Empire BlueCross BlueShield
An Anthem Company

Dental Certificate of Coverage

This is Your

GROUP DENTAL CERTIFICATE OF COVERAGE

Issued By
EMPIRE HEALTHCHOICE ASSURANCE, INC.

Fedcap Rehabilitation Services, Inc.
Group Number 720419

This Certificate of Coverage ("Certificate") explains the benefits available to you under a Group Contract between Empire HealthChoice Assurance, Inc. (hereinafter referred to as "We", "Us", or "Our") and the Group listed in the Group Contract. This Certificate is not a contract between you and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

IMPORTANT NOTICE

In-Network Benefits. This Certificate only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers in Our Empire Dental Care network. Care Covered under this Certificate; must be provided, arranged or authorized in advance by Your Primary Care Dentist and, when required, approved by Us. In order to receive the benefits under this Certificate, You must contact Your Primary Care Dentist before You obtain the services except for Emergency Dental Care described in the Dental Care section of this Certificate. You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP CONTRACT. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

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

The insurance evidenced by this Certificate provides DENTAL insurance ONLY.

IN WITNESS WHEREOF, Empire HealthChoice Assurance, Inc., has caused this Certificate to be executed at New York, New York.

Jay H. Wagner
Corporate Secretary

Lawrence G. Schreiber
President

Empire HealthChoice Assurance, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.

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Section I Definitions

Defined terms will appear capitalized throughout the Certificate.

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

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

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Certificate: This Certificate issued by Empire HealthChoice Assurance, Inc., including the Schedule of Benefits and any attached riders. The Certificate explains the benefits available to You under the Group Contract.

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

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

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

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

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

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

Dependents: The Subscriber's Spouse and Children.

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

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

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

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

Group: The employer or party that has entered into an agreement with Us as a contract holder.

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

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

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

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

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

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

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

Participating Provider: A Provider who has a contract with Us to provide services to You. A list of Participating Providers and their locations is available on Our website at www.EmpireBlue.com or upon Your request to Us. To find a Participating Provider on Our website, select Find a Provider under Useful Tools, select a state and then select your dental plan. You can then select a general dentist or a Specialist who participates in the Essential Dental Care Network. The list will be revised from time to time by Us.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan Year: The 12-month period beginning on the effective date of the Certificate or any anniversary date thereafter, during which the Certificate is in effect.

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

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

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

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

Schedule of Benefits: The section of this Certificate that describes the Copayments, Deductibles, coinsurance, Out-of-Pocket Limits, and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of the following 28 counties in eastern New York State: Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington and Westchester.

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

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

Subscriber: The person to whom this Certificate is issued.

Us, We, Our: Empire HealthChoice Assurance, Inc and anyone to whom We legally delegate performance, on Our behalf, under this Certificate.

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

You, Your: The Member.

Section II How Your Coverage Works

A. Your Coverage under this Certificate.

Your employer (referred to as the "Group") has purchased a Group dental insurance Contract from Us. We will provide the benefits described in this Certificate to covered Members of the Group, that is, to employees of the Group and their covered Dependents. However, this Certificate is not a contract between You and Us. You should keep this Certificate with Your other important papers so that it is available for Your future reference.

B. Covered Services.

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

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

C. Participating Providers.

To find out if a Provider is a Participating Provider:

- Check Your Provider directory, available at Your request.
- Call the number on Your ID card; or.
- Visit our website at www.EmpireBlue.com.

D. The Role of Primary Care Dentists.

This Certificate has a gatekeeper, usually known as a Primary Care Dentist ("PCD"). This Certificate requires that you select a PCD to directly provide and/or coordinate the Dental Services you receive under this Certificate. You may select any Participating PCD who is available from the list of PCDs in the Empire Dental Care Network.

