Empire Dental PPO[SM]
A Dental PPO for
United Welfare Health Fund
721227

Dental

07/2015

COMPANY NAME

GROUP NUMBER: 721227

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The benefits described in this booklet are subject to the terms, conditions, limitations, and exclusions of the contract issued by Empire BlueCross BlueShield to your group. If there is a difference between the information in this booklet and the actual contract, the contract always governs. Please consult your group's contract for additional information.

DENTAL PPO BENEFITS SUMMARY

This summary of your Dental PPO program is not a full contractual description of your benefits. Please see your group's contract for more information about covered services, limitations and exclusions.

PROGRAM BENEFITS	IN-NETWORK DENTIST *(1)*	OUT-OF-NETWORK *(2)*
ANNUAL DEDUCTIBLE	$0	$0
ANNUAL MAXIMUM	Children up to age 19 - Unlimited Age 19 and above - $500	
EMPIRE MAXIMUM ALLOWED AMOUNT	**IN-NETWORK FEE SCHEDULE** *(3)*	**OUT-OF-NETWORK FEE SCHEDULE** *(3)*
DIAGNOSTIC & PREVENTIVE SERVICES	$0	$0
BASIC SERVICES	$0	$0
MAJOR SERVICES	$0	$0
DEPENDENT CHILDREN	Dependents to 26; full-time unmarried students to age 26.	

(1) When services are performed by a PPO Network provider.
(2) When services are provided by an Out-of-Network provider.
(3) There may be Fee Schedules for different geographic areas.

IMPORTANT TELEPHONE NUMBERS

Do you have a question about your benefits? We're here to help you. Call this toll-free number for quick, courteous answers to your questions.

Dental PPO Member Services.....1-800-722-8879
For questions about your benefits, claims, or membership.

STOP FRAUD

Empire BlueCross BlueShield welcomes your help in preventing dental insurance fraud. Fraud costs Empire and its customers millions of dollars each year. If you are aware of any illegal activity involving Empire BlueCross BlueShield, please make a confidential call to this phone number during normal business hours:

INTEGRITY HOTLINE: 1-800-I-C-FRAUD (423-7283).

INTRODUCTION

Your dental plan is a group plan. With Empire Dental XPO, you have a dental insurance program designed to help you get dental benefits at the lowest possible cost, and dedicated to helping you maintain good oral health. **Important: This is <u>not</u> an insured benefit Plan.** The benefits described in this benefit book or any rider or amendments hereto are funded by the Employer who is responsible for their payment. Empire BlueCross BlueShield provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

This benefit booklet is a guide to your Empire Dental XPO coverage. It tells you how to get quality dental care from the dentist *you* choose, control your out-of-pocket expenses, and avoid filing claims. Please read this material and call Empire if you have any questions. Please be aware that this booklet is a summary of your employer's legal contract which controls any disputes. If you would like to consult your contract, please contact your group benefits administrator.

What is a Dental PPO?

Your PPO program is a dental plan built around the Empire Dental XPO network of dentists. You may receive care from any licensed dentist. Empire Dental XPO dentists have signed agreements with Empire to provide services, limit their fees according to the Empire Dental XPO maximum allowed amount and submit claims for covered services directly to Empire. As you can see in your **BENEFITS SUMMARY**, most services have two levels of payment, depending on whether the care was delivered In-Network or Out-of-Network. You may receive care from any licensed dentist, but when you use In-Network providers your out-of-pocket expenses for your dental care services will be lower, and you will virtually never have to submit a claim and wait for payment.

How Dental PPO Works

Each time you need dental care services, Empire Dental XPO allows you to choose whether to receive your care In-Network or Out-of-Network. You may decide to receive In-Network benefits for some services and Out-of-Network benefits for others. The reimbursement level changes, depending on whether services are In-Network or Out-of-Network. When you choose Out-of-Network benefits, you will have generally more out-of-pocket costs.

REMEMBER
YOU'LL HAVE LOWER OUT-OF-POCKET COSTS
WHEN YOU GO TO IN-NETWORK PROVIDERS
FOR YOUR DENTAL CARE.

Annual Benefit Maximum

This program's annual maximum is unlimited for children up to age 19 and $500 for adults age 19 and above.

The annual maximum includes all reimbursement paid by Empire for In-Network and Out-of-Network claims combined.

