, Procedures, Hospitalizations, Drugs, Biological Products or Medical Devices Which are Experimental or Investigational.** Unless otherwise required by law with respect to drugs which are covered under this Group Plan and which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the Food and Drug Administration, we will not cover any treatment, procedure, drug, biological product or medical device (hereinafter "technology"), or any hospitalization in connection with such technology if, in our sole discretion, it is not medically necessary in that such technology is experimental or investigational. Experimental or investigational means that the technology is:

   A. not of proven benefit for the particular diagnosis or treatment of your particular condition; or

   B. not generally recognized by the medical community as reflected in the published peer-reviewed medical literature as effective or appropriate for the particular diagnosis or treatment of your particular condition.

   We will also not cover any technology or any hospitalization in connection with such technology if, in our sole discretion, such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of your particular condition.

   Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of your particular condition.

   We may apply the following five criteria in exercising our discretion and may in our discretion require that any or all of the criteria be met:

   1. Any medical device, drug or biological product must have received final approval to market by the United States Food and Drug Administration for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met.

   2. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.

   3. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e. the beneficial effects outweigh any harmful effects.

4. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.

5. Proof as reflected in the published peer-reviewed medical literature must exist that improvement in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

9. **No-Fault Automobile Insurance.** We will not pay for any service which is covered by mandatory automobile No-Fault benefits.

10. **Payments Available Under Prior Dental Coverage.** We will not pay for any service which is covered under a group dental benefits plan which previously covered your group and which the group contract holder terminated in order to purchase this Plan. In other words, if your group previously had another dental benefits plan which terminates on December 31st, and you received a series of dental treatments from December 10 through January 25 which are all covered under that other dental benefits plan, then we will not make any payments under this Plan even though this Plan may have become effective January 1st.

11. **Charges for Services Provided Pursuant to a Prohibited Referral.** We will not pay for pharmacy services, clinical laboratory services, or x-ray or imaging services furnished by any provider pursuant to a referral prohibited by §238-a of the New York State Public Health Law. Generally, §238-a prohibits physicians and other health care practitioners from making referrals for pharmacy services, clinical laboratory services or x-ray and imaging services to a provider or facility in which the referring physician or practitioner or an immediate family member has a financial interest or relationship.

12. **Services Rendered by an Immediate Family Member.** We will not pay for services rendered to you by a member of your immediate family.

13. **Dental Services Not Covered.** We will not pay for any of the following dental services**:**

A. Gold foil restoration.

B. Oral hygiene instruction; bacteriological studies; caries susceptibility tests; pulp vitality tests; diagnostic photographs; or diet planning.

C. Consulting with another Dentist on the same day your Dentist provides services covered under this Plan.

D. Athletic mouth guards; sealants; analgesia; occlusal analysis; replacement of lost or stolen appliances; myofunctional therapy; precision or semi-precision attachments; denture duplication; charges for broken appointments.

E. General anesthesia, except that we will pay for general anesthesia provided in connection with complex oral surgery, covered under this Plan.

F. Treatment of temporomandibular joint dysfunction and myofacial pain dysfunction by other than surgical methods.

G. Other procedures not included on the above list of covered services or services which do not have uniform professional endorsement.

H. Prescription and non-prescription drugs.

SECTION FIVE - COORDINATION OF BENEFITS - WHEN PAYMENTS WILL BE REDUCED

1. **Applicability.** This section applies only to group subscribers and members of their families covered under "THIS PLAN" who also have group dental benefits coverage with another "Plan." (The terms "THIS PLAN" and "Plan" are defined below .) When that is the case and you receive an item of service, we will coordinate benefit payments with any payment made under the other Plan. One will pay its full benefit as the primary plan and the other will pay secondary benefits, if necessary, to cover some or all of your remaining expenses. This prevents duplicate payments and overpayments.

2. **Definitions.**

   A. "THIS PLAN" is the group plan of which this section is a part.

   B. "PLAN" is another group dental benefits program with which we will coordinate benefits. The term "Plan" includes:

   - Group dental benefits insurance and group, blanket or group remittance dental benefits insurance coverage, whether insured, self-insured, or self-funded. This includes HMO and other prepaid group coverage but does not include blanket school accident coverage or coverage issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the policyholder (the school or organization) pays the premium.
   - Dental benefits coverage in group and individual mandatory automobile "No-Fault" and traditional mandatory automobile "fault" type contracts.
   - Dental benefits coverage of Medicare or a governmental plan offered, required or provided by law, except Medicaid. It also does not include any plan whose benefits are by law excess to any private insurance program or other non-governmental program.

3. **Rules to Determine Payment.** The first of the rules listed below (A-F) which applies shall determine which plan shall be primary:

   A. If the other Plan does not have a provision similar to this one, then it shall be primary.

   B. If you, the person receiving the benefits, are the person belonging to the group through which, or to which THIS PLAN was issued and you are only covered as a dependent under the other Plan, THIS PLAN will be primary.

   C. If a dependent child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer shall be primary. For purposes of determining whose birthday falls earlier in the year, only the month and date are considered. However, if the other Plan does not have this ("birthday") rule but instead has a rule based on the gender of the parent and as a result the plans do not agree on which is primary, then the father's plan shall be primary.

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

i. the plan of the parent who has custody (the custodial parent) shall be primary;

ii. if the custodial parent has remarried, and the child is also covered as a dependent under the step-parent's plan, the custodial parent's plan shall pay first, the step-parent's plan second and non-custodial parent's plan third.

b. If a court decree specifies which parent is to be responsible for the child's health care expenses and that parent's plan has actual knowledge of the decree, then that parent's plan shall be primary.

E. If you are covered under one plan as an active employee (i.e., not laid-off or retired), or as the dependent of such an active employee, and you are covered under another plan as a laid-off or retired employee or as the dependent of such a laid-off or retired employee, the plan which covered you as an active employee, or as the dependent of such an active employee, shall be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the plans do not agree on which shall be primary, this rule shall be ignored.

F. If none of the above rules determines which plan shall be primary, the plan which covered you for the longer period of time shall be primary.

4. **Effects of Coordination**. When THIS PLAN is secondary, the benefits of THIS PLAN will be reduced by the amount paid or provided by the primary plan(s) for the same item of service. The amount THIS PLAN will pay or provide will not be more than the amount it would pay or provide if it were primary.

5. **Private Room Differential.** Regardless of whether THIS PLAN is primary or secondary, THIS PLAN will not pay or provide benefits for the difference between the cost of a private hospital room and the cost of a semi-private hospital room unless a private room is medically necessary in terms of generally accepted medical practice.

6. **Right to Receive and Release Necessary Information.** We have the right to release or obtain information which we need to carry out the purpose of this section. We need not tell you or obtain anyone's consent to do this except as required by Article 25 of the New York General Business Law. We will not be legally responsible to you or anyone else for releasing or obtaining this information. You must furnish to us any information which we request. If you do not, we have the right to deny payments to you.

7. **Payments to Other Plans.** We may repay to any other plan the amount which it paid for your expenses and which we decide we should have paid. These payments are the same as benefits paid to you and they satisfy our obligation to you under THIS PLAN.