1. Services Not Requiring Referral from Your PCD. Your PCD is responsible for determining the most appropriate treatment for Your dental care needs. You do not need a Referral from Your PCD to a Participating Provider for the following services:

D0180	Comprehensive periodontal evaluation
D0220	Intra-oral periapical radiograph first radiographic image
D0230	Intraoral periapical radiograph each additional film
D0270	Bitewing radiograph – single radiographic image
D0272	Bitewing radiograph –two radiographic images
D0273	Bitewing radiograph-four radiographic images
D0330	Cephalometric radiographic image
D0460	Pulp vitality test
D1120	Prophylaxis- child
D1206	Topical Fluoride varnish, therapeutic application for moderate to high risk
D1208	Topical application of fluoride (excluding prophy)
D1310	Nutritional counseling for control of dental disease
D1351	Sealant application

D1352	Preventive resin restoration
D1510	Space maintainer fixed unilateral (primary teeth)
D1550	Recementation of Space Maintainer
D1555	Removal of Space Maintainer, not by DDS who placed the appliance
D2930	Prefabricated stainless steel crown, primary
D3110	Pulp Cap- direct (excluding final restoration)
D3120	Pulp cap-indirect (excluding final restoration)
D3220	Therapeutic pulpotomy (excluding final restoration)
D4270	Pedicle soft tissue graph procedure
D4273	Subepithelial connective tissue graft, per tooth
D4275	Soft tissue allograft

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

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

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

After You select a PCD from the Empire Dental Care Directory and Empire receives and confirms You and Your covered family member's eligibility, You must remain with Your designated PCD for at least three months. During this time, we will add You and Your family members to the monthly eligibility roster that we send to Your PDC's office. If you have an appointment scheduled and the monthly eligibility roster for Your PCD has already been completed, We will verbally confirm Your eligibility and assignment to Your PCD.

You may elect to change Your PCD. Once You have selected another PCD from the Empire Dental Care Directory, contact Customer Service at the number on Your ID card with Your reason for the change and Your new PCD selection. We are not required to honor retroactive notifications of PCD eligibility changes requested by You more than 90 days after the effective date of such request.

You may change Your PCD at any time by calling Customer Services at the number on the back of Your ID card, or by visiting Our website at www.empireblue.com. Generally this can be done with change effective immediately.

You must inform Customer Service of Your choice otherwise You may be responsible for the full cost of Your visit. Customer Service needs to keep an up-to-date record of Your PCP. You will need new Referrals if applicable, as Referrals from Your previous PCP will be invalid.

You may change Your Specialist by contacting Your PCP. You do not need to call Customer

Service directly for permission to change Participating Specialists. Your PCP will make the appropriate changes to Your referral for the new Specialist Provider. Usually, this can be done with changes effective once Your PCP has finalized the changes.

E. **Out-of-Network Services**.
We Cover the services of Non-Participating Providers for Emergency Dental Care only. Your PCD maintains a twenty-four (24) hour emergency telephone service. In case of a dental emergency, you will be advised how and where to obtain emergency assistance. If an emergency occurs more than fifty miles from your PCD's office, you will be reimbursed up to $50 towards the cost of the emergency palliative care. Empire will not make any reimbursement for either non-emergency or unauthorized services provided by a non-Managed network dentist. These costs will be your responsibility.

F. Services Subject To Preauthorization.
Our Preauthorization is not required before You receive certain Covered Services.

G. Pre-Determination/Pre-Treatment Estimates.
We allow You to request and obtain an estimate of coverage. Your Provider may contact Us and request a pre-determination of benefits, also known as a pre-treatment estimate. If We determine that an alternative procedure or treatment is more appropriate than the requested service, You may appeal Our decision through an internal Appeal or external appeal. See the Utilization Review and External Appeal sections of this Certificate for Your right to an internal Appeal and external appeal.

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

I. Medical Necessity.
We Cover benefits described in this Certificate as long as the dental service, procedure, treatment, test, device, or supply (collectively, "service") is Medically Necessary The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:
- Your dental records;
- Our dental policies and clinical guidelines;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of dental care professionals in the generally-recognized dental specialty involved;

Services will be deemed Medically Necessary only if:
- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;

- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of dental practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

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

J. Important Telephone Numbers and Addresses.

CLAIMS
Empire Blue Cross
P.O. Box 810
Minneapolis, MN 55440-0810
(844) 852-1553
Fax number: 651-406-5942
(Submit claim forms to this address.)

COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
Empire Blue Cross
Attention: Appeals Unit
P.O. Box 551
Minneapolis, MN 55440-0551
(844) 852-1553

EMERGENCY DENTAL CARE
(844) 852-1553
Monday – Friday 8:00 a.m. – 5:00 p.m.
Evenings, Weekends and Holidays

MEMBER SERVICES
(844) 852-1553
(Member Services Representatives are available Monday – Friday 8:00 a.m. – 5:00 p.m.)

OUR WEBSITE
www.EmpireBlue.com

Section III Access to Care and Transitional Care

A. Referral to a Non-Participating Provider

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

B. When a Specialist Can Be Your Primary Care Dentist.

If You have a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, You may ask that a Specialist who is a Participating Provider be Your PCD. We will consult with the Specialist and Your PCD and decide whether the Specialist should be Your PCD. Any Referral will be pursuant to a treatment plan approved by Us in consultation with Your PCD, the Specialist and You. We will not approve a non-participating Specialist unless We determine that We do not have an appropriate Provider in Our network. If We approve a non-participating Specialist, Covered Services rendered by the non-participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will only be responsible for any applicable in-network Cost-Sharing.

C. Standing Referral to a Participating Specialist

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

D. When Your Provider Leaves the Network

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

In order for You to continue to receive Covered services for up to 90 days the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of our relationship

with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

E. New Members In a Course of Treatment

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

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

Section IV Cost-Sharing Expenses and Allowed Amount

A. Deductible.
There is no Deductible for Covered in-network Services under this Certificate during each Plan Year.

B. Copayments.
Except where stated otherwise, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits section of this Certificate for Covered in-network Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

C. Coinsurance.
There is no coinsurance for Covered Services under this Certificate.

D. Allowed Amount.
"Allowed Amount" means the maximum amount We will pay for the services or supplies covered under this Certificate, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for Participating Providers will be the amount we have negotiated with the Participating Provider, or the Participating Provider's charge, if less.

The Allowed Amount for Non-Participating Providers will be determined as follows:

The average amounts paid by Us for comparable services to Our Participating Providers in the same county. If there are no like kind Participating Providers in the same county, then the average of amounts paid by Us for comparable services for like kind Participating Providers in the contiguous county or counties.

Our Allowed Amount is not based on UCR. The Non-Participating Provider's actual charge may exceed Our Allowed Amount. You must pay the difference between Our Allowed Amount and the Non-Participating Provider's charge. Contact Us at the number on Your ID card for information on Your financial responsibility when You receive services from a Non-Participating Provider.

Section V Who Is Covered

A. Who is Covered Under this Certificate.
You, the Subscriber to whom this Certificate is issued, are covered under this Certificate. You must live, work, or reside in Our Service Area to be covered under this Certificate. Members of Your family may also be covered depending on the type of coverage You selected.

B. Types of Coverage.
We offer the following types of coverage:

1. Individual. If You selected individual coverage, then You are covered.

2. Individual and Spouse. If You selected individual and Spouse coverage, then You and Your Spouse are covered.

3. Parent and Child/Children. If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.

4. Family. If You selected family coverage, then You and Your Spouse and Your Child or Children, as described below, are covered.

C. Children Covered Under this Certificate.
If You selected parent and child/children or family coverage, Children covered under this Certificate include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns 26 years of age. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order. Foster Children and grandchildren are covered.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this section.

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

D. When Coverage Begins.

1. Coverage under this Certificate will begin as follows:
If You, the Subscriber, elect coverage before becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your Group.

2. If You, the Subscriber, do not elect coverage upon becoming eligible or within 30 days of becoming eligible for other than a special enrollment period, You must wait until the Group's next open enrollment period to enroll, except as provided below.

3. If You, the Subscriber, marry while covered, and We receive notice of such marriage within 30 days thereafter, coverage for Your Spouse starts on the first day of the month following such marriage. If We do not receive notice within 30 days of the marriage, You must wait until the Group's next open enrollment period to add Your Spouse.