Eligibility

Coverage Category

Your coverage category indicates how many people your plan covers. You may choose:

- Individual, which covers only you
- Husband and wife, which covers you and your spouse
- Parent-Child/Children, which covers you and your dependent children
- Two-person, which covers you and your spouse or you and one dependent child
- Family, which covers you and two or more of the following:
  - Your spouse
  - Dependent children (natural or adopted)

Eligible Dependents

The following family members are eligible for coverage:

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

Adding or Removing a Dependent

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

- If you failed to enroll when you became eligible, you may enroll yourself or yourself and your dependents without waiting for the open enrollment period if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption (the qualifying event), provided that you apply for such coverage within 60 days after the qualifying event.
- Your cost for coverage may change if you add a dependent midyear. Any change affecting payment of your premium should go through your employer.
- If you or your eligible dependents reject initial enrollment, you and your eligible dependents can become eligible for coverage under this program if the following enrollment conditions are met:
  - You or eligible dependent was covered under another plan at the time coverage was initially offered, and
  - Coverage was provided in accordance with continuation required by federal or state law and was exhausted, or
  - Contract holder contributions toward the payment of premium for the other plan were terminated, or
  - Coverage under the other plan was subsequently terminated as a result of loss of eligibility for one of the following:
    - Termination of employment
    - Termination of the other plan
    - Death of the spouse
    - An employer no longer offers benefits to a class of indivuduals (i.e., part time workers)
    - Legal separation, divorce or annulment
    - Reduction in the number of hours of employment
    - Premium payments for the other plan were terminated
    - Lifetime maximum being met under such insurance

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

  Coverage must be applied for within 60 days of one of the qualifying special enrollment events described above.
- If you marry and transfer to two-person /husband and wife or family coverage within 60 days of the marriage date, Empire will provide retroactive coverage during this period. Otherwise, coverage begins on the date Empire receives and accepts your completed enrollment form from your employer during the open enrollment period.
- Eligible Employees and Dependents may also enroll under two additional circumstances:
  - the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
  - the Employee or Dependent becomes eligible for a subsidy (state premium assistance program)

  The Employee or Dependent must request Special Enrollment within sixty (60) days of the loss of Medicaid/CHIP or of the eligibility determination.
- Enrolling a newborn child:
  - For a Member who has <u>individual (for self only), employee\spouse, or parent\child (two-person)</u> coverage:
    - He\she MUST notify the Company of his\her desire to switch to a parent\child, parent\children, or family contract within sixty (60) days after the date of birth.
    - He\she MUST formally add his\her **<u>eligible</u>** newborn or a proposed adopted newborn to his\her contract within sixty (60) days from the date of birth by contacting his\her Group Benefit Administrator, Broker,

or Company Representative and submitting an enrollment form in order to have the newborn's enrollment retroactive to the date of birth.

- If the Company does not receive enrollment notification within sixty (60) days, coverage will begin on the date that we receive, and accept from the Group, a completed copy of the Member enrollment form**.**
- If you do not switch to a parent\child, parent\children, or family contract and enroll your **eligible** newborn under that contract as described above, your newborn or proposed adopted newborn will NOT be covered under your Plan , except for newborn nursery charges incurred during the first 48 hours following a vaginal delivery or the first 96 hours following a c-section delivery.

- For a Member who has <u>family or parent\children</u> (more than two person) coverage:
  - An **eligible** newborn child, or a proposed adopted newborn, will be covered from the date of birth**.**
  - He\she MUST formally add his\her **eligible** newborn or a proposed adopted newborn to his\her contract within sixty (60) days from the date of birth by contacting his\her Group Benefit Administrator, Broker, or Company Representative as well as submitting an enrollment form.
  - Coverage will still be effective from the date of birth for an **eligible** newborn or a proposed adopted newborn if an enrollment form is received after sixty (60) days, and enrollment will still be retroactive to the date of birth.
  - Any claims for an **eligible** newborn or a proposed adopted newborn received after sixty (60) days will not be processed until the newborn or proposed adopted newborn is formally enrolled , except for newborn nursery charges incurred during the first 48 hours following a vaginal delivery or the first 96 hours following a c-section delivery.

- An adopted newborn is covered from the moment of birth if:
  - You take custody as soon as the infant is released from the hospital after birth,
  - The newborn is dependent upon you pending finalization of the adoption, and
  - You file an adoption petition within 60 days of the infant's birth.

- Adopted newborns will not be covered from the moment of birth if:
  - The infant has coverage from one of the natural parents for the newborn's initial hospital stay
  - A notice revoking the adoption has been filed
  - One of the natural parents revokes their consent to the adoption

- Qualified Medical Child Support Orders (QMCSO). A court order, judgment or decree that:
  - Provides for child support relating to health benefits with respect to the child of a group health plan participant or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law, or
  - Enforces a state medical child support law enacted under Section 1908 of the Social Security Act.

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

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

Effective Date of Coverage

Your Dental PPO benefits begin either on the effective date of your group's coverage if you are a member of the group on that date or when Empire accepts your complete enrollment information. For a family membership, coverage for your spouse and dependents becomes effective only after you send Empire a completed Notice of Election and Enrollment Form.

