

Group Health Incorporated  
(Hereinafter called "GHI")  
An EmblemHealth Company  
55 Water Street  
New York, New York 10041

**GHI DENTAL**  
**CERTIFICATE OF INSURANCE**

This Policy provides DENTAL insurance only to the extent limited and defined in this Certificate and the Attachment. The Certificate and Attachment are evidence of the benefits provided by the Group Contract to which this Certificate relates during the time a person is insured thereby.

## GROUP HEALTH INCORPORATED

### TABLE OF CONTENTS

		Page
Article One	Introduction	[ ]
Article Two	Definitions	[ ]
Article Three	Dental Services	[ ]
	Prophylaxes	[ ]
	Fluoride Treatments	[ ]
	Examinations	[ ]
	X-Rays	[ ]
	Biopsy & Examination of Oral Tissue	[ ]
	Space Maintainers	[ ]
	Mouth Guards	[ ]
	Palliative Services	[ ]
	Sealants	[ ]
	Basic Restorations	[ ]
	Consultations	[ ]
	Extractions	[ ]
	Repair of Prosthetic Appliances	[ ]
	Bedside Calls	[ ]
	Endodontics (Non-Surgical)	[ ]
	Surgical Endodontics (Root Canal Therapy)	[ ]
	Oral Surgery	[ ]
	Anesthesia & IV Sedation/Analgesia	[ ]
	Periodontal Surgery	[ ]
	Periodontal Treatment (Non-Surgical)	[ ]
	Major Restorative Services	[ ]
	Fixed & Removable Prosthodontics	[ ]
	Orthodontia	[ ]
Article Four	Extent of Benefits	[ ]
Article Five	Predetermination of Benefits	[ ]
Article Six	Exclusions and Limitations	[ ]
Article Seven	Claim Determinations	[ ]
Article Eight	Grievance Procedures	[ ]
Article Nine	Utilization Review	[ ]

Article Ten	External Appeal	[ ]
Article Eleven	Coordination of Benefits	[ ]
Article Twelve	Termination	[ ]
Article Thirteen	Continuation of Coverage	[ ]
Article Fourteen	Miscellaneous	[ ]

## ARTICLE ONE - INTRODUCTION

1. Your Coverage under This Policy. Your group has entered into a Group Contract with Group Health Incorporated (“GHI”) to provide you and your covered dependents with dental insurance benefits. Under this Group Contract, GHI will provide dental benefits to Members.

This booklet is your Certificate of Insurance. Together with the Attachment, it evidences your coverage under the Group Contract. It is not a contract between you and GHI. You should keep this booklet and the Attachment with your other important papers so that it is available for your future reference.

The Attachment provides important information about the nature and extent of your dental coverage. It sets forth:

- The dental services that GHI will cover under this Policy.
- The deductibles, if any, that apply to your coverage.
- The Schedule(s) of Allowances and the other payment terms that apply to covered services.
- The annual maximums that apply to your coverage.
- The limiting ages for coverage of dependent children and dependent students.
- And any lifetime maximums that may apply to your coverage.

This Policy covers only the types of dental services listed as “covered” in the Attachment. The types of dental services that may be covered are described in this booklet. Coverage is subject to all terms, conditions, limitations and exclusions set forth in this Certificate and the Attachment, and the Group Contract.

GHI’s payments for covered services are usually based upon a Schedule of Allowances. Payments for covered, but unlisted procedures will be made in a manner consistent with those for listed procedures.

You may obtain a Predetermination of Benefits from GHI in connection with certain services. Please be sure to review Article Five of this booklet before you receive any dental services.

2. Criteria for Coverage. The fact that your physician or dentist prescribed or provided care does not automatically mean that the care qualifies for payment by GHI. GHI will provide benefits only for the services that are listed as “covered” in the Attachment and described in this Policy. GHI will cover such services only if they are medically necessary and not otherwise excluded under this Policy. A Provider must also render the services, and the services must be within the scope of

the Provider's license. The Dentist or Provider must also have a license or certification to perform the service(s) in the jurisdiction where the service(s) is rendered. Other conditions for coverage may apply to specific covered services. These other conditions are set forth in the specific benefit descriptions in the articles that follow.

Medically necessary services are dental services that are found by GHI to meet all of the criteria listed below.

- They are provided for the diagnosis, or direct care or treatment of the condition, illness, disease, injury or ailment.
- They are consistent with the symptoms or proper diagnosis and treatment of the medical condition, disease, injury or ailment.
- They are in accordance with accepted standards of good dental practice in the community.
- They are furnished in a setting commensurate with the patient's medical needs and condition.
- They cannot be omitted under the standards referenced above.
- They are not in excess of the care indicated by generally accepted standards of good dental practice in the community.
- They are not furnished primarily for the convenience of the patient, the patient's family or the Provider.

Review for medical necessity is performed under the supervision of GHI's Dental Director. Please see the Article Nine for more information about how GHI determines whether a service is medically necessary or that a service is experimental or investigational and, therefore, not covered.

**This dental insurance policy does not require you to obtain preauthorization from GHI for any covered dental services. GHI also does not perform concurrent review for any covered dental services. However, GHI may perform a retrospective review of your claim(s) to confirm medical necessity.** Please see Article Nine for more information.

In all instances GHI reserves the right to determine benefits, taking into account alternate procedures, services or courses of treatment. Also, when a more costly material or service is substituted for a less costly material or service having the same function, the allowance for the less costly material or service will be applied.

3. Benefit Waiting Period. This Policy may impose a waiting period(s) for certain dental services when your Group first becomes covered under this Policy. If such a waiting period(s) applies, this Policy will not cover the dental services that are subject to the waiting period(s) until

the Group Contract has been in effect for the length of the waiting period(s). The Attachment will tell you whether or not such a waiting period(s) applies. The Attachment will also tell you the length of the waiting period(s) and it will set forth the dental services that are subject to the waiting period(s). For example, if the Attachment indicates that a twelve (12) month waiting period applies to orthodontia under this Policy, then this Policy does not cover orthodontia services performed during the first twelve (12) months the Group Contract was in effect. Note that the effective date of the Group Contract may pre-date your individual effective date of coverage under this Policy. GHI will never pay for any services performed prior to your individual effective date of coverage under this Policy.

4. **Late Entrant Waiting Period.** Late entrants may be subject to a waiting period for certain dental benefits. A late entrant is any person whose effective date of coverage under this Policy is more than thirty (31) days from the date the person qualifies for the coverage, or who has elected to become insured again after canceling a premium contribution agreement. The Attachment will tell you whether or not a waiting period applies to late entrants. If a waiting period applies, the Attachment will also set forth the length of the waiting period and the dental services that are subject to the waiting period. A late entrant is not eligible for those dental service(s) that are subject to the waiting period until he/she has been covered under this Policy for the length of the waiting period. For example, if the Attachment indicates that late entrants are subject to a twelve (12) month waiting period for orthodontia, then a late entrant is not covered for orthodontia performed during the first twelve (12) months that he/she is covered under this Policy.

## **ARTICLE TWO - DEFINITIONS**

Except as specifically provided otherwise in this Certificate, the following definitions apply to this Policy.

1. **Allowed Charge.** Allowed Charges are fee profiles that GHI uses to reimburse covered services received from Non-Network Providers. The Attachment will tell you whether you have benefits for dental services received from Non-Network Providers, and if so, it will also tell you whether GHI will reimburse you for such services based upon a Schedule or based upon an Allowed Charge. GHI develops its Allowed Charges using charge data based upon a percentile of FAIR Health. The FAIR Health percentile is selected by your group and it is set forth on the

Attachment. GHI will update its FAIR Health data once per year. GHI may modify or update its Allowed Charges at any time. GHI's Allowed Charges may not reflect actual FAIR Health charges for a particular covered service in a particular geographic area, and may instead reflect a GHI determined regionally blended amount. For services rendered outside of New York, GHI will develop its Allowed Charges using the FAIR Health data for an area selected by GHI within New York. If your Provider's actual and customary billed charge is less than the Allowed Charge, GHI will consider your Provider's charge the Allowed Charge for that claim.