4. If You, the Subscriber, have a newborn or adopted newborn Child and We receive notice of such birth within 30 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 30 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law and consent to the adoption has not been revoked. If you have individual or individual and Spouse coverage, You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional premium within 30 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice and premium payment.

Children that are not newborn or adopted newborn may be added to the Contract at the time the eligible employee originally becomes effective or may be added anytime up to 30 days following the child's 3rd birthday. In the event that the child is not added by 30 days following their 3rd birthday, that child may be added only if there is a family status change or at the next Open Enrollment period.

E. Special Enrollment Periods

You, Your Spouse or Child can also enroll for coverage within 30 days of the loss of coverage in another group dental plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other group dental plan due to:

1. Termination of employment;
2. Termination of the other group dental plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions towards the group dental plan were terminated; or
7. A Child no longer qualifies for coverage as a Child under the other group dental plan.

You, Your Spouse or Child can also enroll 30 days from exhaustion of Your COBRA coverage.

We must receive notice and premium payment within 30 days of the loss of coverage. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

In addition, You, Your Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. You or Your Spouse or Child loses eligibility for Medicaid or a state child dental plan, or
2. You or Your Spouse or Child becomes eligible for Medicaid or a state child dental plan.

We must receive notice and premium payment within 60 days of one of these events. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

F. Domestic Partner Coverage.

This Certificate covers domestic partners of Subscribers as Spouses. If You selected family coverage, Children covered under this Certificate also includes the Children of Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last twelve (12) months where such registry exists; or
2. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.

   a. The affidavit must be notarized and must contain the following:

   - The partners are both eighteen years of age or older and are mentally competent to consent to contract;
   - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York;
   - The partners have been living together on a continuous basis prior to the date of the application;
   - Neither individual has been registered as a member of another domestic partnership within the last twelve (12) months; and

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

   c. Proof that the partners are financially interdependent. Two or more of the following are collectively sufficient to establish financial interdependence:

   - A joint bank account;
   - A joint credit card or charge card;
   - Joint obligation on a loan;
   - Status as an authorized signatory on the partner's bank account, credit card or charge card;
   - Joint ownership of holdings or investments;
   - Joint ownership of residence;

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

Section VI Dental Care

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

Your dental benefits cover:

Diagnostic and Preventive Care includes:

- Examinations
- Cleanings
- Routine x-rays
- Fluoride treatments through age 18

Basic Restorative Care includes:

- Amalgam fillings
- Sealants for dependents through age 15
- Space maintainers for missing primary teeth
- Oral surgery for simple extractions

Major Restorative Care includes:

- Periodontics
- Endodontics
- Oral surgery (complex and surgical procedures)
- Crowns
- Bridges
- Dentures
- Repairs to bridges and dentures

Orthodontic Care (braces) (i.e., the correction of a handicapping malocclusion) which include an initial exam, insertion of appliance, and treatments. If you are eligible for orthodontic benefits, you can receive this service through your designated Primary Care Provider's referral to one of our plan participating Orthodontists. Orthodontic benefits are available to all covered dependents age 8 years old or older and are subject to a $2,000 member copay.

- Limitation of Benefits. Orthodontic services are limited to and subject to a treatment limit of 24 months per lifetime for each member eligible for benefits. Payments to the provider are made on a quarterly basis.

- Coverage is not provided for the repair or replacement of any orthodontic appliance (fixed or removable), splint or occlusal guard.

Section VII Exclusions and Limitations

No coverage is available under this Certificate for the following:

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

B. Coverage Outside of the United States, Canada or Mexico.
We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico.

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

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

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

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

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

H. Military Service.
We do not Cover an illness, treatment or medical condition due to service in the armed forces or auxiliary units.