8. **Our Right to Recover Overpayment.** In some cases we may have made payment even though you had coverage under another plan. Under these circumstances, you agree to refund to us the amount by which we should have reduced the payment we made. We also have the right to recover any overpayment from the other plan and you agree to sign all documents necessary to help us recover any overpayment.

9. **Coordination with "Always Excess", "Always Secondary" or "Non-Complying" Plans**. We will coordinate benefits with plans which provide benefits which are always excess or always secondary or use order of benefit determination rules which are inconsistent with those described above ("non-complying plans") in the following manner:

   A. If THIS PLAN is primary, it will pay or provide benefits first;

   B. If THIS PLAN is secondary, we will still pay or provide benefits first, but the amount paid or benefits provided will be limited to what we will pay or provide if we were secondary; and

   C. If we request information from a non-complying plan and do not receive it within 30 days of our request, we can calculate the amount we should pay or provide on the assumption that the non-complying plan and THIS PLAN provide identical benefits. When the information requested is received, we will make the necessary adjustments.

SECTION SIX - TERMINATION OF COVERAGE

Described below are reasons why this Plan may terminate, or why your coverage under this Plan may terminate.

1. **Termination of the Group Plan.** This Plan is provided under the terms of a group dental insurance contract between us and the group contract holder, whose name is indicated on the front cover. The group contract is effective for a fixed term and will automatically be renewed unless either we or the group contract holder wish to terminate it. After the group contract is terminated, we will no longer provide any of the benefits of this Plan.

2. **Default in Payment of Premiums.** This Plan will terminate on a date stated in a notice to be mailed by us to the group contract holder if we do not receive the group contract holder's premium on time. If the premium is not paid on time, we will not make any payments for any service given to you after the Plan terminates.

3. **If You are No Longer a Member of the Group.** If your employment or membership in the group terminates, your coverage under this Plan will automatically terminate on the date to which the group premium has been paid. However, the longest that your coverage will continue after you are no longer a member of the group is 30 days. For example, if your employment in the group terminates on May 15 and the premium has been paid to June 1, your coverage will terminate on June 1. However, if the premium has been paid to August 1, your coverage would terminate on June 15.

4. **On Your Death.** Your coverage under this Plan will automatically terminate on the date of your death.

5. **Termination of Your Marriage.** If you become divorced or your marriage is annulled, the coverage of your wife or husband under this Plan will automatically terminate on the date of the divorce or annulment.

6. **Termination of Coverage of a Child.** The coverage of your child under this Plan will automatically terminate on:

   A. the date the child marries; or

   B. the child becomes 26 years of age; or

   C. for children incapable of self-support, on the date the child becomes capable of self-support;

   D. for children who are covered while enrolled as full-time students, on the date the child becomes 25 years of age or is no longer a full-time student with a principal residence with a parent.

7. **Benefits After Termination.** We will not make payments for any dental care you receive after your coverage under this Plan terminates.

   However, if prior to the termination date your Dentist begins a course of treatment which evokes a series of visits, we will pay for the services performed within 30 days after the date your coverage under this Plan terminated if your coverage terminated because you are no longer a member of the group, as described in paragraph 3 above. However, we will not pay for more care than you would have been entitled to receive if your coverage after the Plan had not been terminated.

Continuation of Group Coverage

You may continue your group health coverage for you and certain dependents under certain circumstances outlined below:

- your employment terminates
- a dependent no longer meets the contract's eligibility requirements.

You may be entitled to continue coverage under the federal government's Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Otherwise, you may be entitled to such coverage under New York State law ("State Law").

IMPORTANT INFORMATION

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

WHAT IS CONTINUATION COVERAGE?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee. To be eligible, a qualified beneficiary must be enrolled in the plan on the day before the qualifying event. A child who is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of the federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to Plan Administrator of the birth or adoption.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including*:* open enrollment and special enrollment rights.

Notice of Qualifying Events:

Your plan will offer COBRA continuation coverage (generally, the same coverage that the qualified beneficiary had immediately before qualifying for coverage) to qualified beneficiaries only after your Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, your death, if your plan provides retiree health coverage, commencement of a proceeding in bankruptcy with respect to your employer, or you becoming entitled to Medicare benefits (under Part A, Part B, or both, if applicable), your employer must notify your Plan Administrator of the qualifying event.

For the other qualifying events, (your divorce or legal separation, or a dependent child's losing eligibility for coverage as a dependent child), you must notify your Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your Plan Sponsor or the Group Benefits Administrator for your group.

HOW LONG WILL CONTINUATION COVERAGE LAST?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

HOW CAN YOU EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify your Plan Sponsor or the Group Benefits Administrator responsible for COBRA administration, of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

DISABILITY

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until

the end of the 18-month period of continuation coverage. Contact your plan administrator for additional information. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan Administrator of that fact within 30 days after SSA's determination.

SECOND QUALIFYING EVENT

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

HOW CAN YOU ELECT COBRA CONTINUATION COVERAGE?

To elect continuation coverage, you must complete the Cobra Continuation Coverage Election Form available from your Plan Administrator and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

HOW MUCH DOES COBRA CONTINUATION COVERAGE COST?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. Contact your Plan Administrator for additional information.

[*For employees eligible for trade adjustment assistance:* The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty

Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

WHEN AND HOW MUST PAYMENT FOR COBRA CONTINUATION COVERAGE BE MADE?

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact your Plan Administrator or other party responsible for COBRA administration under the Plan to confirm the correct amount of your first payment.

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in the Election Notice. If you fail to make a periodic payment before the end of any applicable grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

FOR MORE INFORMATION

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from the Plan Administrator.

If you have any questions concerning the information in this notice or your rights to coverage, you should contact the Group Benefits Administrator.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

The Veterans Benefits Improvement Act of 2004

The Veterans Benefits Improvement Act of 2004, which amends the 1994 Uniformed Services Employment and Reemployment Rights Act (USERRA), extends the period for continuation of health care coverage as follows:

If a covered person's health plan coverage would terminate because of an absence due to military service, the person may elect to continue the health plan coverage for up to 24 months after the absence begins or for the period of service. Similar to COBRA, the person cannot be required to pay more than 102 percent (except where State requirements provide for a lesser amount) of the full premium for the coverage. If military service was for 30 or fewer days, the person cannot be required to pay more than the normal employee share of any premium.

Reservists Supplementary Continuation and Conversion

If the group's plan qualifies as an employer group heath plan subject to federal continuation of coverage provision of COBRA, previously described, the supplementary continuation and conversion right described in this section does not apply.

- If a covered member who is a member of a reserve component of the armed forces of the United States, including the National Guard, enters upon active duty and the group does not voluntarily maintain coverage for such member, coverage will be suspended unless the member elects in writing, within 60 days of being ordered to active duty, to continue coverage under this program for the covered member and their eligible covered dependents. Such continued coverage shall not be subject to evidence of insurability. The member must pay the group the required group rate premium in advance, but more frequently than once a month.
- Reservists' supplementary continuation will not be available to any person who is, could be, covered by Medicare or any other group coverage. Coverage available to active duty members of the armed forces will not be considered group coverage for the above purposes.
- In the event that the Member is re-employed or restored to participation in the Group upon return to civilian status after the period of continuation of coverage or suspension, the member will be entitled to resume coverage under program for the member and eligible dependents. If coverage has been suspended, resumed coverage will be retroactive to the date of termination of active duty. No exclusion or waiting period will be imposed in connection with resumed coverage except regarding:
    - a condition that arose during the period of active duty and that has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty; or
    - a waiting period imposed that had not been completed prior to the period of suspension. The sum of the waiting periods imposed prior and subsequent to the suspension shall not exceed eleven months.