There may be occasions where GHI does not have an Allowed Charge for a particular service. When this is the case, GHI will make payment based upon FAIR Health data to determine comparability between procedures.

2. Attachment. Attachment means the attachment to this Certificate. It provides important information about the nature and extent of your dental coverage. It sets forth the types of dental services that GHI will cover. It also sets forth the payment terms that apply to covered services. It advises you whether or not you are covered for covered services rendered by Network and/or Non-Network Providers. It sets forth the annual and lifetime maximums that apply to your coverage. It also sets forth the limiting ages for coverage of dependent children and dependent students.

3. Bank. Bank means the amount of an accrued Reward(s) under the Rollover Maximum provisions of this Policy.

4. Bank Maximum. The Bank Maximum is the maximum amount of Reward(s) that can be stored in the Bank under the Rollover Maximum provisions of this Policy.

5. Certificate. This document is a Certificate of Insurance.

6. Group Contract. The Group Contract is the agreement GHI has with your group.

7. Late Entrant. A late entrant is any person whose effective date of coverage under this Policy is more than thirty (30) days from the date the person qualifies for the coverage, or who has elected to become insured again after canceling a premium contribution agreement.

8. Member. A Member is a Subscriber. It may also be a person who is eligible for coverage under this Policy by reason of a family relationship to the Subscriber, and has been added to the Policy by the Subscriber. Each Member other than the Subscriber must be a person described below.

(a) Spouse. He or she must be the spouse of the Subscriber. An ex-spouse is not eligible for coverage regardless of the terms of any settlement agreement. The submission of a claim by or for an ex-spouse under this policy is an insurance fraud.

- (b) Unmarried, Dependent Child. He or she must be an unmarried, dependent child of the Subscriber under the age set forth in the Attachment. A dependent that is not the natural child of the Subscriber may also be eligible for coverage. An adoptive child or stepchild is eligible for coverage. The child must be dependent upon the Subscriber for support, or the subscriber must have assumed legal responsibility in place of the parent. A dependent adoptive child will be covered on the same basis as a natural child during any waiting period prior to finalization of the adoption. An adoptive child is covered at the earliest of the dates set forth below.
- (i) Upon the filing of an adoption petition. A proposed adoptive child will be covered as of the first day of the waiting period prior to the finalization of the adoption.
  - (ii) A court of law accepts a consent to adopt and you enter into an agreement to support the child.
  - (iii) An adoptive newborn is covered from the moment of birth for injury or sickness. The Subscriber must take physical custody of the newborn upon the newborn's release from the hospital. The Subscriber must also file a petition for adoption or an application for temporary guardianship within thirty (30) days after the child's birth.
- (c) Unmarried, Dependent Child Incapable of Self-Sustaining Employment. An unmarried, dependent child over the age set forth in the Attachment may also be eligible for benefits. The child must meet all of the conditions set forth below.
- (i) He or she must be incapable of sustaining employment due to mental illness, developmental disability or mental retardation as defined in the New York State Mental Hygiene Law, or physical handicap.
  - (ii) He or she must have been so incapable before the age at which dependent coverage would otherwise terminate.
  - (iii) He or she must have been eligible for benefits before the age at which dependent coverage would otherwise terminate.
  - (iv) A physician must certify the child's condition.
  - (v) Proof of the condition is submitted to GHI within thirty-one (31) days of the date the dependent reaches the age at which dependent coverage would otherwise terminate.



GHI has the right to check whether a child is and continues to qualify as an unmarried, dependent child incapable of self-sustaining employment.

- (d) Unmarried Full-Time Dependent Student. He or she must be an unmarried, dependent full time student under the age set forth in the Attachment. The student must be enrolled in an accredited educational institution. The institution must grant a degree or diploma. You must supply at least fifty percent (50%) of the student's support. Unmarried, dependent full time students are covered until they reach the limiting age and time set forth in the Attachment or until the end of the month in which they otherwise lose eligibility. An unmarried, dependent student will otherwise lose eligibility if he or she marries, loses dependent status or loses full time student status.
9. Network Provider. A Network Provider is any Dentist or Provider who has an agreement with GHI to accept GHI's Schedule of Allowances or a negotiated rate(s) as payment in full for covered dental services and who participates in the GHI provider network that applies to this Policy. GHI will pay a Network Provider directly for covered services. The Attachment will state whether or not GHI will provide benefits for covered services rendered by Network Providers. If you have benefits for covered services received from Network Providers, you will not have to make any payments, other than applicable deductibles and coinsurance charges, to a Network Provider for covered services, subject to any applicable terms and limits. The Network Provider will file a claim form on your behalf.
10. Non-Network Provider. A Non-Network Provider is any Dentist or Provider who does not have an agreement with GHI to accept GHI's Schedule of Allowances or negotiated rate(s) as payment in full for covered dental services and/or who does not participate in the GHI provider network that applies to this Policy. The Attachment will state whether or not GHI will provide benefits for covered services rendered by a Non-Network Providers. You must pay a Non-Network Provider's full bill. You must file a claim form with GHI in order to be eligible to receive benefits. If you are covered for services rendered by Non-Network Providers, GHI will issue payment for covered services rendered by a Non-Network Provider according to the terms set forth in this Certificate and the Attachment. GHI will pay benefits directly to you for covered services.
11. Policy. Policy refers to this Certificate, the Attachment and the underlying Group Contract.
12. Predetermination of Benefits. Predetermination of Benefits is a process whereby GHI

estimates benefits before services are rendered. To obtain a Predetermination of Benefits, a Treatment Plan should be sent to GHI before certain services are performed. GHI will review the plan and send you an estimate of the benefits for covered services. (See Article Five.)

13. Provider. Provider means a dentist, a dental clinic or dental facility that is permitted to perform covered services. A dentist means a licensed dentist or physician who renders covered dental care. The dentist or physician must be licensed or certified to perform the service in the jurisdiction in which the service is rendered.
14. Reward. Reward means the dollar amount which may be added to the Bank when benefits received in a calendar year do not exceed the Rollover Threshold under the Rollover Maximum provisions of this Policy.
15. Rollover Threshold. Rollover Threshold means the maximum amount of benefits that you may receive during a calendar year and still be entitled to receive a Reward under the Rollover Maximum provisions of this Policy.
16. Schedule of Allowances. A Schedule of Allowances or “Schedule” is a set of allowances for covered services. The Schedule(s) of Allowances that applies to covered services rendered by Network Providers is identified on the Attachment. GHI will pay Network Providers for covered services based upon the Schedule(s) unless GHI has negotiated a separate rate(s) with the Provider. If GHI has a negotiated rate(s) with a Network Provider, then the Schedule of Allowances for that Provider refers to GHI’s negotiated rate(s) with the Provider. GHI may also reimburse you for covered services rendered by Non-Network Providers based upon a Schedule of Allowances. However, if a Non-Network Provider’s actual and customary billed charge is less than the Scheduled amount, then GHI will consider your Provider’s charge the Scheduled amount for that claim. Please refer to the Attachment for information about how GHI will reimburse services received from Non-Network Providers. GHI’s Schedules of Allowances may be amended from time to time. GHI’s Schedules of Allowances are on file with the New York State Department of Financial Services. They are available for inspection at the offices of the New York State Department of Financial Services and at GHI’s offices. In the event that the GHI Allowance for a covered service rendered exceeds the amount billed by the Dentist or Provider for that service, GHI will consider the Dentist or Provider’s billed charge to be the Scheduled amount for that particular service.

17. Subscriber. A Subscriber is the person to whom this Policy is issued. He or she is insured by virtue of his or her membership in or employment by the group.
18. Treatment Plan. A Treatment Plan is a proposed detailed statement of the dental services to be rendered and the fees to be charged. To obtain a Predetermination of Benefits, you should submit a Treatment Plan to GHI before services are rendered. Based on the Treatment Plan, GHI will estimate your benefits.
19. You. In order to make this document easier to read, we have used the word “you” instead of Subscriber or Member in the text.

### **ARTICLE THREE – DENTAL SERVICES**

All of the various dental services that GHI may cover are described in this Article. The Attachment will tell you which of these dental services are actually covered under this Policy.