If you marry and notify Empire within 60 days of the marriage, family coverage will begin on the marriage date. Otherwise, family coverage begins on the date when we accept complete enrollment information.

Our Role in Notifying You

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

IN-NETWORK BENEFITS

In order to receive In-Network benefits, you must receive treatment from a dentist participating in the Empire Dental XPO Network.

When an In-Network dentist provides your care, Empire usually covers the services in full. Empire pays network dentists directly, so you won't need to send claim forms and wait for payment.

In-Network Reimbursement

For all covered dental services, Empire will make payment directly to the participating Empire Dental XPO dentist based on Empire's Maximum Allowed Amount for In-Network services.

For services not covered under the Dental coverage, the participating dentist may **not** charge more than Empire's Maximum Allowed Amount for that covered service.

How To Choose A Dentist

If you have family coverage each family member may use a different dentist. You may change Empire Dental XPO dentists at any time simply by making an appointment with the new participating dentist of your choice. Empire does not require any notification when you make a change.

To choose a dentist, first decide whether you prefer a dentist close to your home or near your workplace. Then turn to the listing in your Empire Dental XPO Directory for that county. Dentists are listed in the directory alphabetically by county and type of practice. Select your dentist and call the office directly to schedule your first appointment.

When you make your first appointment for routine treatment or specialty care, inform the dentist that you are a member of the Empire Dental XPO Program. Have your ID card available to answer questions about your dental coverage.

OUT-OF-NETWORK BENEFITS

If you receive dental services from a non-participating dentist, benefits will be will be paid based on Empire's In-Network Schedule of Allowances for the geographic area in which the services were rendered and payment will go to the member. The non-participating dentist may charge their usual fee for covered or non-covered services**.**

You will be responsible for the difference between the maximum allowed amount and the non-participating dentist's usual fee. Fees for non-covered services are your responsibility.

In most cases, you must fill out and mail claim forms whenever you receive Out-of-Network services.

Note: Covered services charged by non-participating dentists are reimbursed up to Empire's Maximum Allowed Amount for Out-of-network services.

COVERED DENTAL SERVICES

Diagnostic Services

Periodic oral examination [1]
Emergency oral exam - only when performed in connection with accidental injury
Intraoral x-rays complete series [2]
Intraoral x-ray periapical first film [3,4]
Intraoral x-ray periapical additional film [4]
Intraoral x-ray occlusal film [4]
Bitewing x-ray single film [3,4]
Bitewing x-ray two films [3,4]
Bitewing x-ray four films [3,4]
Panoramic film [2]
Cephalometric films only when done in connection with orthodontic treatment[5]
Diagnostic casts

Preventive Services

Prophylaxis adult [6]
Prophylaxis child [6]
Topical application of fluoride - child (excluding prophylaxis) [7]
Space maintainer fixed unilateral [8]
Space maintainer fixed bilateral [8]
Space maintainer removable unilateral [8]
Space maintainer removable bilateral [8]
Recementation of space maintainer
Sealant per tooth [9]

LIMITATIONS AND EXCLUSIONS ON DIAGNOSTIC, RADIOGRAPHIC & PREVENTIVE SERVICES

1. Oral exams are covered one (1) time per six months.
2. Full mouth series or panoramic x-ray studies are limited to one (1) time per thirty-six (36) months.
3. A maximum of 4 bitewing x-rays are limited to two (2) times in a twelve (12) month period.
4. Allowances for individual x-rays cannot exceed the allowance for full mouth series.
5. Cephalometric x-rays are available for orthodontia only, and when medically necessary as determined by Empire.
6. Adult prophylaxis and child prophylaxis are limited to not more than one (1) time in a six (6) month period.
7. The topical application of fluoride is limited to patients under age sixteen (16) and one (1) time in a six (6) month period.
8. Space maintainers are limited to patients up to the age of 12, one time per tooth.
9. Topical application of sealants - benefits will be provided for sealants only one (1) time per twenty-four (24) month period per tooth with a maximum of two (2) times per tooth and limited to primary and permanent molars only. This benefit is only available to covered persons under age 16.

Restorative Services *

Amalgam one surface primary or permanent [1]
Amalgam two surfaces primary or permanent [1]
Amalgam three surfaces, primary or permanent [1]
Amalgam four surfaces, primary or permanent [1]
Resin-one surface, anterior [1]
Resin-two surfaces, anterior [1]
Resin-three surfaces, anterior [1]
Resin-four or more surfaces or involving incisal angle [1]
Resin-one surface, posterior [1]
Resin-two surfaces, posterior [1]
Resin-three surfaces, posterior [1]
Three or more surface metallic inlay
Onlay per tooth
Porcelain/ceramic - two surfaces inlay
Porcelain/ceramic - three surfaces inlay
Crown - resin (laboratory)
Crown - resin with high noble metal
Crown - resin with predominantly base metal
Crown - resin with noble metal
Porcelain crown/ceramic substrate
Crown - porcelain fused to high noble metal
Crown - porcelain fused to predominantly base metal
Crown - porcelain fused to noble metal
Crown (full cast) high noble metal
Crown - full cast predominantly base metal
Crown - full cast noble metal
Crown three-quarter cast metallic
Re-cement an inlay
Re-cement a crown
Prefab.stainless steel crown, primary tooth [2]
Prefab.stainless steel crown, permanent tooth [2]

* Benefits for crowns, inlays and onlays shall be limited to those cases where individual teeth cannot be restored to function by fillings and are limited for replacement once every five years.