In the event that the covered member is not re-employed or restored to participation in the group upon return to civilian status, the member shall have the right within 31 days of the termination of active duty, or discharge from hospitalization, incident to active duty which continues for a period of not more than one (1) year, to submit a written request for continuation to the group, or a request for conversion directly to Empire, as described in this booklet. Such individual conversion policy will be effective on the day after the end of the period of supplementary

continuation. If the member elects supplementary continuation or if coverage is suspended, the supplementary conversion right will be available to the member's spouse if divorce or annulment of the marriage occurs during the period of active duty, and, in the event the member dies while on active duty, to the member's spouse and children, and to each individually upon attaining the limiting age of coverage under this program, but not the child's dependents.

Under State Law

If you are not entitled to continuation of coverage under COBRA, you may be entitled to continue coverage under the New York State Insurance Law. These laws vary from those under COBRA, but generally also require continued coverage for up to 18, 29 or 36 months.

Call or write your employer or Empire to find out if you are entitled to temporary continuation of coverage under COBRA or under the New York State Insurance Law.

Ending and Continuing Coverage

Your employer reserves the right to amend or terminate its group health plan coverage provided to you at any time without prior notice or approval. The decision to end or amend the health plan coverage may be due to changes in federal or state laws governing welfare benefits, the requirements of the Internal Revenue Code or ERISA, or any other reason.

Any amendment or termination may apply to all or any portion of the group health plan coverage and to all or to only a portion of the participants and beneficiaries.

Portability of Coverage

Your contract may require an 11-month waiting period before paying benefits for pre-existing conditions. At the same time, you may be eligible for credit toward the satisfaction of this waiting period.

If you had similar coverage (hospital, medical, or major medical) from another insurance carrier before the effective date of your Empire coverage, you will receive credit for whatever waiting period you met under that prior contract (Creditable Coverage). The pre-existing condition provision in your Empire contract provides that credit towards the pre-existing condition waiting period will be given for the time you were previously covered under Creditable Coverage of a prior plan, if the previous Creditable Coverage was continuous to a date not more than 63 days prior to the enrollment date under your Empire plan.

Please note that you have a right to request a certificate of Creditable of Coverage from a prior plan or issuer, and that Empire will assist you in obtaining a certificate from any prior plan or issuer, if necessary.

To determine you are eligible for this portability of coverage, you must provide Empire with the certificate of Creditable of Coverage or a letter of proof from the prior carrier or group that contains the covered person's name, contract type, start and end dates of coverage, and names of covered dependents.

The evidence of prior coverage should be submitted immediately to avoid possible claim rejections.

SECTION SEVEN - GENERAL PROVISIONS

1. **No Assignment.** You cannot assign any benefits or Moines due under this Plan 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 Plan or your right to collect money from us for the services.

2. **Right to Develop Guidelines.** We reserve the right to develop or adopt criteria which set forth in more detail the instances and procedures when we will make payments under this Plan. Examples of the use of the criteria are: (1) your Dentist restores a tooth when a filling would have been appropriate because the loss of tooth structure or level of decay does not justify the restoration with a crown; (2) your Dentist performs a microscopic bacteria evaluation or a hair analysis in connection with periodontic treatment, both of which are services not clinically significant in relation to periodontic treatment. Those criteria will not be contrary to the descriptions in this booklet. If you have a question about the criteria which apply to a particular benefit, you may contact us and we will explain the criteria or send you a copy of the criteria.

3. **Notice.** Any notice which we give to you will be mailed to you at your address as it appears on our records, or addressed to you in care of your employer in a sealed envelope. If you have to give us any notice, it should be mailed to our principal office at P.O. Box 11800, Albany, NY 12211-0800.

4. **Notice of Claim.** In order for us to make payments under this Plan, a completed Health Insurance Claim Form including any necessary reports and records must be received by us within eighteen (18) months of the date that care was provided or the claim will not be paid by us. These forms can be obtained from us or the provider. Your identification number must be reported as it appears on your Identification Card, and all questions on the Health Insurance Claim Form must be answered. Otherwise, we will return the form for completion.

5. **Recovery of Overpayments.** On occasion a payment will be made when you are not covered, for a service which is not covered, or which is more than is proper. When this happens we will explain the problem to you and you must return to us within 60 days the amount of the overpayment.

6. **Time to Sue.** You must start any lawsuit against us under this Plan within two years from the date you received the service which you want us to pay for.

7. **Your Medical Records.** In order to process your claims under this Plan, it may be necessary for us to obtain your medical records and information from hospitals, skilled nursing facilities, dentists or other practitioners or facilities which are proposing to treat you or which have already treated you. When you become covered under this Plan, you automatically give us permission to obtain and use those records and that information. That permission extends to the physicians, agencies and other health care personnel who we contract with to assist us in administering this Plan and reviewing the medical necessity of services covered under this Plan. We will keep those records confidential.

8. **Who Receives Payment Under this Plan.** Payments under this Plan for services provided by Dentists who participate in our Matrix One program will be made by us directly to the participating Dentist. If you receive care from a Dentist who does not participate in our Matrix One Dental program, we reserve the right to pay either you or the Dentist.

9. **Changes to this Plan.** Changes to this Plan will be made only by a rider or addendum signed by an officer of Empire BlueCross and approved by the Superintendent of Insurance of the State of New York. No agent or broker may change the benefits or other terms of this Plan or waive any of its provisions. We will not be bound by any promise or statement made by an agent or broker which is inconsistent with the terms of this Plan. If this Plan is changed all care you receive after the effective date of the change will be subject to the change, even if you were receiving care before the change became effective.

HOW TO FILE A DENTAL CLAIM

SPECIAL NOTE: The following information is not part of your Empire BlueCross Dental Contract. It is here to help you obtain the benefits under the Contract which precedes this informational material.

MEMBER DENTIST

If a Dentist is a Member Dentist with Empire BlueCross, our payment for dental services under this program will be made directly to the Dentist. You will not have to pay any fee to the Dentist for a service covered under this Plan, except a deductible or coinsurance where applicable.

IMPORTANT

If your Dentist has not signed an agreement with Empire BlueCross, **or** if he or she is located outside the area we serve, your Dentist may bill us directly. But, our payment will be sent directly to you. You will be responsible for any balance remaining. Once a claim is processed, an Explanation of Benefits (EOB) will be sent directly to you.

HOW TO FILE A DENTAL CLAIM

If you must submit the Dentist's charges yourself, please follow these instructions:

1. To obtain a dental claim form ask your employer or call our office. Take this claim form with you to your Dentist. Ask your employer or call our office for the proper claim form.
2. Complete the patient section of the claim form, include **all** the information requested.
3. Please have the Dentist fill out the appropriate section. The Dentist's signature **must** be included on the claim form.
4. Mail the claim form to:

   Empire BlueCross
   Dental Benefits Program
   P. O. Box 791
   Minneapolis, MN 55440-0791

Remember - You can call our office directly if you have questions. The telephone numbers is 1-800-722-8879.