GHI will cover only those dental services that are specifically included on the Attachment as part of a service class or type that the Attachment indicates as “covered.” For example, if Type A – Preventive Services are listed in the Attachment as “covered”, and prophylaxes is listed in the Attachment as a component service of Type A - Preventive Services, then you have prophylaxes coverage, subject to the terms listed in the Attachment for Type A - Preventive Services. If prophylaxes is not listed among the dental services that are part of the types or classes of dental services that are listed as “covered” on the Attachment, then you do not have coverage for prophylaxes under this Policy even though prophylaxes is described in this Certificate.

The Attachment also tells you whether benefits are available for covered dental services received from Network Providers, Non-Network Providers, or both, and what payment terms apply.

You may obtain a Predetermination of Benefits from GHI for certain services. A Predetermination of benefits is an estimate of the benefits payable under this Policy for certain dental services obtained in advance of the services being performed. Please review Article Five of this Certificate before you receive any dental services. The procedures and terms that apply to a Predetermination of Benefits are set forth in Article Five.

**GHI does NOT require you or your Provider to obtain pre-authorization for any covered dental services under this Policy. Note that a Pre-authorization is different from a Predetermination of Benefits. GHI also does not perform concurrent review in connection with any covered dental services. However, GHI may perform a retrospective review of your claim(s) to confirm medical necessity. Please see Article Nine for more information about retrospective review.**

The various dental services that GHI may cover follow below. Charges for items and services used or provided by Dentists and Providers to comply with federal, state and local laws and regulations and charges for behavioral management are not covered unless specifically listed as covered in this Policy. Prescription drugs and medications are not covered. Except as specifically provided otherwise, services and appliances for the treatment of temporo-mandibular joint (TMJ) dysfunction syndrome are not covered unless dental in nature and medically necessary.

**Prophylaxes.** If prophylaxes is included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover prophylaxes. Prophylaxis is the scaling, cleaning and polishing of the teeth. GHI will cover only the number of prophylaxes set forth on the Attachment per Member per calendar year. Please refer to the portion of the Attachment entitled Special Benefit Limits for this number.

**Fluoride Treatments.** If fluoride treatments are included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover fluoride treatment for dependent covered children. GHI will cover [one (1) fluoride treatment][two (2) fluoride treatments] per child per calendar year. Coverage is available for this service until the end of the calendar year in which the child reaches age nineteen (19).

**Examinations.** If examinations are included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover routine examinations of the oral cavity. This includes charting of the teeth, if performed. GHI will cover the number of examinations set forth on the Attachment per person per calendar year. Please refer to the portion of the Attachment entitled Special Benefit Limits for this information. GHI will only cover one (1) initial comprehensive oral evaluation per Provider per lifetime. All

subsequent non-emergency examinations done by the same Provider are covered as periodic examinations.

**X-Rays.** If x-rays are included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover the taking of x-ray films of the teeth, mouth or jaw. GHI will cover four (4) bitewing x-rays for each Member in each calendar year. GHI will cover the taking of fourteen (14) standard periapical x-ray films or one (1) panoramic film once every [three (3) – five (5)] years. GHI will also cover two (2) occlusal intra-oral x-ray films within a three (3) year period. Individual periapical x-rays performed on the same day as a full mouth series are not covered. Duplication of x-rays is not covered.

**Biopsy & Examination of Oral Tissue.** If biopsy and examination of oral tissue are included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover biopsy and examination of oral tissue. However, you are not covered for salivagraphy, temporo-mandibular joint (TMJ) arthrogram (including injection), tomographic survey, bacteriological studies, caries susceptibility, pulp vitality test, diagnostic casts and photographs.

**Space Maintainers.** If space maintainers are included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover one (1) space maintainer per covered dependent child per lifetime. GHI covers the treatment and the appliance. GHI will cover space maintainers only until the end of the calendar year in which the child reaches age nineteen (19). If the insertion of a space maintainer is performed in conjunction with the re-cementation of a space maintainer, GHI’s allowance will be the scheduled amount for insertion of the space maintainer. GHI will not provide a separate allowance for the re-cementation.

**Mouth Guards.** If mouth guards are included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover one (1) mouth guard per lifetime for each covered dependent child. The mouth guard must be for use in athletic activity. A Dentist must also prescribe it. Coverage is provided for this protective appliance only until the end of the calendar year in which the child reaches age nineteen (19).

**Palliative Services.** If palliative services are included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover one (1) palliative service for each Member in each calendar year. This is a service for the relief of pain. You must have made an emergency visit to your Provider. This includes an adjustment of a prosthetic appliance that must have been installed for over one (1) year.

**Sealants.** If sealants are included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover sealants for each covered dependent child between the ages of 6 through 14. GHI will only cover sealants applied to the occlusal (biting) surface of the first and second permanent molars and bicuspid. GHI will not cover sealants applied to other surfaces or teeth. Benefits are available once per covered tooth every three (3) calendar years.

**Basic Restorations.** If basic restorations are included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover basic restorations. Basic restorations are fillings. GHI will not cover temporary fillings, sedative fillings, tissue conditioning and acid etch. Benefits are subject to the terms set forth below.

- The Schedule of Allowances imposes a maximum benefit for fillings done on the same tooth by the same Dentist or Provider within a six (6) month period. GHI will not pay more than this maximum benefit for fillings for each Member in any six (6) month period.
- If two (2) fillings are done on the same posterior tooth on the same day, GHI’s allowance will be up to the Scheduled or Allowed amount for a three (3) surface amalgam.
- If two (2) fillings are done on the same anterior tooth on the same day, GHI’s allowance will be up to the Scheduled or Allowed amount for three (3) composite fillings.
- If a three (3) surface inlay, crown or abutment is done on a tooth that has been filled within the last six (6) month period, GHI will deduct the Scheduled or Allowed amount for the filling from its payment for the inlay, crown or abutment.
- [▪ The allowance for a one (1) surface inlay will be the Scheduled or Allowed amount for a one (1) surface filling.]

- If an onlay and inlay are done on the same tooth on the same day, GHI's allowance will be the Scheduled or Allowed amount for the inlay. A separate allowance for the onlay will not be provided.
- [▪ The allowance for composite resin inlays will be the Scheduled or Allowed amount for a filling.]
- The charge for cementation for a crown/inlay is included in the allowance for the crown/inlay.

**Consultations.** If consultations are included in a type of dental service that is listed as "covered" on the Attachment, then GHI will cover a consultation with a specialist. GHI will cover the consultation if there is no other service rendered by the specialist on that date or within one (1) month. If you have coverage for examinations, then a consultation will count as an examination toward the examination maximum per person per calendar year set forth on the Attachment. The report of the specialist must be submitted with your claim form.

**Extractions.** If extractions are included in a type of dental service that is listed as "covered" on the Attachment, GHI will cover the routine removal of a tooth or teeth. GHI's allowance for the extraction includes pre-and post-operative x-rays, post-operative care and local anesthesia.

**Repair of Prosthetic Appliances.** If repair of prosthetic appliances is included in a type of dental service that is listed as "covered" on the Attachment, then GHI will cover the repair of dentures, the replacement of broken teeth or clasps in a denture, recementation of inlays, crowns, bridges and space maintainers, repair of inlays and veneers, and the replacement of broken facings. The Schedule of Allowances imposes an annual maximum benefit for all repairs. GHI will not pay more than the maximum benefit for each member in each calendar year for repairs.

- GHI will cover the replacement of broken teeth or clasps in a denture. GHI will also cover the recementation of bridges and the replacement of broken facings. The Schedule of Allowances imposes an annual maximum benefit for all repairs. GHI will not pay more than that maximum benefit for each Member in each calendar year for repairs.

- Duplication (Jump), rebase, or chairside reline to a denture is limited to one (1) per denture in a [five (5) – ten (10)] year period. This applies to both partial and full dentures.
- Rebase or repair of new dentures are covered only after six (6) months have passed after the date of the insertion of the denture.

**Bedside Calls.** If bedside calls are included in a type of dental service that is listed as “covered” in the Attachment, then GHI will cover bedside calls. The call must be made due to an emergency.