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

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

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

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

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

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

In addition the following dental services are not covered:

- Dental services that were not prescribed, arranged, rendered, nor approved by your network dentist, except for a dental emergency occurring more than 50 miles from your network dentist's office;
- Alternative Treatment Plans. In all cases in which there are alternative treatment plans carrying different costs, appropriate for treatment of the covered person, the decision as to which course of treatment to be followed shall be solely that of the covered member and the PCD. However, the benefits payable will be the amount of benefits payable for the least costly, of the most commonly performed appropriate course of treatment, with the balance of the treatment cost remaining the payment responsibility of the covered member.
- Reconstructive Surgery. Benefits shall be provided for reconstructive surgery when the dental procedure is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, provided that such procedures are dental reconstructive surgical procedures.
- Benefits for inpatient or outpatient expenses arising from dental treatment, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip an cleft palate are limited.
- Experimental, investigational or obsolete procedures. Experimental or investigational means that the technology or treatment is:

Not of proven benefit for the particular diagnosis or treatment of the covered member's condition; or
Not generally recognized by the dental community as effective or appropriate for the particular diagnosis or treatment of the covered member's particular condition.
Empire will not cover any technology or treatment if, in our sole discretion, it is obsolete or ineffective and is not used generally by the dental community for the particular diagnosis or treatment of the covered member's particular condition.

- Treatment of Temporomandibular Joint Syndrome; which are medical in nature.
- Replacement of lost, stolen or misplaced bridges, dentures, or other dental appliances are not covered.
- Appliances or restoration used solely to increase vertical dimensions;
- Replacement of any teeth missing on the effective date of the coverage. This includes alteration of existing removable dentures or fixed bridgework unless the procedure includes the full or partial replacement of at least one diseased and unrestorable natural tooth that was removed while the member was covered under this Certificate.
- Services rendered by a scope of the dentist's license.
- Dental services not considered within the scope of normal good dental practice or which are considered dentally or medically necessary as determined by Empire. No dental benefits will be provided for services where in the professional judgment of the attending dentist, a satisfactory result cannot be obtained.
- A more costly dental procedure when a lower cost alternate treatment with professionally acceptable results can be used. If the member selects a more costly alternative, the dentist may charge the member the difference between the maximum allowed amount usual charges for that service and the dentist's usual charge for the least costly procedure.
- Prescription and non-prescription drugs and medications.
- Precious and semi-precious metals.
- Laboratory tests and fees.
- Orthognathic surgery (surgical orthodontics)
- Appliances and bridgework used solely to splint periodontally involved teeth.
- No benefits will be provided for metal, baked porcelain restorations, inlays, crowns and jackets if the tooth can be restored with amalgam, silicate or composite resins. The judgment will be solely that of the PCD providing the service.
- Empire will pay for an amalgam restoration to restore posterior teeth. If resins are used the difference in cost between the amalgam and resin will be the member's responsibility.
- Services that are necessary to make an existing appliance satisfactory will be provided in accordance with the contract.

Section VIII Claim Determinations

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

B. Notice of Claim.
Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting dental records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on your ID card or visiting Our website at www.EmpireBlue.com. If we do not provide claim forms within fifteen (15) days after we receive notice, you can meet the proof of loss requirement by giving us a written statement of nature and extent of the loss within the time limit stated in the Timeframe for Filing Claims provision. Completed claim forms should be sent to the address in the How Your Coverage Works section of this Certificate or on Your ID card. You may also submit a claim to Us electronically by sending it to the fax number in the How Your Coverage Works section of this Certificate.

C. Timeframe for Filing Claims.
Claims for services must be submitted to Us for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120 days period, You must submit it as soon as reasonably possible. In no event, except in the absence of legal capacity, may a claim be filed more than one (1) year from the time the claim was required to be filed.

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

E. Claim Determinations.
Our claim determination procedure applies to all claims that do not relate to a Medical Necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials and Referrals. If You disagree with Our claim determination, you may submit a Grievance pursuant to the Grievance Procedures section of this Certificate.

For a description of the Utilization Review procedures and Appeal process for Medical Necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Certificate.