IF YOU HAVE A QUESTION ABOUT COVERAGE OR A CLAIM

1. This booklet about your Empire BlueCross Dental program has been written in "plain language" so as to be easily read and understood. It provides a thorough description of your program and should answer most of your questions about coverage.

2. If you cannot find an answer to your question in this booklet, or if you have a question about a specific claim, write or call us directly. When writing, include all identification information (identification number, including any prefix, and group number), and as much detail about the particular claim as possible.

   Mail to: Empire BlueCross
   Dental Benefits Program
   P. O. Box 791
   Minneapolis, Minnesota 55440-0791

3. If you call Empire BlueCross Customer Service Department, be sure to have identification information (your Empire BlueCross Identification Card) ready, as well as documents relating to any specific claim about which you may have a question. Call (toll free), **1-800-722-8879.**

CLAIMS INFORMATION

The Blue Cross Plan has 90 days to make a decision on your claim after it receives the bills from the Dentist or from you directly.

If the claim is allowed by the Plan, the Plan will pay the Dentist or you as described in this booklet.

Refer to Complaints, Appeals and Grievances for more information.

For Members Who Do Not Speak English

Empire can help members who speak languages other than English ask questions and file appeals in their first language. When a Member Services representative receives a call from someone who speaks a language other than English, the representative puts the caller on hold and calls the AT&T Language Line. The AT&T Language Line operator links the Member Representative and the caller to an interpreter in the appropriate language. Through a three-way connection, the interpreter facilitates the inquiry or appeal.

Empire's application forms allow members to indicate if their primary language is other than English. Empire tracks this information, and when enrollment of non-English speaking members reaches a significant level, Empire develops member materials in that language.

THIS BOOKLET PROVIDES A GENERAL DESCRIPTION
OF YOUR EMPIRE BLUECROSS DENTAL BENEFITS PROGRAM

Reimbursement for Covered Dental Services

Maximum Allowed Amount

This section describes how We determine the amount of reimbursement for Covered Services. Reimbursement for dental services rendered by In-Network and Out-of-Network dentists is based on Your Plan's Maximum Allowed Amount for the type of service performed.

The Maximum Allowed Amount for Your Plan is the maximum amount of reimbursement Empire will pay for services and supplies:

- that meet our definition of Covered Services, to the extent such services and supplies are covered under Your Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in Your Plan

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from an Out-of-Network dentist, you may be responsible for paying any difference between the Maximum Allowed Amount and the Dentist's actual charges. This amount can be significant.

When you receive Covered Services from a Dentist, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the dental procedure. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your dentist may have submitted the claim using several procedure codes when there is a single procedure code that includes all or a combination of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same dentist or dental Provider or other dental Providers, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent a duplicate payment for a dental procedure that may have already been considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network dentist or an Out-of-Network dentist.

In-Network Dentist

An In-Network dentist is a Dentist who is in the contracted network for this specific plan or who has a participation contract with us. For Covered Services performed by an In-Network Dentist, the Maximum Allowed Amount for Your Plan is the rate the Dentist has agreed with Empire to accept as reimbursement for the Covered Services. Because In-Network dentists have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed

Amount to the extent you have not met your Deductible, or have a Copayment or Coinsurance. Please call Customer Service for help in finding an In-Network dentist or visit www.empireblue.com.

Out-of-Network Dentist

Dentists who have not signed any contract with Us and are not in any of our networks are Out-of-Network dentists.

For Covered Services You receive from an Out-of-Network dentists, the Maximum Allowed Amount for Your Plan will be one of the following as determined by Empire:

1. An amount based on Our Out-of-Network Provider Fee Schedule/Rate, which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: record fee data, reimbursement amounts accepted by like/similar providers contracted with Empire, reimbursement amounts accepted by like/similar providers for the same services or supplies, or other industry cost, reimbursement and utilization data; or

2. An amount based on information provided by a third party vendor which may reflect comparable Providers' fees and costs to deliver care; or

3. An amount negotiated by Us or a third party vendor which has been agreed to by the In-Network Provider; or

4. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

Dentists who are not contracted for this Plan but contracted for other Plans with Us are also considered Out-of-Network. For Your Plan, the Maximum Allowed Amount for services from these dentists will be one of the four methods shown above unless the contract between Us and that dentist specifies a different amount.

Unlike In-Network dentists, Out-of-Network dentists may send You a bill and collect for the amount of the Dentist's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Dentist charges. This amount can be significant. Choosing an In-Network dentist will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding an In-Network dentist or visit our website at www.empireblue.com.

Customer Service is also available to assist you in determining Your Plan's Maximum Allowed Amount for a particular service from an Out-of-Network dentist. In order for us to assist you, you will need to obtain from your dentist the specific procedure code(s) for the services the dentist will render. You will also need to know the dentist's charges to calculate your out of pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the dentist.

Member Cost Share

For certain Covered Services and depending on Your Plan, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and out of pocket limits may vary depending on whether you received services from an In-Network or Out-of-Network dentist. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network dentists. Please see the Schedule of Benefits attached to Your Plan's Certificate for your cost share responsibilities and limitations, or call Customer Service to learn how Your Plan's benefits or cost share amounts may vary by the type of dentist you use.

Empire will not provide any reimbursement for non-covered services. You may be responsible for the total amount billed by your Dentist for non- covered services, regardless of whether such services are performed by an In-Network or Out-of-Network dentist. Both services specifically excluded by the terms of Your Plan and those received after benefits have been exhausted are non-covered services. Benefits may be exhausted by exceeding, for example, your annual or lifetime maximum, benefit maximums, or day/visit limits.

Authorized Services

In some circumstances, such as where there is no In-Network dentist available for the Covered Service, we may authorize the Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Out-of-Network dentist. In such circumstance, You must contact Us in advance of obtaining the Covered Service. We also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if You receive Emergency services from an Out-of-Network dentist and are not able to contact Us until after the Covered Service is rendered. If we authorize a Covered Service so that You are responsible for the In-Network cost share amounts, You may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network dentist's charge. Please contact Customer Service for Authorized Services information or to request authorization.

The following are examples for illustrative purposes only. Please see Your Schedule of Benefits for Your applicable amounts.

Example: You require the services of a specialty Provider; but there is no In-Network dentist for that specialty in Your state of residence. You contact Us in advance of receiving any Covered Services, and We authorize You to go to an available Out-of-Network dentist for that Covered Service and We agree that the In-Network cost share will apply.

Your plan has a $45 Copayment for Out-of-Network dentists and a $25 Copayment for In-Network dentists for the Covered Service. The Out-of-Network dentist's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the In-Network cost share amount to apply in this situation, You will be responsible for the In-Network Copayment of $25 and Empire will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Out-of-Network dentist's charge for this service is $500, You may receive a bill from the Out-of-Network dentist for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with Your In-Network Copayment of $25, Your total out of pocket expense would be $325.

COMPLAINTS, APPEALS AND GRIEVANCES

An appeal is a request to review and change an adverse determination made when (i) Empire's Medical Management Program (MMP) or Mental and Behavioral Health Care Manager (MBHCM) determines a service is not Medically Necessary, or is excluded from coverage because it is considered Experimental or Investigational; or (ii) if we deny a claim, wholly or partly, for services already rendered, based on our utilization review process.