**Endodontics (Non-Surgical).** If endodontics (non-surgical) is included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover non-surgical endodontics. The guidelines below apply to your coverage for these services.

- Pulpotomy is covered once per tooth per lifetime.
- Pulp capping is not covered.
- [Surgical replacement][Placement] of rubber dam, recalcification of perforation, preparation of canal for posts or dowels, and bleaching of discolored teeth are not covered.
- Inter-operative radiographs are considered part of non-surgical endodontic therapy and are included in the allowance for non-surgical endodontic therapy. No separate allowance is provided for intra-operative radiographs.

**Surgical Endodontics (Root Canal Therapy).** If surgical endodontics (root canal therapy) is included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover surgical endodontics. You may obtain a Predetermination of Benefits for certain surgical endodontics. (See Article Five). The guidelines below apply to your coverage for this service.

- If any combination of apicoectomy, root end amalgam and apical curettage is done on the same tooth by the same Provider within a three (3) month period of root canal therapy, GHI will not apply the Scheduled or Allowed amounts for these services. GHI will apply a combined allowance for these services.



- The allowance for incision and drainage done within two (2) weeks of root canal therapy or periodontal surgery on the same tooth by the same Provider will be deducted from the allowance for the root canal therapy or periodontal surgery.
- Intra-operative radiographs are considered part of surgical endodontic therapy and are included in the allowance for surgical endodontic therapy. No separate allowance is provided for intra-operative radiographs.

**Oral Surgery.** If oral surgery is included in a type of dental service that is listed as “covered” in the Attachment, then GHI will cover oral surgery. You may obtain a Predetermination of Benefits for certain types of oral surgery. (See Article Five). GHI will cover the surgical removal of an erupted tooth. You are covered for surgical procedures in or about the oral cavity. X-rays taken solely for your surgery, local anesthesia and post-operative care are not separately covered. They are included in GHI’s allowance for oral surgery. The guidelines below apply to your coverage for this service.

- The Schedule of Allowances imposes an annual maximum benefit per arch for alveolectomy and alveoplasty. GHI will not pay more than that maximum benefit per arch for each Member in each calendar year for these services.
- Alveolectomy done in conjunction with a surgical extraction is not covered.
- Surgery on fractured jaws, impactions, and lesions in and around the mouth is covered. Orthognathic surgery and surgery relating to accidental injury are not covered.
- [Implants and transplantations][Transplantations] are not covered. Reimplantations are covered.
- Reimplantation of an implant is not covered.

**Anesthesia & IV Sedation/Analgesia.** If anesthesia and IV sedation/analgesia are included in a type of dental service that is listed as “covered” in the Attachment, then GHI will cover anesthesia rendered in or out of a hospital. The anesthesia or IV sedation/analgesia must be rendered in connection with a covered service. As with all covered services, the services must be consistent with accepted standards of dental practice as well as GHI’s other criteria for medical necessity, and the services must be performed by a licensed provider certified to provide the anesthesia or IV sedation/analgesia by the state in which the services are rendered.

**Periodontal Surgery.** If periodontal surgery is included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover periodontal surgery, including soft tissue and osseous surgery. You may obtain a Predetermination of Benefits for certain periodontics. (See Article Five). GHI will cover five (5) periodontal treatments in each calendar year. You are covered for one (1) type of periodontal surgery and/or one (1) graft per quadrant. Five (5) single tooth periodontal surgeries or grafts are considered to be a quadrant. Periodontal appliances are not covered.

- Repeated periodontal surgeries or grafts will not be covered for a period of three (3) years from the date of the original surgery or graft.
- You are covered for guided tissue regeneration.

**Periodontal Treatment (Non-surgical).** If periodontal treatment (non-surgical) is included in a type of dental service that is listed as “covered” on the Attachment, GHI will cover non-surgical periodontics. Non-surgical periodontics is the treatment of diseases of the gums and the long structure of the jaw, including subgingival scaling, periodontal prophylaxis and minor bite correction (occlusal adjustment). You are covered for five (5) periodontal treatments in each calendar year. The guidelines below apply to your coverage.

- GHI will cover two (2) periodontal maintenance procedures per calendar year.
- Occlusal adjustments done on the same tooth and in conjunction with fillings, prosthetic services, root canal therapy or repairs, inlays and crowns are not covered.
- Splints are covered only in connection with the replacement of a missing tooth. GHI will cover only that portion of the splint replacing the missing tooth. Splints using enamelite or similar material are not covered.
- Achatite synthetic fiber and unscheduled dressing changes are not covered.

GHI will also cover localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, per tooth. This must be performed in conjunction with periodontal scaling and root planning or periodontal maintenance. GHI will cover two (2) teeth per quadrant, eight (8) teeth per mouth in each twenty-four (24) month period.

**Major Restorative Services.** If major restorative services are included in a type of dental service that is listed as “covered” in the Attachment, then GHI will cover major restorative

services. These services include: crowns; inlays; prosthetic services; removable, complete and partial dentures; fixed bridges; crowns or inlays used as abutments. You may obtain a Predetermination of Benefits for certain Major Restorative Services. (See Article Five). The following guidelines apply to your coverage for Major Restorative Services.

- Replacement or the substitution of inlays and single crowns is covered only after [five (5) –ten (10)] years have passed since the appliance was inserted.
- Posts are covered only if there is evidence of root canal therapy on the tooth.
- Pins are covered once every six (6) months. [However, pins are not covered if they are inserted in conjunction with a prosthetic service.]
- [▪ Core buildups including pins are not covered, unless done on a root canal tooth in lieu of a post/core subject to a limit of one (1) per tooth every five (5) years.]
- Acrylic crowns are only covered on the six (6) anterior teeth. They must be laboratory processed and permanent. The allowance for acrylic crowns will be the Schedule amount for single crowns, not the Scheduled amount for a bridge abutment or splint.
- If a three (3) surface inlay, crown or abutment is done on a tooth that has been filled within the last six (6) month period, GHI will deduct the Scheduled or Allowed amount for the filling from its payment for the inlay, crown or abutment.
- If an onlay and inlay are done on the same tooth on the same day, GHI's allowance will be the Scheduled or Allowed amount for the inlay. A separate allowance for the onlay will not be provided.
- [▪ The allowance for composite resin inlays will be the Scheduled or Allowed amount for a filling.]
- The charge for cementation for a crown/inlay is included in the allowance for the crown/inlay.
- GHI will cover splints only when a missing tooth is being replaced. Only that portion replacing the missing tooth is covered.
- [▪ Precious metal material or porcelain/ceramic substrate used in crowns is reimbursed at the [base metal rate][full cast high noble metal rate].]
- There is no separate allowance for a temporary service or appliance. The allowance for a temporary service or appliance is included in the allowance for the completed, permanent service or appliance.

The procedures listed below are excluded from Major Restorative Services coverage.

- Crowns used in splints for periodontal conditions.
- [▪ Crown build-ups done in connection with individual crowns and abutments.]
- Services or appliances used solely as an adjunct to periodontal care.
- Tissue conditioning and stress breakers.
- Cosmetic surgery and/or treatment unless otherwise medically necessary

**Fixed & Removable Prosthodontics.** If fixed and removable prosthodontics is included in a type of dental service that is listed as “covered” in the Attachment, then GHI will cover removable and fixed prosthodontic services as set forth below. You may obtain a Predetermination of Benefits for certain prosthetic services and appliances. (See Article Five). Note that there is no separate allowance for a temporary service or appliance. The allowance for a temporary service or appliance is included in the allowance for the completed, permanent service or appliance.

- GHI will cover dentures that are constructed prior to the removal of teeth. These are known as immediate dentures. The dentures must be put in the same day the teeth are removed.
- GHI will cover permanent dentures. These may be full or partial.
- GHI will cover fixed bridgework and removable partial dentures.
- Transplantations are not covered.
- Posts are covered only if there is evidence of root canal therapy on the tooth.
- Pins are covered once every six (6) months. [However, pins are not covered if they are inserted in conjunction with a prosthetic service.]
- [▪ Core buildups including pins are not covered.]

Fixed & Removable Prosthodontics coverage is subject to the guidelines below.