1. Amalgam, resin, acrylic, plastic or porcelain restorations on primary or permanent teeth are allowed one time per tooth per six (6) month period for the same surface.
2. Stainless steel crowns are limited to patients up to the age of 19.

Restorative Services (Continued) *

Sedative filling (temporary filling)
Pin retention - per tooth, in addition to filling
Cast post and core in addition to crown
Prefab. post and core in addition to crown
Labial veneer - resin/lab
Labial veneer - (porcelain laminate) - lab
Temporary crown (fractured tooth)
Crown repair, by report

Endodontic Services

Pulp cap-direct (excluding final restoration) (1)
Therapeutic pulpotomy (excluding final restoration) (2)
Anterior (excluding final restoration) (3)
Biscuspid (excluding final restoration) (3)
Molar (excluding final restoration) (3)
Apexification (per treatment visit) (4)
Apicoectomy
Apicoectomy - each additional root
Retrograde filling - per root
Root amputation - per root

* Benefits for crowns, inlays and onlays shall be limited to those cases where individual teeth cannot be restored to function by fillings and are limited for replacement once every five years.

1. Direct pulp capping is limited to one time per tooth for permanent teeth only. Indirect pulp capping is not covered.
2. Pulpotomy is allowed only one time per tooth and for patients under 14 years of age only.
3. All root canal therapy procedures includes six months of follow-up care. Retreatment is limited to one time after 36 months from initial treatment and only one tooth per lifetime.
4. Apexification is allowed only one time per tooth and for patients under 14 years of age not to exceed 3 treatment visits for a single tooth.

Benefits for labial veneers, pin retention and post and core are limited for replacement once every five years.

Periodontic Services

Gingivectomy or gingivoplasty – four or more contiguous teeth, per quadrant [1]
Gingivectomy or gingivoplasty - per quadrant, one to three teeth [1]
Gingival flap procedure, including root planing per quadrant [1]
Osseous surgery (including flap entry and closure) per quadrant [1]
Osseous graft-single site (including flap entry and donor site) [1]
Osseous graft-multiple sites (including flap entry and donor sites) [1]
Pedicle soft tissue graft procedure [1]
Free soft tissue graft procedure (including donor site surgery)
Apically repositioned flap procedure
Periodontal scaling and root planing – four or more contiguous teeth [2]
Periodontal scaling and root planing - per quadrant, one to three teeth [2]
Periodontal maintenance procedures following active therapy [4]

1. Surgical periodontic procedures must be precertified and are limited to once in a 36-month period, twice in a lifetime per quadrant. This benefit is available for patients age 23 and older. However, when medically necessary and if supported by documentation supplied by the dentist and sufficient to Empire, the benefit will be available for patients under age 23.
2. Periodontal scaling and root planing is limited to one time per 18 month period. Coverage is for patients age 23 and older. However, when medically necessary and if supported by documentation supplied by the dentist and sufficient to Empire, the benefit will be available for patients under age 23. This procedure is not allowed on the same date of service as a periodontal surgical procedure performed in the same area of the mouth.
3. Periodontal preventive maintenance procedures will not exceed one time in a 3 month period and will exclude the benefit for prophylaxis in the same period. The total prophylaxis and periodontal maintenance procedures together will not exceed more than 4 services in a 12-month period.

Prosthetic Services*

Complete upper denture
Complete lower denture
Immediate upper denture
Immediate lower denture
Upper partial-acrylic base (including any conventional clasps and rests)
Lower partial-acrylic base (including any conventional clasps and rests)
Upper partial-predominantly base cast base with acrylic saddles (including any conventional clasps and rests)
Lower partial-predominantly base cast base with acrylic saddles (including any conventional clasps and rests)
Removable unilateral partial denture-one piece predominantly base casting, clasp attachments-per unit (including pontics)
Adjust complete denture-upper
Adjust complete denture-lower
Adjust partial denture-upper
Adjust partial denture-lower
Repair broken complete denture base
Replace missing or broken teeth-complete denture (each tooth)
Repair acrylic saddle or base
Repair cast framework
Repair or replace broken clasp
Replace broken teeth-per tooth
Add tooth to existing partial denture
Add clasp to existing partial denture
Rebase complete upper denture
Rebase complete lower denture
Rebase upper partial denture
Rebase lower partial denture
Reline complete upper denture (chairside)
Reline complete lower denture (chairside)
Reline upper partial denture (chairside)
Reline lower partial denture (chairside)
Reline complete upper denture (laboratory)
Reline complete lower denture (laboratory)
Reline upper partial denture (laboratory)
Reline lower partial denture (laboratory)
Pontic-cast high noble metal
Pontic-cast predominantly base metal
Pontic-cast noble metal
Pontic-porcelain fused to high noble metal
Pontic-porcelain fused to predominantly base metal
Pontic-porcelain fused to noble metal
Pontic-resin with high noble metal