In the event that Empire renders an adverse determination without attempting to discuss such matter with the Covered Person's health care provider who specifically recommended the health care service, procedure or treatment under review, such health care provider shall have the opportunity to request a reconsideration of the adverse determination. Except in cases of retrospective reviews, such reconsideration shall occur within one (1) business day of receipt of the request and shall be conducted by the Covered Person's health care provider and the clinical peer reviewer making the initial determination or a designated clinical peer reviewer if the original clinical peer reviewer cannot be available. In the event that the adverse determination is upheld after reconsideration, Empire shall provide notice as required pursuant to subsection 3 of this Section. Nothing in this Section shall preclude the Covered Person from initiating an appeal from an adverse determination.

Failure by Empire to make a determination within these described time periods shall be deemed to be an adverse determination subject to appeal rights pursuant to the standard and expedited appeal process of Section 4904 of the New York State Insurance law, described below

STANDARD LEVEL 1 APPEALS

The Covered Person (or the Covered Person's authorized representative, or health care provider) may file a formal appeal by telephone or in writing. An appeal must be filed within one hundred, eighty (180) calendar days from the date of receipt of notice of a denial of services. An appeal submitted beyond the one-hundred, eighty (180) day filing limit will not be accepted for review.

Empire will send written notice of acknowledgement of the appeal within fifteen (15) days of receipt of that appeal to the Covered Person or the Covered Person's authorized representative. The appeal will be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination. A final determination will be made within the following timeframes after receiving all necessary information or medical records related to the appeal request:

- Precertification. We will complete our review of a precertification appeal (other than an expedited appeal) within 15 calendar days of receipt of the appeal.
- Concurrent. We will complete our review of a concurrent appeal (other than an expedited appeal) within 15 calendar days of receipt of the appeal.
- Retrospective. We will complete our review of a retrospective appeal within 30 calendar days of receipt of the appeal.

Empire will provide a written notice of our determination to the Covered Person or the Covered Person's representative, and Provider within two (2) business days of reaching a decision. The decision will include the reason(s) for the determination, including the clinical rationale if the adverse determination is upheld, date of service, claim amount (if applicable), diagnosis code and treatment code, and corresponding meaning of these codes. The notice will specify that you may request a copy of the clinical review criteria used to make the determination. The notice will also specify what, if any, additional necessary information must be provided to or obtained by Empire in order to render a decision on appeal and an explanation of why the information is necessary. The notice will also advise you of your right to appeal our determination, give instructions for requesting a standard or expedited internal appeal and initiating an external appeal.

If Empire does not make a decision within sixty (60) calendar days of receiving all necessary information to review your appeal, Empire will approve the service.

In addition, if the groups is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Group members have certain rights and protections and the group may have duties as the Group Health Plan Administrator. Among them is the right to appeal a claim decision. Under ERISA, if we deny a claim, wholly or partly, the Covered Person may appeal our decision. The Covered Person will be given written notice of why the claim was denied, and of his right to appeal the decision. Then the Covered Person has 180 days to appeal our decision.

The Covered Person (or his authorized representative) may submit a written request for review. The Covered Person may ask for a review of pertinent documents, and the Covered Person may also submit a written statement of issues and comments. The claim will be reviewed and we will make a decision within sixty (60) days after the appeal is received. If special circumstances require an extension of time, the extension will not exceed one-hundred, twenty (120) days after the appeal is received. The decision will be in writing, containing specific reasons for the decision.

EXPEDITED LEVEL 1 APPEALS

Empire will speed up the appeal process (an "expedited appeal") and deliver a rapid decision when the situation involves:

i. Continuations or extensions of health care services, procedures or treatments already begun;

ii. Additional required or provided care during an ongoing course of treatment; or

iii. A case in which the Provider believes an immediate appeal is warranted; or

iv. When home health care is requested following discharge from an inpatient hospital admission.

When requested under these circumstances, the following time frames will apply:

- Empire will provide the Covered Person or his Provider with reasonable access to our clinical reviewer within one (1) business day of receiving a request for an expedited appeal. The Provider and clinical peer reviewer may exchange information by telephone or fax.
- Empire will make a decision on an expedited appeal within the lesser of seventy-two (72) hours of recept of the appeal request or two (2) business days following receipt of all necessary information about the case, but in any event within seventy-two (72) hours of receipt of the appeal.

- Empire will notify the Covered Person and his Provider immediately of the decision by telephone and will transmit a copy of the decision in writing within twenty-four (24) hours after the decision is made.
- If the Covered Person is not satisfied with the resolution of the expedited appeal, a further appeal may be made through the standard appeal process, as described in this subsection, or through an external appeal agent if the appeal is based on Medical Necessity or Experimental or Investigational denials. The notice of appeal determination will include the time frame for external appeals as required by 4904 (C)(2) of the New York State Insurance Law.
- If Empire does not make a decision within two (2) business days of receiving all necessary information to review the Covered Person's appeal, Empire will approve the service.

STANDARD LEVEL 2 APPEALS

If the Covered Person is dissatisfied with the outcome of the Level 1 Appeal, a Level 2 Appeal may be filed with Empire within sixty (60) business days from the receipt of the notice of the letter denying the Level 1 Appeal. If the appeal is not submitted within that timeframe, we will not review it and our decision on the Level 1 appeal will stand. Appeals may be filed by telephone or in writing.

We will make a decision within the following timeframes for Level 2 Appeals:

- Precertification. We will complete our review of a precertification appeal within 15 calendar days of receipt of the appeal.
- Concurrent. We will complete our review of a concurrent appeal within 15 calendar days of receipt of the appeal.
- Retrospective. We will complete our review of a retrospective appeal within 30 calendar days of receipt of the appeal.

HOW TO REQUEST AN APPEAL

To submit an appeal, call Member Services at the telephone number located on the back of your identification card, or write to the applicable address(es) listed below. Please submit any data to support your request and include your member identification number and if applicable, claim number and date of service.

Empire Appeal and Grievance Department
PO Box 1407
Church Street Station
New York, NY 10008-1407

Send appeals concerning behavioral health care to:

Grievances and Appeals – Behavioral Health
P.O. Box 2100
North Haven, CT 06473

EXTERNAL APPEALS

Your Right to an External Appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the Plan has denied coverage on the basis that the service does not meet the Plan's requirements for medical necessity (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), you or your representative may appeal that decision to an external appeal agent, an independent entity certified by the State to conduct such appeals.