- If the repair of a partial denture is done in conjunction with the insertion of a new denture in the same area of the mouth, GHI’s allowance will be the Scheduled amount for the insertion of the new denture.
- If a denture adjustment is performed in conjunction with palliative treatment, GHI’s allowance will be the Scheduled amount for the palliative treatment.
- [The allowance for an upper or lower overdenture will be the Scheduled amount for full upper and lower dentures.] There will be no benefits for any treatment of the abutment tooth or attachment tooth.

- Replacement or the substitution of appliances is covered only after [five (5) – ten (10)] years have passed since the appliance was inserted.
- When a fixed bridge and a partial denture are inserted in the same arch, only the partial denture is covered unless [five (5) – ten (10)] years have passed since the prior insertion of the fixed bridge or partial denture.
- You are covered for crowns or pontics for attachment or clasp purposes, only if the tooth is so broken down that it cannot be restored by fillings.
- You are covered for splints only when a missing tooth is being replaced. Only that portion replacing the missing tooth is covered.
- Crowns and inlays used as abutments are covered only when they are used as primary support for fixed appliances.
- Acrylic crowns are only covered on the six (6) anterior teeth. They must be laboratory processed and permanent. The allowance for Acrylic crowns will be the Scheduled amount for single crowns, not the Scheduled amount for a bridge abutment or splint.
- Adjustment of appliances are covered only after one (1) year of insertion.
- [▪ Precious metal material or porcelain/ceramic substrate used in abutment crowns is reimbursed at the [base metal rate][full cast high noble metal rate].]
- There is not a separate allowance for a temporary service or appliance. The allowance for a temporary service or appliance is included in the allowance for the completed, permanent service or appliance.

The procedures below are excluded from coverage under Fixed & Removable Prosthodontics.

- A cantilever pontic, when used for attachment purposes, is not covered.
- Double or multiple abutments.
- Crowns used in splints for periodontal conditions.
- [▪ Crown build-ups done in connection with abutment crowns.]
- Services or appliances used solely as an adjunct to periodontal care.
- Precision attachment, metal coping, tissue conditioning and stress breakers.
- Cosmetic surgery and/or treatment unless otherwise medically necessary.

**Implant Services.** If Implant Services is included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover Implant Services as described in this paragraph.

- GHI will cover surgical placement of the implant body; endosteal implant once per tooth per lifetime.
- GHI will cover single crowns, implant supported at the allowance for single crowns. GHI will cover replacement or substitution of single crowns, implant supported only after [five (5) – ten (10)] years have passed since the appliance was inserted.
- GHI will not cover implant services for wisdom teeth (i.e. tooth numbers 1, 16, 17 and 32).
- There is no separate benefit and/or payment allowance for temporary service.

You may request a pre-determination of benefits for implant services. (See Article Five.)

**Orthodontia.** If Orthodontia is included in a type of dental service that is listed as “covered” on the Attachment, then GHI will cover Orthodontia. Orthodontia is commonly known as the straightening of teeth. These services are covered only if rendered to covered unmarried, dependent children under the age set forth on the Attachment. GHI will not cover adult orthodontics unless the Attachment states that adult orthodontics is “covered.” If adult orthodontics is listed as “covered,” GHI will provide benefits for adult orthodontia to the same extent that orthodontia benefits would be available to a dependent child. You may obtain a Predetermination of Benefits for orthodontia. (See Article Five).

- GHI will issue payment for the first twenty (20) months of active comprehensive orthodontic treatment. This includes all office visits, appliances, follow-up visits and retention. There is no limit on the total number of months required for the completion of a full course of orthodontic treatment. The twenty (20) month benefit period represents reimbursement for the initial payment for the appliance fee and diagnostic work-up, up to the patient’s maximum. This provision does not apply if your benefit for the services is based upon the Preferred Plus Schedule of Allowances.

- The allowance for orthodontic treatment does not include charges for missed appointments or additional cosmetic banding options. Charges for these items are the responsibility of the member and reflect the dentist's standard charges.
- GHI will not cover any appliance that was installed during a period when you were not covered under this Policy.
- GHI will not pay for the orthodontics unless it is medically necessary. The teeth must also be correctable.
- All orthodontic services will be deemed rendered on the date performed. The purpose of this is only important in determining work progress at the start or end of your coverage.
- If GHI covered a preliminary appliance, that payment will be deducted from the total payment for the insertion of a permanent appliance. If the appliance was inserted before you became covered under this Policy, GHI will not cover the appliance.
- There is no separate allowance for a temporary service or appliance. The allowance for a temporary service or appliance is included in the allowance for the completed, permanent service or appliance.

#### **ARTICLE FOUR - EXTENT OF BENEFITS**

1. Covered Services. This Policy covers only the dental services included under a dental service type that is listed as "covered" on the Attachment and described in this Certificate. Coverage is subject to all terms, conditions, limitations and exclusions set forth in this Certificate, the Attachment and the Group Contract. You are responsible for a Provider's normal charge for a service that is not a covered service under this Policy.
2. Deductible. You may be subject to a deductible(s). If so, the amount of the deductible(s) is set forth on the Attachment. Each calendar year, you must meet the deductible(s) before GHI will pay benefits for covered services. The amount credited toward your deductible(s) is based upon the Schedule of Allowances or Allowed Charge. It is not based upon your out-of-pocket expenses or your Provider's charge.

3. Coinsurance. You may be required to share the cost of some or all covered services. This is known as coinsurance. Coinsurance is a percentage of the Scheduled or Allowed amount payable by you, not GHI, for covered services. For example, if the Attachment states that GHI will pay eighty percent (80%) of the Schedule of Allowances or Allowed Charge for a covered service, you must pay coinsurance in the amount of the remaining twenty percent (20%) of the Scheduled or Allowed amount for the service (in addition to any applicable deductible amount). There may be certain other charges that you are responsible to pay that are not considered to be coinsurance. For example, you are responsible to pay for:
  - Annual deductible(s), if any.
  - Charges for services and/or materials that are not covered.
  - Charges that exceed the Schedule of Allowance or Allowed Charge for a covered service if Non-Network Providers are used.
  - Charges incurred in a calendar year after you have exhausted the annual maximum.
  - Charges incurred after you have exhausted the lifetime maximum.
4. Annual Maximum. GHI will only pay up to a certain dollar amount in benefits per person per calendar year under this Policy. This amount is known as the annual maximum. Your annual maximum(s) is shown on the attachment. GHI will not pay more than this amount per person in each calendar year.
5. Lifetime Maximum(s). GHI may only pay up to a certain dollar amount of benefits per person per lifetime for orthodontic services. This amount is known as the lifetime maximum. If Orthodontic Services are listed as “covered” on the Attachment, the amount(s) of the orthodontic lifetime maximum benefit, if applicable, is also set forth on the Attachment. If a Lifetime Maximum(s) applies, then GHI will not pay more than the amount(s) shown per person per lifetime for orthodontic services.
6. Time of Charge. GHI will consider a charge to be incurred on the date the service is rendered.
7. Rollover Maximum. If the Attachment states that the Rollover Maximum “applies”, then, GHI will allow you to rollover a portion of your unused annual maximum for non-orthodontic services. This amount is known as the Rollover Maximum. The Rollover Maximum is set forth on the Attachment. If you submit



one (1) or more claims for covered services during a calendar year and, in that year, receive benefits that are in excess of any applicable deductible, coinsurance or co-payments, which in total, do not exceed the Rollover Threshold set forth in the Attachment, you may be entitled to a Reward. The Reward amount is set forth on the Attachment and it will vary depending whether you use only In-Network Providers, or you use only Non-Network Providers or a combination of In-Network Providers and Non-Network Providers. Rewards are determined at the end of each calendar year and can be accrued and stored in your Bank. If you reach your annual maximum for non-orthodontic services, GHI will pay benefits for services that would otherwise be covered under this Policy up to the amount stored in your Bank from past calendar years. The amount of the Reward stored in the Bank will never be greater than the Bank Maximum set forth on the Attachment. Your Bank will be eliminated, and the accrued Reward lost, if you have a break in coverage of any length of time, for any reason.