*Precertification with Empire is required before services can begin.

Prosthetic Services (Continued)*

Pontic-resin with predominantly base metal
Pontic-resin with noble metal
Inlay-metallic-two surfaces
Inlay-metallic-three or more surfaces
Crown-resin with high noble metal
Crown-resin with predominantly base metal
Crown-resin with noble metal
Crown-porcelain fused to high noble metal
Crown-porcelain fused to predominantly base metal
Crown-porcelain fused to noble metal
Crown 3/4 cast high noble metal
Crown-full cast predominantly base metal
Crown-full cast high noble metal
Recement bridge
Cast post and core in addition to bridge retainer
Prefabricated post and core in addition to bridge retainer
Bridge repair, by report

Oral Surgery (1)

Extraction, erupted or exposed tooth/root
Surgical removal of erupted tooth requiring elevation
Removal of impacted tooth-soft tissue
Removal of impacted tooth-partially bony
Removal of impacted tooth-completely bony
Removal of impacted tooth-completely bony with unusual surgical complications
Surgical removal of residual tooth roots (cutting procedure)
Tooth reimplantation and/or stabilization of accidentally evulsed or displace tooth and/or alveolus
Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments)
Surgical exposure of impacted or unerupted tooth to aid eruption
Biopsy of oral tissue-hard (2)
Biopsy of oral tissue-soft (2)
Alveoloplasty in conjunction with extractions per quadrant
Alveoloplasty not in conjunction with extractions per quadrant
Excision of benign tumor lesion diameter up to 1.25 cm
Excision of benign tumor lesion diameter greater than 1.25 cm

* Benefits must be precertified with Empire before services can begin.

1. For multiple surgical procedures performed at the same time and through the same incision, payment is made only for the procedure with the highest allowed amount. When done through different incisions payment will be made for each procedure.
2. Coverage for a biopsy of hard or soft tissue is limited to reimbursement of the surgical procedure and does not provide coverage for laboratory charges.

Oral Surgery (Continued)

Removal of odontogenic cyst or tumor lesion diameter up to 1.25 cm
Removal of odontogenic cyst or tumor lesion diameter greater than 1.25 cm
Removal or nonodontogenic cyst or tumor lesion diameter up to 1.25 cm
Removal of nonodontogenic cyst or tumor lesion diameter greater than 1.25 cm
Removal of exostosis-maxilla or mandible
Incision and drainage of abscess-intraoral soft tissue (1)
Incision and drainage of abscess-extraoral soft tissue (1)
Removal of foreign body, skin or subcutaneous areolar tissue
Removal of reaction-producing foreign bodies-musculoskeletal system
Suture of recent small wounds up to 5cm
Suture-up to 5 cm
Frenulectomy (frenectomy or frenotomy) separate procedure
Excision of hyperplastic tissue per arch
Excision of pericoronal gingiva

Adjunctive General Services

Palliative treatment for dental pain
General anesthesia

1. Incision and drainage of an abscess is not payable when done within 60 days following a covered endodontic, periodontic or surgical procedure.

LIMITATIONS AND EXCLUSIONS

Benefits are not provided for:

- Services covered under any government program; federal, state, county or municipal law or under the laws of any other country or the United States (except Medicaid).
- Services covered under Workers' Compensation law, mandatory no-fault automobile insurance or similar legislation.
- Experimental or obsolete procedures that are neither of proven benefit nor generally recognized by the dental profession as effective.
- Elective or cosmetic treatment for any reasons.
- Replacement of misplaced or lost, damaged or stolen crowns, bridges, dentures, or other dental appliances.
- Implants or bridges involving implants.
- Treatment of Temporomandibular Joint Syndrome, which is medical in nature.
- Appliances or restoration used solely to increase vertical dimensions; (i.e. crown lengthening)
- Dental services rendered beyond the scope of the provider's license.
- Dental services or items not needed for proper dental care or not considered within the scope of normal good dental practice or which are inconsistent with the highest standards of the dental profession. No benefits will be provided for services where in the professional judgment of the Empire consultant dentist, a satisfactory result cannot be obtained.
- Dental services not listed in the contract or any rider in the contract.
- Services when there is more than one professionally acceptable method of treatment, coverage will be limited to the least costly method. If a covered person selects a more costly alternative, the participating dentist may charge the member the difference between the Empire Maximum Allowed Amount for that more costly alternative method and Empire's Maximum Allowed Amount for the least costly method. A non-participating dentist may charge his usual fee.
- Coverage will not be provided for the replacement of any teeth missing on the effective date of the covered person's coverage under this contract until a two-year waiting period has been completed.
- Services for multiple abutments for fixed bridgework.
- Services for any hospital charges when a covered dental service must be performed in a hospital. Empire will only cover the dental benefits specifically listed in the contract, when performed by a dentist in connection with such hospitalization.
- Services rendered prior to the covered person's effective date of coverage under the contract.
- Services for treatment for any disease, condition or injury sustained as a result of war, declared or undeclared.
- General anesthesia, unless the medical necessity for such general anesthesia is documented. Benefits for local anesthesia and analgesia are included in the payment to the covered person's provider for the covered service performed. Separate payment may be made for general anesthesia when approved by Empire in its sole discretion, only when administered by an anesthetist other than the covered person's own provider or provider's employees.
- Prescription and non-prescription drugs and medications.
- Miscellaneous tests and laboratory examinations.
- Orthognathic surgery.

- Appliances and bridgework used solely to splint periodontally involved teeth.
- Empire will not pay for any service if it is usually provided without charge, including but not limited to situations where a provider does not usually collect payment in the absence of insurance coverage. Coverage will not be provided for services rendered by a member of the covered person's immediate family.
- A prosthetic appliance (including crown, bridge, and denture) will be provided only once in every five years. The five year period will be measured from the date on which the existing appliance was last supplied whether such appliance was provided while covered under this contract or not. The appliance will not be replaced within the five year period even if the appliance is no longer in the possession of the covered person.
- A reline of a denture will be covered once in a 36-month period.
- An adjustment to a denture will be covered once in a twelve-month period.
- Benefits are not provided for gold foil restorations.
- Endodontic endosseious implants are not covered.
- Occlusal adjustment is not covered.
- All orthodontic services.

COORDINATION OF BENEFITS

Occasionally, individuals have health care coverage under two programs. This commonly happens when a husband and wife both have employee health coverage that includes family members. When this occurs, the two programs coordinate benefit payments so that total payments do not exceed the allowable expenses incurred by the insured.

The Coordination of Benefits provision of your contract establishes which health coverage program has primary responsibility and which has secondary responsibility when an individual is covered by more than one group plan. The primary health program must reimburse you first. If Empire is the secondary program, we will reimburse you (up to the Maximum Allowed Amount) for the remaining expenses for the covered services.

How Empire Determines Primary Coverage

To determine primary coverage, we use the following criteria and in the following order:

- If the other health coverage program does not have a coordination of benefits provision similar to this one, that plan will have primary responsibility.
- If the covered person receiving benefits is the member of the Group covered by the contract, and is only a dependent under the other plan, this contract will be primary.
- A dependent child covered under both parents' health coverage programs will receive coverage as follows:
  - ⇒ the program of the parent whose birthday comes earlier in the calendar year (i.e., month and day) will have primary responsibility
  - ⇒ the health coverage program covering the parent longer will be primary, if the parents have the same birthday
  - ⇒ the father's health coverage program will have primary responsibility if the other health coverage program does not have a "birthday" provision and uses gender to determine primary responsibility.
- A dependent child covered by divorced or separated parents who have no court decree establishing financial responsibility for the child's health care expenses, will receive primary coverage under the custodial parent's health care program. If the parent with custody has remarried, and the child is also covered by the step-parent's program:
  - ⇒ the custodial parent's plan pays first.
  - ⇒ the step-parent's program pays second and the non-custodial parent's plan pays third.
- A dependent child, covered by either divorced or separated parents who have a court decree specifying which parent has financial responsibility for the child's health care expenses, will have primary coverage under that parent's contract once that plan has actual knowledge of that decree.
- Coverage of active employees and their dependents are primary to coverage for laid-off employees, retired employees, or their dependents. This rule applies only where both programs in question have this rule, and the two insurance carriers agree which coverage is primary, otherwise this rule should be ignored.
- If none of the previous rules apply, the health program that has covered the patient the longest will have primary responsibility.

CLAIMING BENEFITS

Benefits Precertification

Precertification helps you make an informed decision before treatment begins by letting you know **in advance** how much the program will pay for certain services. Precertification is required for crowns, fixed bridgework, periodontal surgery and all orthodontic services.