Your Right to Appeal a Determination That a Service is not Medically Necessary

If the Plan has denied coverage on the basis that the service does not meet the Plan's requirements for medical necessity, you may appeal to an external appeal agent if you satisfy the following two (2) criteria:

- The service, procedure, or treatment must otherwise be a Covered Service under the Subscriber Contract; and
- You must have received a final adverse determination through the first level of the Plan's internal appeal process and the Plan must have upheld the denial **or** you and the Plan must agree in writing to waive any internal appeal **or** you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal **or** the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

Your Right to Appeal a Determination that a Service is Experimental or Investigational

If the Plan has denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two (2) criteria:

- The service must otherwise be a Covered Service under this Subscriber Contract; and

- You must have received a final adverse determination through the first level of the Plan's internal appeal process and the Plan must have upheld the denial **or** you and the Plan must agree in writing to waive any internal appeal **or** you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal **or** the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

In addition, your attending physician must certify that your condition or disease is one for which standard health services are ineffective or medically inappropriate **or** one for which there does not exist a more beneficial standard service or procedure covered by the Plan **or** one for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation – your

attending physician should contact the State in order to obtain current information as to what documents will be considered or acceptable); or

- A clinical trial for which you are eligible (only certain clinical trials can be considered);or
- A rare disease treatment for which your attending physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

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

The External Appeal Process

If, through the first level of the Plan's internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary, or is an experimental or investigational treatment you have four (4) months from receipt of such notice to file a written request for an external appeal. If you and the Plan have agreed in writing to waive any internal appeal, you have four (4) months from receipt of such waiver to file a written request for an external appeal. If the Plan fails to adhere to claim processing requirements, you have four (4) months from such failure to file a written request for an external appeal. The Plan will provide an external appeal application with the final adverse determination issued through the first level of the Plan's internal appeal process or its written waiver of an internal appeal.

You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified external appeal agent.

You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information you submit represents a material change from the information on which the Plan based its denial, the external appeal agent will share this information with the Plan in order for it to exercise its right to reconsider its decision. If the Plan chooses to exercise this right, the Plan will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), the Plan does not have a right to reconsider its decision.

In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from you, your physician, or the Plan. If the external appeal agent requests additional information, it will have five (5) additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two (2) business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending physician certifies that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function; or if you received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, you may request an expedited external appeal. In that case, the external appeal agent must make a

decision within seventy-two (72) hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and the Plan by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns the Plan's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment the Plan will provide coverage subject to the other terms and conditions of this subscriber contract. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-experimental or non-investigational treatments provided in such clinical trial.

The external appeal agent's decision is binding on both you and the Plan. The external appeal agent's decision is admissible in any court proceeding.

Your Responsibilities

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

Under New York State law, your completed request for appeal must be filed within four (4) months of either the date upon which you receive written notification from the Plan that it has upheld a denial of coverage, or the date upon which you receive a written waiver of any internal appeal, or the failure of the Plan to adhere to claim processing requirements. The Plan has no authority to grant an extension of this deadline.

Covered Services/Exclusions

In general, the Plan does not cover experimental or investigational treatments. However, the Plan shall cover an experimental or investigational treatment approved by an external appeal agent in accordance with the subscriber contract. If the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-experimental or non-investigational treatments provided in such clinical trial.

COMPLAINTS

A complaint is a verbal or written statement of dissatisfaction where Empire is not being asked to review and overturn a previous determination. For example: You feel you waited too long for an answer to your letter to Empire. If you have a complaint about any of the health care services your Plan offers, plan procedures or our customer service, call Member Services. Member Services may ask you to put your complaint in writing if it is too complex to handle over the telephone.

Empire Member Services
PO Box 1407
Church Street Station
New York, NY 10008-1407

Send appeals concerning behavioral health care to:

Grievances and Appeals – Behavioral Health
P.O. Box 2100
North Haven, CT 06473

We will resolve complaints within the following time frames:

- *Standard complaints*. Within 30 days of receiving all necessary information.
- *Expedited complaints*. Within 72 hours of receiving all necessary information.

LEVEL 1 GRIEVANCE

A grievance is a verbal or written request for a review of an adverse determination concerning an administrative decision not related to medical necessity.

A Level 1 Grievance is your first request for review of Empire's administrative decision. You have one-hundred, eighty (180) calendar days from the receipt of the notification letter to file a grievance. A grievance submitted beyond the one-hundred, eighty (180) calendar day limit will not be accepted for review.

If the services have already been provided, Empire will acknowledge your grievance in writing within fifteen (15) calendar days from the date Empire received your grievance. The written acknowledgement will include the name, address, and telephone number of the department that will respond to the grievance, and a description of any additional information required to complete the review.

We will make a decision within the following timeframes for 1st Level Grievances:

- *Pre-service (services have not yet been rendered)*. We will complete our review of a pre-service grievance (other than an expedited grievance) within fifteen (15) calendar days of receipt of the grievance.
- *Post-service (services have already been rendered)*. We will complete our review of a post-service grievance within thirty (30) calendar days of receipt of the grievance.

LEVEL 2 GRIEVANCES

If you are dissatisfied with the outcome of your Level 1 Grievance, you may file a Level 2 Grievance with Empire. Empire must receive your request for a Level 2 Grievance by the end of the sixtieth (60th) business day after you receive our notice of determination on your Level 1 Grievance. If the Level 2 Grievance is not submitted within that timeframe, we will not review it and the decision on the Level 1 Grievance will stand. We will acknowledge receipt of the 2nd Level Grievance within fifteen (15) days of receiving the grievance. The written acknowledgement will include the name, address and telephone numbers of the department that will respond to the grievance. A qualified representative (including clinical personnel, where appropriate) who did not participate in the Level 1 Grievance decision will review the Level 2 Grievance.

We will make a decision within the following timeframes for 2nd Level Grievances:

- *Pre-service*. We will complete our review of a pre-service grievance within fifteen (15) calendar days of receipt of the grievance.
- *Post-service*. We will complete our review of a post-service grievance within thirty (30) calendar days of receipt of the grievance.

EXPEDITED GRIEVANCES

You can file an expedited Level 1 or Level 2 Grievance and receive a quicker response if a delay in resolution of the grievance would pose an imminent or serious threat to your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Expedited Grievances may be filed by telephone and in writing. When you file an expedited grievance, Empire will respond as soon as possible considering the medical circumstances of the case, subject to the following maximum timeframes:

- Empire will make a decision within 48 hours of receipt of all necessary information, but in any event within seventy-two (72) hours of receipt of the grievance.
- Empire will notify you immediately of the decision by telephone, and within two (2) business days in writing.

DECISION ON GRIEVANCES

Empire's notice of its Grievance decision (whether standard or urgent) will include:

- The reason for Empire's decision, or a written statement that insufficient information was presented or available to reach a determination
- The clinical rationale, if appropriate, and
- For Level 1 Grievances, instructions on how to file a Level 2 Grievance if you are not satisfied with the decision.

HOW TO FILE A GRIEVANCE

To submit an appeal or grievance, call Member Services at the telephone number located on the back of your ID card, or write to the following address with the reason why you believe our decision was wrong. Please submit any data to support your request and include your member ID number and, if applicable, claim number and date of service.

Empire Appeal and Grievance Department
PO Box 1407
Church Street Station
New York, NY 10008-1407

Send appeals concerning behavioral health care to:

Grievances and Appeals – Behavioral Health
P.O. Box 2100
North Haven, CT 06473

HOW YOU CAN PARTICIPATE IN POLICY DEVELOPMENT

We welcome your input on policies that we have developed or you would like us to initiate. If you wish to share any ideas with us, we encourage you to write to us at:

Empire Member Services
PO Box 1407
Church Street Station
New York, NY 10008-1407

We will forward your ideas to the department responsible for developing the type of policy involved, and your suggestions will be reviewed and considered. You will then receive a response to your comments. In addition, we review member complaints, member satisfaction information, new technology, and new procedures to determine if changes should be made to your benefits.