If the Group Contract initially became effective in July, August, September, October, November or December, this rollover provision will not apply until January 1 of the next full benefit year. This means that:

- only claims incurred on or after January 1 of the next year will count toward the Rollover Threshold; and
- Rewards will not be applied to the Bank until the benefit year that starts one year from the date the rollover provision first applies.

If benefits for any dental services are not payable for a period set forth in the provisions of this Policy called Benefit Waiting Period and Late Entrant Waiting Period, then this rollover provision will not apply until the end of such period. And, if such period ends within the six (6) months prior to the start of the next calendar year, this rollover provision will not apply until the next calendar year. This means that:

- Only claims incurred on or after the start of the next calendar year will count toward the Rollover Threshold; and
- Rewards will not be applied to the Bank until the calendar year that starts one (1) year from the date the rollover provision first applies.

8. Services Rendered by a Network Provider. A Network Provider has agreed with GHI to accept GHI's Schedule(s) of Allowances or negotiated rate(s) as payment in full for

covered services. If the Attachment indicates that GHI will provide benefits for services received from Network Providers and you use a Network Provider, GHI will pay the Network Provider directly for covered services, less any deductible and coinsurance that applies to your coverage.

A Network Provider will bill you for any deductible and coinsurance that applies to your coverage. A Network Provider will also bill you for services that are not covered and for services rendered to you after you have exhausted applicable annual and/or lifetime maximums.

9. Services Rendered by Non-Network Provider. A Non-Network Provider has not agreed with GHI to accept GHI's Schedule(s) of Allowances or negotiated rate(s) as payment in full for covered services or is not part of the Provider network that applies to this Policy. If you use a Non-Network Provider, you must file a claim form with GHI. If the Attachment indicates that GHI will provide benefits for services received from Non-Network Providers, then GHI will reimburse you at the applicable Scheduled or Allowed amount for dental services listed as "covered" in the Attachment, less any deductible and coinsurance that applies to your coverage. You are responsible to pay any difference between GHI's payment and the Non-Network Provider's charge.
10. Preventive Services Annual Maximum Waiver. If the Attachment states that the Preventive Maximum Waiver "applies", then GHI will not apply benefits paid for services listed under Type A – Preventive Services toward your Annual Maximum.

#### **ARTICLE FIVE - PREDETERMINATION OF BENEFITS**

You have the option to obtain a Predetermination of Benefits from GHI prior to the onset of certain treatments. Predetermination of Benefits is a process by which GHI will review and estimate benefits before certain services are rendered.

To obtain a Predetermination of Benefits, you should submit a Treatment Plan to GHI before receiving oral surgery, prosthetic services, appliances or orthodontic services. GHI will review the Treatment Plan and inform you and your Dentist or Provider of the results of this review. The results will provide an estimate of the benefit(s) that GHI will provide for the item or service. It will also state if any item or service is not covered and why it is not covered. The results of the Predetermination of Benefits are only an estimate. This estimate may change based upon any new information received by GHI after it has issued

the Predetermination of Benefits and/or if your coverage changes after GHI has issued the Predetermination of Benefits, but before you receive services.

If you do not take advantage of the Predetermination of Benefits service, you will not know in advance the services and materials that GHI will cover or the benefits that GHI will provide. GHI reserves the right to determine your benefits taking into account alternate procedures, services or courses of treatment. If you or your Provider feel that the alternate procedure, service or course of treatment is not appropriate in your case, your request will be subject to medical necessity review and internal and external utilization review appeals. (See Articles Nine and Ten).

Predetermination of Benefits is not available for the Preventive and Diagnostic Services.

**IMPORTANT:** Please note that Predetermination of Benefits is available only for certain types of dental services. Network Providers usually have a list of the American Dental Association (ADA) codes for which Predetermination of Benefits is available. Non-Network Providers may not have this list. Before receiving any oral surgery or prosthetic or orthodontic services, you should obtain the ADA procedure code(s) for the service(s) you will receive and call GHI to determine whether Predetermination of Benefits is available for the service(s). If so, you should ask your Provider to submit a Treatment Plan to GHI before services are rendered if you would like a Predetermination of Benefits.

## **ARTICLE SIX – EXCLUSIONS AND LIMITATIONS**

No coverage is available under this Certificate for the following:

- A. Aviation. GHI does not cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.
- B. Convalescent and Custodial Care. GHI does not cover services related to rest cures, custodial care or transportation. “Custodial care” means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include covered services determined to be medically necessary.
- C. Cosmetic Services. GHI does not cover cosmetic services or surgery unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such

service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered child which has resulted in a functional defect. Cosmetic surgery does not include surgery determined to be medically necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the utilization review process in the Utilization Review and External Appeals articles of this Certificate unless medical information is submitted.

- D. Experimental or Investigational Treatment. GHI does not cover any health care service, procedure, treatment, or device that is experimental or investigational. However, GHI will cover experimental or investigational treatments, including treatment for your rare disease or patient costs for your participation in a clinical trial, when our denial of services is overturned by an external appeal agent certified by the State. However, for clinical trials, GHI will not cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be covered under the Certificate for non-investigational treatments. See the Utilization Review and External Appeal articles of this Certificate for a further explanation of your appeal rights.
- E. Felony Participation. GHI does not cover any illness, treatment or medical condition due to your participation in a felony, riot or insurrection.
- F. Government Facility. GHI does not cover care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.
- G. Medical Services. GHI does not cover medical services or dental services that are medical in nature, including any hospital charges or prescription drug charges.
- H. Medically Necessary. In general, GHI will not cover any dental service, procedure, treatment, test or device that we determine is not medically necessary. If an external appeal agent certified by the State overturns our denial, however, GHI will cover the service,

procedure, treatment, test or device for which coverage has been denied, to the extent that such service, procedure, treatment, test or device, is otherwise covered under the terms of this Certificate.

- I. Medicare or Other Governmental Program. GHI does not cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).
- J. Military Service. GHI does not cover an illness, treatment or medical condition due to service in the armed forces or auxiliary units.
- K. No-Fault Automobile Insurance. GHI does not cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under a mandatory no-fault policy.
- L. Services not Listed. GHI does not cover services that are not listed in this Certificate as being covered.
- M. Services Provided by a Family Member. GHI does not cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of you or your spouse.
- N. Services Separately Billed by Hospital Employees. GHI does not cover services rendered and separately billed by employees of hospitals, laboratories or other institutions.
- O. Services with No Charge. GHI does not cover services for which no charge is normally made.
- P. War. GHI will not cover an illness, treatment or medical condition due to war, declared or undeclared.

- Q. Workers' Compensation. GHI does not cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

## **ARTICLE SEVEN – CLAIM DETERMINATIONS**

### **A. Claims.**

A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When you receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either you or the Provider must file a claim form with us. If the Non-Participating Provider is not willing to file the claim form, you will need to file it with us. See the Coordination of Benefits section of this Certificate for information on how we coordinate benefit payments when you also have group health coverage with another plan.

### **B. Notice of Claim.**

Claims for services must include all information designated by us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from us by calling [1-800-624-2414] or the number on your ID card or visiting our website at [www.emblemhealth.com]. Completed claim forms should be sent to the address on your ID card. Effective on the date of issuance or renewal of this Certificate on or after April 1, 2015, you may also submit a claim to us electronically by [visiting Our website at www.emblemhealth.com].

### **C. Timeframe for Filing Claims.**

Claims for services must be submitted to us for payment within eighteen (18) months after you receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the eighteen (18) month period, you must submit it as soon as reasonably possible.

### **D. Claims for Prohibited Referrals.**

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

**E. Claim Determinations.**

Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, our claim determination procedure applies to contractual benefit denials. If you disagree with our claim determination, you may submit a grievance pursuant to the Grievance Procedures article of this Certificate.

For a description of the utilization review procedures and appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal articles of this Certificate.

**F. Pre-service Claim Determinations.**

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

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

2. Urgent Pre-service Reviews. With respect to urgent pre-service requests, if we have all information necessary to make a determination, We will make a determination and provide notice to you (or your designee) by telephone, within seventy-two (72) hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If we

need additional information, we will request it within twenty-four (24) hours. You will then have forty-eight (48) hours to submit the information. We will make a determination and provide notice to you (or your designee) by telephone within forty-eight (48) hours of the earlier of our receipt of the information or the end of the 48-hour time period. Written notice will follow within three (3) calendar days of the decision.