The precertification process requires your dentist to fill out a claim form with the *complete* treatment plan, **before treatment begins**. To reduce the processing time, please ask your dentist for your X-rays*****. Either you or the dentist must send the treatment plan and X-rays to:

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

Our dental benefits professionals will process the treatment plan and send both the dentist and you a precertification form that identifies the covered services. You and the dentist will also receive (separately) an Explanation of Payment form that identifies services not covered by the program.

During the treatment plan, you can receive payment for the services rendered to date. In these situations, the dentist inserts the date(s) of the authorized service(s) on the precertification form. You and your dentist then sign and submit the precertification form to Empire BlueCross BlueShield. We will send the dentist payment for services rendered to date, and you and the dentist will receive a new, updated precertification form. We will repeat this process each time we receive and process a part of the treatment plan.

*****We routinely require x-rays for the following treatments: single crowns, inlays, onlays, fixed prosthetics, periodontics, and orthodontics.

Claiming Benefits

Participating PPO network dentists will file claims directly with Empire. If your dentist is in the network, the dentist will file the claim for you and we will send payment directly to your dentist based on Empire's maximum allowed amount. A claim must be filed with Empire by the covered person or the non-participating provider of covered dental services. A non-participating provider may also choose to bill you directly. The covered person must then file the claim with Empire. When a claim is submitted for a covered dental service, the person must give Empire, or arrange for us to receive the following items which should be in English, or submitted with an English translation.

A completed claim form including any necessary reports and records must be submitted upon completion of services. ***This must be received by Empire within eighteen (18) months of the date that care was provided or the claim will not by honored or paid by Empire.***

You must complete a claim form when a dentist treats either you or an eligible dependent. When filling out a claim form, you complete the top portion of the claim form and the dentist completes the rest. You need to complete a separate claim form both for each patient and for each provider. Both you and the dentist must sign the bottom of the claim form. Once you have completed the claim form, send the form to:

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

Claim Review

Empire BlueCross BlueShield screens all incoming claim forms for completeness. We then code, number, register, and check claim forms for eligibility. Our examiners then review claims for coverage and issue either an approval or a rejection of benefits. You and your dentist will receive an Explanation of Benefit form from us showing the benefits we provided.

If you disagree with a claim disposition, you may request a review. You, or your duly authorized representative, must make the request in writing within 60 days. If we deny a claim, wholly or partly, you have the right to appeal our decision under the Employee Retirement Income Security Act of 1974 (ERISA). We will send you written notice of why the claim was denied. You will then have 60 days to submit a written request for review. Please submit your request to:

Claim Review Coordinator
Empire BlueCross BlueShield
Dental Benefits Program
P.O. Box 791
Minneapolis, Minnesota 55440-0791

We will send you a written decision with an explanation within 60 days of receiving the appeal. If special circumstances require more time, we can extend the review period for up to 120 days from the date we receive the appeal.

Be sure to include your current identification number, the claim number, and any pertinent information or comments. The request for claim review will incorporate any additional materials we receive. You will then receive written notification of the decision, explaining the basis for either upholding or modifying the original claim's disposition.

You may call **1-800-722-8879** for additional information. If you call, be sure to have your Empire BlueCross BlueShield identification number handy as well as any claim-related documents.

REIMBURSEMENT FOR COVERED DENTAL SERVICES

Maximum Allowed Amount

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

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

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

You will be required to pay a portion of the Maximum Allowed Amount . In addition, when you receive Covered Services from an Out-of-Network dentist, you may be responsible for paying any difference between the Maximum Allowed Amount and the Dentist's actual charges. This amount can be significant.

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

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

Provider Network Status

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

In-Network Dentist

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

Out-of-Network Dentist

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

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

1. An amount based on Our Out-of-Network Provider Fee Schedule/Rate, which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: record fee data, reimbursement amounts accepted by like/similar providers contracted with Empire, reimbursement amounts accepted by like/similar providers for the same services or supplies, or other industry cost, reimbursement and utilization data; or
2. An amount based on information provided by a third party vendor which may reflect comparable Providers' fees and costs to deliver care; or
3. An amount negotiated by Us or a third party vendor which has been agreed to by the In-Network Provider; or
4. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

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

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

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

Member Cost Share

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

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

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

Authorized Services

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

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

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

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

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

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

TERMINATION AND CONTINUATION OF COVERAGE

Termination of Coverage

Your Dental PPO coverage will continue unless terminated for any of the reasons set forth in the group contract. These include but are not limited to:

- your group terminates the contract on 60 days notice
- your employer no longer meets our underwriting standards
- your employer fails to pay premiums
- you fail to pay premiums (if required)
- the covered employee dies
- either you or your covered dependents no longer meet either your employer's or the contract's eligibility requirements
- you or your covered dependents have made a false statement on either an application for coverage or a health insurance claim form or if you or your group have otherwise engaged in fraud.
- Empire discontinues this class of coverage from the group market.