PROVIDER QUALITY ASSURANCE

Because your health care is so important, Empire has a Quality Assurance Program designed to ensure that our network providers meet our high standards for care. Through this program, we continually evaluate our network providers.

If you have a complaint about a network provider's procedures or treatment decisions, share your concerns directly with your provider. If you are still not satisfied, you can submit a complaint at the above address. Empire will refer complaints about the clinical quality of the care you receive to the appropriate clinical staff member to investigate.

We also encourage you to send suggestions to Member Services for improving our policies and procedures. If you have any recommendations on improving our policies and procedures, please send them to the Member Services address above.

STATEMENT OF ERISA RIGHTS

The Employee Retirement Income Security Act Of 1974 (ERISA)

If your group is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you have certain rights and protections under ERISA. Under ERISA you are entitled to:

- Examine, without charge, at the Plan Administrator's office and other specified locations, all documents governing the plan, including insurance contracts and a copy of the latest annual report filed by the plan with the U.S. Department of Labor or Internal Revenue Service.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each covered member with a copy of this summary annual report.

Duties Of The Plan Fiduciaries

In addition to creating certain rights for covered members, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate the plan, called plan "fiduciaries," have a duty to do so prudently and in the interest of you and other covered members. Your employment cannot be terminated, nor can you be discriminated against in any way, to prevent you from obtaining your benefits or exercising your rights under ERISA.

Steps You Can Take to Enforce Your Rights

ERISA specifically provides for circumstances under which you may take legal action as a covered member of the plan.

- Under ERISA, you have the right to have your Plan Administrator review and reconsider your claim. If we deny a claim, wholly or partly, you may appeal our decision. You will be given written notice of why the claim was denied, and of your right to appeal the decision. You have 180 days to appeal our decision. You, or your authorized representative, may submit a written request for review. You have the right to obtain copies of documents relating to the decision without charge. You may ask for a review of pertinent documents, and you may also submit a written statement of issues and comments. The claim will be reviewed and we will make a decision within 60 days after the appeal is received. If special circumstances require an extension of time, the extension will not exceed 120 days after the appeal is received. The decision will be in writing, containing specific reasons for the decision. If your claim for benefits is ignored or denied, in whole or in part, you may file suit in a state or federal court. A lawsuit for benefits denied under this coverage can be filed no earlier than 60 days after the claim was filed, and no later than two years from the date that the services were received. In addition, if you disagree with the Plan Administrator's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.
- If you submit a written request for copies of any plan documents or other plan information to which you are entitled under ERISA and you do not receive them within 30 days, you may bring a civil action in a federal court. The court may require the Plan Administrator to pay up to $110 for each day's delay until you receive the materials. This provision does not apply, however, if the materials were not sent to you for reasons beyond the control of the Plan Administrator.

- In the unlikely event that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. But if you lose, because, for example, the case is considered frivolous, you may have to pay all costs and fees.

If you have any questions about your plan, contact your Plan Administrator or Member Services at 1-800-342-9816.

If you have any questions about your rights under ERISA, contact the regional office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor

U.S. Department of Labor
Employee Benefits Security Administration (EBSA)
Director, New York Regional Office
33 Whitehall Street
New York, NY 10004
Telephone: 1-212-607-8600
Fax: 1-212-607-8681
Toll-Free 1-866-444-3272

Your Rights and Responsibilities

We are committed to:

- Recognizing and respecting you as a member.
- Encouraging your open discussions with your health care professionals and providers.
- Providing information to help you become an informed health care consumer.
- Providing access to health benefits and our network providers.
- Sharing our expectations of you as a member.

You have the right to:

- Participate with your health care professionals and providers in making decisions about your health care.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with state and federal laws, and our policies.
- Receive information about our organization and services, our network of health care professionals and providers, and your rights and responsibilities.
- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's members' rights and responsibilities policies.
- Voice complaints or appeals about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your physician(s) of the medical consequences.
- Participate in matters of the organization’s policy and operations.
- The member has the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a physician or other provider in terms that the member can be reasonably expected to understand. When it is not advisable to give such information to the member, the information will be made available to an appropriate person acting on the member's behalf.

You have the responsibility to:

- Choose a participating primary care physician if required by your health benefit plan.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your doctor, and call the doctor’s office if you have a delay or cancellation.
- Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
- Understand your health problems and participate, along with your health care professionals and providers in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that we and/or your health care professionals and providers need in order to provide care.
- Follow the plans and instructions for care that you have agreed on with your health care professional and provider.
- Tell your health care professional and provider if you do not understand your treatment plan or what is expected of you.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let our Customer Service Department know if you have any changes to your name, address, or family members covered under your policy.
- Provide us with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with us.

We are committed to providing quality benefits and customer service to our members. Benefits and coverage for services provided under the benefit program are governed by the Subscriber Agreement and not by this Member Rights and Responsibilities statement.

HIPAA Notice of Privacy Practices

Effective July 1, 2007

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information
We may collect, use, and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For Payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To You: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To Others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. They can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong, out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on your ID card. They can help you apply your rights, file a complaint, or talk with you about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

STATE NOTICE OF PRIVACY PRACTICES

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter. PI could also be used to make judgments about your health, finances, character, habits, hobbies, reputation, career, and credit.

We may collect PI about you from other persons or entities such as doctors, hospitals, or other carriers.

We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

We take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

AMENDMENT TO MEMBER'S EVIDENCE OF COVERAGE

Empire HealthChoice Assurance, Inc.
11 West 42nd Street
New York, New York 10036

You are hereby notified that pursuant to Empire HealthChoice, Inc.'s conversion to a for-profit health insurer and corporate merger with Empire HealthChoice Assurance, Inc., all references in your certificate of coverage and/or benefit booklet ("evidence of coverage") to "Empire HealthChoice, Inc." are hereby changed to "Empire HealthChoice Assurance, Inc."

Any claim or any right against Empire HealthChoice, Inc. you may have had under your group's contract as of the date of the conversion and merger (including, but not limited to, a right to receive payments for services incurred prior to the date of the conversion and merger) will, as a result of the conversion and merger, be against Empire HealthChoice Assurance, Inc. instead. All benefits for services received on or after the date of the conversion and merger shall be the responsibility of Empire HealthChoice Assurance, Inc.

All correspondence and inquiries concerning your coverage, including premium payments, contract changes, and notices of claims, should be submitted to:

Empire HealthChoice Assurance, Inc.
11 West 42nd Street
New York, New York 10036

Except as set forth in this Amendment, your rights as a group member will not be affected and the terms and conditions of your coverage will not be changed by reason of the conversion and merger. This Amendment forms a part of and should be attached to your evidence of coverage issued to you by Empire HealthChoice, Inc.

This Amendment hereby amends your evidence of coverage by adding the following provisions:

1. The group contract is between your group and Empire HealthChoice Assurance, Inc.
2. No statement you make will void the insurance provided by the contract or evidence of coverage, or reduce its benefits, unless it is contained in a written document you have signed. All statements contained in such a document will be deemed representations, not warranties.
3. No agent has authority to change the contract or evidence of coverage or waive any of its provisions. No change in the contract or evidence of coverage shall be valid unless approved by an officer of Empire HealthChoice Assurance, Inc. and evidenced by endorsement on the contract. A change may also be valid when it is in the form of an amendment to the contract signed by the group and Empire HealthChoice Assurance, Inc.
4. All new employees or new members in the classes eligible for insurance must be added to the class for which they are eligible.