**G. Post-service Claim Determinations.**

A post-service claim is a request for a service or treatment that you have already received. If we have all information necessary to make a determination regarding a post-service claim, we will make a determination and notify You (or Your designee) within thirty (30) calendar days of the receipt of the claim. If we need additional information, we will request it within thirty (30) calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to you (or your designee) in writing within fifteen (15) calendar days of the earlier of our receipt of the information or the end of the forty-five (45) day period.

**ARTICLE EIGHT – GRIEVANCE PROCEDURES**

**A. Grievances.**

Our grievance procedure applies to any issue not relating to a medical necessity or experimental or investigational determination by us. For example, it applies to contractual benefit denials or issues or concerns you have regarding our administrative policies or access to providers.

**B. Filing a Grievance.**

You can contact us by phone [at 1-800-624-2414] [or at the number on Your ID card] or in writing [at GHI Dental Correspondence, P.O. Box 1701, New York, NY 10023] to file a grievance. You may submit an oral grievance in connection with a denial of urgent care. We may require that you sign a written acknowledgement of your oral grievance, prepared by us. You or your designee has up to 180 calendar days from when you received the decision you are asking us to review to file the grievance.

When we receive your grievance, we will mail an acknowledgment letter within fifteen (15) business days. The acknowledgment letter will indicate what additional information, if any, must be provided.



We keep all requests and discussions confidential and we will take no discriminatory action because of your issue. We have a process for both standard and expedited grievances, depending on the nature of your inquiry.

**C. Grievance Determination.**

Qualified personnel will review your grievance, or if it is a clinical matter, a licensed, certified or registered health care professional will look into it. We will decide the grievance and notify you in writing within the following timeframes:

Expedited/Urgent Grievances: 72 hours of receipt of your grievance.

Pre-Service Grievances:

(A request for a service or a treatment that has not yet been provided.)

15 calendar days of receipt of your grievance.

Post-Service Grievances:

(A claim for a service or a treatment that has already been provided.)

30 calendar days of receipt of your grievance.

**D. Assistance.**

If you remain dissatisfied with our appeal determination, or at any other time you are dissatisfied, you may:

Call the New York State Department of Financial Services at

1-800-342-3736 or write them at:

New York State Department of Financial Services

Consumer Assistance Unit

One Commerce Plaza

Albany, NY 12257

[www.dfs.ny.gov](http://www.dfs.ny.gov)

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

Community Health Advocates

105 East 22nd Street

New York, NY 10010

Or call toll free: 1-888-614-5400; or e-mail [cha@cssny.org](mailto:cha@cssny.org)

[www.communityhealthadvocates.org](http://www.communityhealthadvocates.org)

## **ARTICLE NINE – UTILIZATION REVIEW**

### **A. Utilization Review.**

We review health services to determine whether the services are or were medically necessary or experimental or investigational ("medically necessary"). This process is called utilization review. Utilization review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If you have any questions about the utilization review process, please call [1-800-624-2414]. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not medically necessary will be made by: 1) licensed physicians; or 2) licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the Provider who typically manages your medical condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to our employees or reviewers for determining that services are not medically necessary. We have developed guidelines and protocols to assist us in this process. Specific guidelines and protocols are available for your review upon request. For more information, call [1-800-624-2414] or visit Our website [at [www.emblemhealth.com](http://www.emblemhealth.com)].

### **B. Preauthorization Reviews.**

1. If We have all the information necessary to make a determination regarding a preauthorization review, we will make a determination and provide notice to you (or your

designee) and your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

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

2. **Urgent Preauthorization Reviews.** With respect to urgent preauthorization requests, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your Provider, by telephone, within seventy-two (72) hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If we need additional information, we will request it within twenty-four (24) hours. You or your Provider will then have forty-eight (48) hours to submit the information. we will make a determination and provide notice to you (or your designee) and your Provider by telephone within forty-eight (48) hours of the earlier of our receipt of the information or the end of the 48-hour time period. Written notification will be provided within the earlier of three (3) business days of our receipt of the information or three (3) calendar days after the verbal notification.

### **C. Concurrent Reviews.**

1. Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If we need additional information, we will request it within one (1) business day. You or your Provider will then have forty-five (45) calendar days to submit the information. We will make a determination and provide notice to you (or your designee) and your Provider, by telephone and in writing, within one (1) business day of our receipt of the information or, if we do not receive the information, within fifteen (15) calendar days of the end of the 45-day time period.

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

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

#### **D. Retrospective Reviews.**

If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and notify you within thirty (30) calendar days of the receipt of the request. If we need additional information, we will request it within thirty (30) calendar days. You or your Provider will then have forty-five (45) calendar days to provide the information. We will make a determination and provide notice to you in writing within fifteen (15) calendar days of the earlier of our receipt of the information or the end of the 45-day period.

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

#### **E. Retrospective Review of Preauthorized Services.**

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

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

#### **F. Reconsideration.**

If we did not attempt to consult with your Provider before making an adverse determination, your Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to you and your Provider, by telephone and in writing.

#### **G. Utilization Review Internal Appeals.**

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

You have up to one hundred and eighty (180) calendar days after you receive notice of the adverse determination to file an appeal. We will acknowledge your request for an internal appeal within fifteen (15) calendar days of receipt. This acknowledgment will if necessary, inform you of any additional information needed before a decision can be made. A clinical peer reviewer who is a physician or a health care professional in the same or similar specialty as the Provider who typically

manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the appeal.

#### **H. Standard Appeal.**

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

**Retrospective Appeal.** If your appeal relates to a retrospective claim, we will decide the appeal within sixty (60) calendar days of receipt of the appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate, your Provider, within two (2) business days after the determination is made, but no later than sixty (60) calendar days after receipt of the appeal request.

**Expedited Appeal.** An appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. An expedited appeal is not available for retrospective reviews. For an expedited appeal, your Provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one (1) business day of receipt of the request for an appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited appeal will be determined within the earlier of seventy-two (72) hours of receipt of the appeal or two (2) business days of receipt of the information necessary to conduct the appeal.

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

Our failure to render a determination of your appeal within sixty (60) calendar days of receipt of the necessary information for a standard appeal or within two (2) business days of receipt of the

necessary information for an expedited appeal will be deemed a reversal of the initial adverse determination.

### **I. Appeal Assistance.**

If you need Assistance filing an appeal, you may contact the state independent Consumer Assistance Program at:

Community Health Advocates

105 East 22nd Street

New York, NY 10010

Or call toll free: 1-888-614-5400, or email [cha@cssny.org](mailto:cha@cssny.org)

[www.communityhealthadvocates.org](http://www.communityhealthadvocates.org)

## **ARTICLE TEN – EXTERNAL APPEAL**

### **A. Your Right to an External Appeal.**

In some cases, you have a right to an external appeal of a denial of coverage. If we have denied coverage on the basis that a service does not meet our requirements for medical necessity (including appropriateness, health care setting, level of care or effectiveness of a covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), you or your representative may appeal that decision to an external appeal agent, an independent third party certified by the State to conduct these appeals.

In order for you to be eligible for an external appeal you must meet the following two requirements:

- The service, procedure, or treatment must otherwise be a covered service under the Certificate; and
- In general, you must have received a final adverse determination through our internal appeal process. But, you can file an external appeal even though you have not received a final adverse determination through our internal appeal process if:
  - We agree in writing to waive the internal appeal. We are not required to agree to your request to waive the internal appeal; or
  - You file an external appeal at the same time as you apply for an expedited internal appeal; or

- We fail to adhere to utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and we demonstrate that the violation was for good cause or due to matters beyond our control and the violation occurred during an ongoing, good faith exchange of information between you and us).

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

If we have denied coverage on the basis that the service does not meet our requirements for medical necessity, you may appeal to an external appeal agent if you meet the requirements for an external appeal in paragraph “A” above.