IMPORTANT INFORMATION

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

WHAT IS CONTINUATION COVERAGE?

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

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

Notice of Qualifying Events:

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

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

HOW LONG WILL CONTINUATION COVERAGE LAST?

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

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

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

HOW CAN YOU EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE?

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

DISABILITY

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your plan administrator for additional information. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan Administrator of that fact within 30 days after SSA's determination.

SECOND QUALIFYING EVENT

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation

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

HOW CAN YOU ELECT COBRA CONTINUATION COVERAGE?

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

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

HOW MUCH DOES COBRA CONTINUATION COVERAGE COST?

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

[*For employees eligible for trade adjustment assistance:* The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.]

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

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

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

lose all rights to continuation coverage under the Plan.

FOR MORE INFORMATION

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

If you have any questions concerning the information in this notice or your rights to coverage, you should contact your Plan Sponsor or the Group Benefits Administrator responsible for COBRA administration for your group.

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

The Veterans Benefits Improvement Act of 2004

The Veterans Benefits Improvement Act of 2004, which amends the 1994 Uniformed Services Employment and Reemployment Rights Act (USERRA), extends the period for continuation of health care coverage as follows: If a covered person's health plan coverage would terminate because of an absence due to military service, the person may elect to continue the health plan coverage for up to 24 months after the absence begins or for the period of service. Similar to COBRA, the person cannot be required to pay more than 102 percent (except where State requirements provide for a lesser amount) of the full premium for the coverage. If military service was for 30 or fewer days, the person cannot be required to pay more than the normal employee share of any premium.

Under State Law

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

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

Ending and Continuing Coverage

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

COMPLAINTS, APPEALS AND GRIEVANCES

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

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

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

STANDARD LEVEL 1 APPEALS

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

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

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

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

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

The claim will be reviewed and we will make a decision within sixty (60) days after the appeal is received. If special circumstances require an extension of time, the extension will not exceed one-hundred, twenty (120) days after the appeal is received. The decision will be in writing, containing specific reasons for the decision.

EXPEDITED LEVEL 1 APPEALS

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

i. Continuations or extensions of health care services, procedures or treatments already begun;
ii. Additional required or provided care during an ongoing course of treatment; or
iii. A case in which the Provider believes an immediate appeal is warranted; or
iv. When home health care is requested following discharge from an inpatient hospital admission.

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

- Empire will provide the Covered Person or his Provider with reasonable access to our clinical reviewer within one (1) business day of receiving a request for an expedited appeal. The Provider and clinical peer reviewer may exchange information by telephone or fax.
- Empire will make a decision on an expedited appeal within the lesser of seventy-two (72) hours of recept of the appeal request or two (2) business days following receipt of all necessary information about the case, but in any event within seventy-two (72) hours of receipt of the appeal.
- Empire will notify the Covered Person and his Provider immediately of the decision by telephone and will transmit a copy of the decision in writing within twenty-four (24) hours after the decision is made.
- If the Covered Person is not satisfied with the resolution of the expedited appeal, a further appeal may be made through the standard appeal process, as described in this subsection, or through an external appeal agent if the appeal is based on Medical Necessity or Experimental or Investigational denials. The notice of appeal determination will include the time frame for external appeals as required by 4904 (C)(2) of the New York State Insurance Law.
- If Empire does not make a decision within two (2) business days of receiving all necessary information to review the Covered Person's appeal, Empire will approve the service.

STANDARD LEVEL 2 APPEALS

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

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

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

- Retrospective. We will complete our review of a retrospective appeal within 30 calendar days of receipt of the appeal.

HOW TO REQUEST AN APPEAL

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

Empire Dental Grievance and Appeals Department
P.O. Box 551
Minneapolis, MN 55440-0551

COMPLAINTS

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

Empire Dental Grievance and Appeals Department
P.O. Box 551
Minneapolis, MN 55440-0551

We will resolve complaints within the following time frames:

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

LEVEL 1 GRIEVANCE

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

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

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

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

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

LEVEL 2 GRIEVANCES

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

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

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

EXPEDITED GRIEVANCES

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

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

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

DECISION ON GRIEVANCES

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

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

HOW TO FILE A GRIEVANCE

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

Empire Dental Grievance and Appeals Department
P.O. Box 551
Minneapolis, MN 55440-0551

YOUR RIGHTS AND RESPONSIBILITIES

We are committed to:

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

You have the right to:

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

You have the responsibility to:

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

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

AMENDMENT TO MEMBER'S EVIDENCE OF COVERAGE

Empire HealthChoice Assurance, Inc.
PO Box 1407
Church Street Station
New York, NY 10008-1407

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

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

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

Empire HealthChoice Assurance, Inc.
PO Box 1407
Church Street Station
New York, NY 10008-1407

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President