5. CONVERSION. The provisions of the group contract and your evidence of coverage that describe the conversion privilege upon termination of coverage are deleted and replaced with the following:

   If the insurance on an employee or member insured under the group contract ceases because of termination of (i) employment or of membership in the class or classes eligible for coverage under the contract or (ii) the contract, for any reason whatsoever, unless the contract holder has replaced the group contract with similar and continuous coverage for the same group whether insured or self-insured, such employee or member who has been insured under the group contract for at least three months shall be entitled to have issued to him by Empire without evidence of insurability upon application made to Empire within forty-five days after such termination, and payment of the quarterly, or at the option of the employee or member, a less frequent premium applicable to the form and amount of insurance, an individual contract of insurance. Empire may, at its option elect to provide the insurance coverage under a group insurance contract, delivered in this state, in lieu of the issuance of a converted individual contract of insurance. Such individual contract, or group contract, as the case may be, is hereafter referred to as the converted contract. The benefits provided under the converted contract shall be those required by subsection (f), (g), (h) or (i) of Section 3221 of the New York State Insurance Law, whichever is applicable and, in the event of termination of the converted group contract of insurance, each insured thereunder shall have a right of conversion to a converted individual contract of insurance.

   Written notice by your group given to you or mailed to your last known address, or written notice by Empire sent by first class mail to you at the last address furnished to Empire by your group, shall be deemed full compliance with the provisions of this subsection for the giving of notice.

   The converted contract shall, at the option of the employee or member, provide identical coverage for the dependents of such employee or member who were covered under the group contract. If delivery of any individual converted contract is to be made outside this state, it may be on such form as Empire may then be offering for such conversion in the jurisdiction where such delivery is to be made.

   Notice of such conversion privilege and its duration shall be given by the contract holder to each certificate holder upon termination of his group coverage.

6. The provisions of the group contract and your evidence of coverage that describe claim submission requirements are deleted and replaced with the following:

   Written proof of claim for benefits covered under the contract must be furnished to Empire within ninety days after the date of services were rendered. Failure to furnish such proof within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof within such time, provided such proof was furnished as soon as reasonably possible.

   Empire will furnish to the person making claim or to the group for delivery to such person, upon request, such forms as are usually furnished by it for filing proof of claim. If such forms are not furnished in response to such request, the person making such claim shall be deemed to have complied with the requirements of the contract as to proof of claim upon submitting within the time fixed in the contract for filing proof of claim, written proof covering the occurrence, character and extent of the services for which claim was made.

7. Benefits payable under the group contract and your evidence of coverage will be payable not more than 45 days after receipt of a claim, except in a case where our obligation to pay a claim submitted is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the Insurance Department that such claim was submitted fraudulently.

8. The provisions of the group contract and your evidence of coverage that describe who will receive payment under the contract are deleted and replaced with the following:

   All benefits of the group contract and your evidence of coverage are payable to the insured. Payments under the group contract and evidence of coverage for services provided by participating providers will be made directly to the participating provider.

9. Termination and Nonrenewal. The provisions of the group contract and your evidence of coverage that describe the termination and nonrenewal of the group contract are deleted and replaced with the following:

   (A) The group may terminate the contract with Empire at any time upon 60 days notice. The group contract will be renewed and continued in force, except that Empire may nonrenew or discontinue coverage under the group contract based only on one or more of the following:

      (1) The group has failed to pay premiums or contributions in accordance with the terms of the group contract or Empire has not received timely premium payments.

      (2) The group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

      (3) The group has failed to comply with the material plan provision relating to employer contribution or group participation rules, as permitted under section four-thousand two hundred thirty-five of the Insurance Law of the State of New York.

      (4) Empire ceases to offer group or blanket policies in a market in accordance with this provision.

      (5) The group ceases to meet the requirements for a group under section four thousand two hundred thirty-five of the Insurance Law of the State of New York, or a participating employer, labor union, association or other entity ceased membership or participation in the group to which the contract is issued. Coverage terminated pursuant to this paragraph shall be done uniformly without regard to any health status-related factor relating to any covered individual.

      (6) Where Empire offers a group contract in a market through a network plan, there is no longer any enrollee in connection with such plan who lives, resides or works in Empire's operating area.

      (7) Such other reasons as are acceptable to the superintendent and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of ("HIPAA") the Act.

   (B) In any case where Empire decides to discontinue offering a particular class of group contract of hospital, surgical or medical expense insurance offered in the small or large group market, the contract of such class may be discontinued only if:

      (1) Empire provides written notice to the superintendent and to each contract holder provided coverage of this class in such market (and to all participants and beneficiaries covered under such coverage) of such discontinuance at least ninety (90) days prior to the date of discontinuance of such coverage; and

      (2) Empire offers to each contract holder provided coverage of this class in such market, the option to purchase all (or, in the case of the large group market, any) other hospital, surgical and medical expense coverage currently being offered by Empire to a group in such market; and

(3) Empire acts uniformly without regard to the claims experience of those contract holders or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.

(C) In any case in which Empire elects to discontinue offering all hospital, surgical and medical expense coverage in the small group market or the large group market, or both markets, in the state, health insurance coverage may be discontinued only if:

(1) Empire provides written notice to the superintendent and to each contract holder (and participants and beneficiaries covered under such coverage) of such discontinuance at least one hundred eighty days prior to the date of the discontinuance of such coverage;

(2) all hospital, surgical and medical expense coverage issued or delivered for issuance in this state in such market (or markets) is discontinued and coverage under such policies in such market (or markets) is not renewed; and

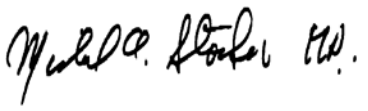
(3) Empire provides the Superintendent with a written plan to minimize potential disruption in the marketplace occasioned by its withdrawal from the market.

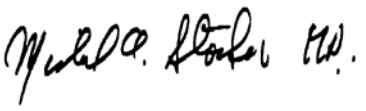
10. Any references in the group contract and your evidence of coverage which describe Empire's right to modify the group contract or your evidence of coverage are deleted and replaced with the following:

    At the time of coverage renewal only, Empire may modify the health insurance coverage for a group contract offered to a large or small group contract holder so long as such modification is consistent with New York State Insurance Law, and effective on a uniform basis among all small group contract holders with the contract form.

11. All terms, conditions, limitations, and exclusions of the group contract and evidence of coverage apply to this Amendment except where specifically changed herein. If there are any inconsistencies between this Amendment and the group contract and evidence of coverage, the provisions of this Amendment shall control.

IN WITNESS WHEREOF, Empire HealthChoice, Inc. and Empire HealthChoice Assurance, Inc. have caused this Amendment to Member's Evidence of Coverage to be duly signed and issued.





_____ _____

Michael A. Stocker, M.D.
Chief Executive Officer,
Empire HealthChoice, Inc.

Michael A. Stocker, M.D.
Chief Executive Officer,
Empire HealthChoice Assurance, Inc.