**C. Your Right to Appeal A Determination that A Service is Experimental or Investigational.**

If we have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), you must satisfy the two requirements for an external appeal in paragraph “A” above and your attending physician must certify that your condition or disease is one for which:

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

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

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation – your attending physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which you are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which your attending physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending physician



must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

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

#### **D. The External Appeal Process.**

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

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

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

In general, the external appeal agent must make a decision within thirty (30) days of receipt of your completed application. The external appeal agent may request additional information from you, your physician, or us. If the external appeal agent requests additional information, it will have five

(5) additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two (2) business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending physician certifies that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function; or if you received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within seventy-two (72) hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must notify you and us by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

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

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

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

#### **E. Your Responsibilities.**

It is your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial

Services. You may appoint a representative to assist you with your application; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed the representative.

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

### **ARTICLE ELEVEN - COORDINATION OF BENEFITS**

This section applies when you also have group dental coverage with another plan. When you receive a covered service, we will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

#### A. Definitions.

1. “Allowable expense” is the necessary, reasonable, and customary item of expense for dental care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.
2. “Plan” is other group dental coverage with which we will coordinate benefits. The term “plan” includes:
  - Group dental benefits and blanket or group remittance dental benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.

- Dental benefits coverage, in group and individual automobile “no-fault” and traditional liability “fault” type contracts.
  - Dental benefits coverage of a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.
3. “Primary plan” is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).
  4. “Secondary plan” is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

#### B. Rules to Determine Order of Payment.

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

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.
2. If the person receiving benefits is the Subscriber and is only covered as a dependent under the other plan, this Certificate will be primary.
3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a

result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's dental care expenses:
  - The plan of the parent who has custody will be primary;
  - If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
  - If a court decree between the parents says which parent is responsible for the child's dental care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.
  
5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
  
6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

#### C. Effects of Coordination.

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed our maximum available benefit for each covered service. Also, the amount we pay will not be more than the amount we would pay if we were primary. As each claim is submitted, we will determine our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

D. Right to Receive and Release Necessary Information.

We may release or receive information that we need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give us any needed information for coordination purposes, in the time frame requested.

E. Our Right to Recover Overpayment.

If we made a payment as a primary plan, you agree to pay us any amount by which we should have reduced our payment. Also, we may recover any overpayment from the primary plan or the provider receiving payment and you agree to sign all documents necessary to help us recover any overpayment.

F. Coordination with “Always Excess,” “Always Secondary,” or “Non-Complying” Plans.

We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this Certificate is primary, as defined in this section, we will pay benefits first.
2. If this Certificate is secondary, as defined in this section, we will pay only the amount we would pay as the secondary insurer.
3. If we request information from a non-complying plan and do not receive it within 30 days, we will calculate the amount we should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, we will make any necessary adjustments.

**ARTICLE TWELVE - TERMINATION**

1. Termination. Your coverage under this Policy will terminate in the event of any of the circumstances set forth below.

- (a) You are no longer eligible for group benefits. Examples of loss of eligibility may include:
- the Subscriber's loss of employment with or membership in the group;
  - divorce from the Subscriber;
  - death of the Subscriber;
  - a dependent reaching the age limitation.
- (b) The Group Contract between your Group and GHI is terminated.
- (c) By operation of law. You will be notified as required by law.

2. Benefits after Termination. If your coverage is terminated through no fault of your own, GHI will provide a sixty (60) day extension of benefits for covered dental procedures/treatment in progress on the date of termination of coverage. A dental procedure or treatment is in progress if it was commenced prior to the termination of your coverage and its completion requires a number of visits pursuant to a defined treatment plan. Treatment provided after your coverage has terminated for a condition treated while your coverage was in effect is not treatment in progress unless it is part of a defined treatment plan and the treatment commenced prior to the termination of your coverage. Benefits will not be extended for dental procedures and treatments that require only one visit for completion.

### **ARTICLE THIRTEEN – CONTINUATION OF COVERAGE**

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. If you are not entitled to temporary continuation of coverage under COBRA, you may be entitled to temporary continuation coverage under the New York Insurance Law as described below. Call or write your employer to find out if you are entitled to temporary continuation of coverage under COBRA or under the New York Insurance Law. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA or the New York Insurance Law.

#### A. Qualifying Events.

Pursuant to federal COBRA and state continuation coverage laws, you, the Subscriber, your spouse and your children may be able to temporarily continue coverage under this Certificate in certain situations when you would otherwise lose coverage, known as qualifying events.

1. If your coverage ends due to voluntary or involuntary termination of employment or a change in your employee class (e.g., a reduction in the number of hours of employment), you may continue coverage. Coverage may be continued for you, your spouse and any of your covered children.
  
2. If you are a covered spouse, you may continue coverage if your coverage ends due to:
  - Voluntary or involuntary termination of the Subscriber's employment;
  - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Divorce or legal separation from the Subscriber; or
    - Death of the Subscriber.
  
3. If you are a covered child, you may continue coverage if your coverage ends due to:
  - Voluntary or involuntary termination of the Subscriber's employment;
  - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
  - Loss of covered child status under the plan rules; or
  - Death of the Subscriber.

If you want to continue coverage, you must request continuation from the Group in writing and make the first premium payment within the 60-day period following the later of:

1. The date coverage would otherwise terminate; or
2. The date you are sent notice by first class mail of the right of continuation by the Group.

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



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

1. The date 36 months after the Subscriber's coverage would have terminated because of termination of employment;
2. If you are a covered spouse or child, the date 36 months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the Subscriber's eligibility for Medicare, or the failure to qualify under the definition of "children";
3. The date you become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
4. The date you become entitled to Medicare;
5. The date to which premiums are paid if you fail to make a timely payment; or
6. The date the Group Contract terminates. However, if the Group Contract is replaced with similar coverage, you have the right to become covered under the new Group Contract for the balance of the period remaining for your continued coverage.

#### **ARTICLE FOURTEEN - MISCELLANEOUS PROVISIONS**

1. **No Assignment.** You cannot, without GHI's consent, assign any benefits, payments, causes of action or rights to appeal benefits or claims determinations under this policy to any person, corporation, or other organization. Any assignment by you will be void. Assignment means the transfer to another person or organization of your right to the services provided or your rights under this policy.
2. **Your Dental Records.** In order to process your claims it may be necessary for GHI to obtain records and data from practitioners who treated you. When you become covered, you give GHI permission to obtain and use these records. The information will be kept confidential.
3. **Recovery of Overpayments.** If GHI pays benefits under this policy for services incurred on your account and it is found that GHI paid more benefits than should have been paid because you were: (a) not covered; (b) the services were not covered; (c) payment was in an amount greater than that to which you are entitled under this policy; or (d) payment was in an amount greater than that to which you are entitled because you were repaid for all or some of those expenses by another source; then GHI will have the right to a refund from you. You must return the amount of the overpayment within sixty (60) days of GHI's

- request. In addition, if you (or your legal representative, estate or heirs) make recovery from any liable party (including an insurance carrier) and the funds that are specifically identified in the judgement or settlement as medical expenses that GHI has previously paid, you must promptly reimburse GHI for any proceeds received.
4. Lawsuits. A lawsuit against GHI regarding this policy must be started within two (2) years from the date you received the service for which you want GHI to pay.
  5. New York Law. This policy is in all respects governed by the laws of New York State.
  6. Who Receives Payment Under This Policy. Payments for covered services rendered by a Network Provider will be made directly to that Network Provider. If you receive covered services from a Non-Network Provider, GHI reserves the right to pay you or the Provider.
  7. Patient's Relationship with the Dentist or Provider. Nothing in this Policy shall force a Dentist or Provider to accept you as a patient. This Policy is not meant to change the normal relationship between the provider and patient. At all times, the provider's usual rules will govern the service provided to the patient. GHI cannot guarantee receipt of any particular service or accommodation.
  8. Non-Vesting. Under no circumstances do you acquire a vested interest in continued receipt of a particular benefit or level of benefits. Benefits shall be determined according to the Group Contract terms in effect when an expense is incurred. Benefits may be amended at any time in accordance with applicable provisions of the Group Contract.