F. Pre-service Claim Determinations.

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

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

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

G. Post-service Claim Determinations.

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

Section VIV Grievance Procedures

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

B. Filing a Grievance.
You can contact Us by phone at the number on Your ID card or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

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

C. Grievance Determination.
Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:	By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or a treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service	In writing, within 30 calendar days of receipt of Your Grievance.

D. Grievance Appeals.
If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at the number on Your ID card or in writing. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

When We receive Your Appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:	The earlier of 2 business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.
Pre-Service Grievances: (A request for a service or a treatment that has not yet been provided.)	15 calendar days of receipt of Your Appeal.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	30 calendar days of receipt of Your Appeal.
All Other Grievances: (That are not in relation to a claim or request for a service.)	30 business days of receipt of all necessary information to make a determination

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

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

If You need assistance filing a Grievance or Appeal, You may also contact the state independent Consumer Assistance Program at:
Community Health Advocates
105 East 22nd Street
New York, NY 10010
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
www.communityhealthadvocates.org

Section X Utilization Review

A. Utilization Review.

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

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your ID card or visit Our website at www.EmpireBlue.com.

B. Preauthorization Reviews.

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

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

C. Concurrent Reviews.

1. Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information,

We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within 15 calendar days of the end of the 45-day time period.

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

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

D. Retrospective Reviews.

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

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

E. Retrospective Review of Preauthorized Services.

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

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

F. Reconsideration.

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

G. Utilization Review Internal Appeals.

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

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will if necessary, inform You of any additional information needed before a decision can be made. A clinical peer reviewer who is a Physician or a health care professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the Appeal.

1. Out-of-Network Service Denial. You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. You are not eligible for a Utilization Review Appeal if the service You request is available from a Participating Provider, even if the Non-Participating Provider has more experience in diagnosing or treating Your condition. (Such an Appeal will be treated as a Grievance.) For a Utilization Review Appeal of denial of an out-of-network health service, You, or Your designee, must submit:

- A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
- Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. Out-of-Network Referral Denial. You also have the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network referral denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:

- That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and

- Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

H. Standard Appeal.

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

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

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

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

I. Appeal Assistance.

If you need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:
Community Health Advocates
105 East 22nd Street
New York, NY 10010
Or call toll free: 1-888-614-5400, or email cha@cssny.org
www.communityhealthadvocates.org

Section XI External Appeal

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

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

- The service, procedure, or treatment must otherwise be a Covered Service under the Certificate; and
- In general, You must have received a final adverse determination through the first level of Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through the first level of Our internal Appeal process if:
    - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
    - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
    - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

B. Your Right to Appeal A Determination that A Service Is Not Medically Necessary.
If We have denied coverage on the basis that the service does not meet Our requirements for Medical Necessity, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph “A” above.

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

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

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

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or

3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

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

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

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

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

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

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

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

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

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

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

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

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

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, We will provide coverage subject to the other terms and conditions of this Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

G. Your Responsibilities.

It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of

Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

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

Section XII Coordination of Benefits

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

A. Definitions.

"Allowable expense" is the necessary, reasonable, and customary item of expense for dental care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

"Plan" is other group dental coverage with which We will coordinate benefits. The term "plan" includes:

Group dental benefits and blanket or group remittance dental benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverage issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.

Dental benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.

Dental benefits coverage of a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

"Primary plan" is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

"Secondary plan" is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment.

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

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.

2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.

3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both

parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's dental care expenses:
    - The plan of the parent who has custody will be primary;
    - If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
    - If a court decree between the parents says which parent is responsible for the child's dental care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

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

D. Right to Receive and Release Necessary Information.
We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

E. Our Right to Recover Overpayment.
If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.

F. Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans.
We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this Certificate is primary, as defined in this section, We will pay benefits first.

2. If this Certificate secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer.

3. If We request information from a non-complying plan and do not receive it within 30 days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

Section XIII Termination of Coverage

Coverage under this Certificate will automatically be terminated on the first of the following to apply:

1. The Group, and/or Subscriber, has failed to pay Premiums within 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.

2. The date on which the Subscriber ceases to meet the eligibility requirements as defined by the Group.

3. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium has been paid.

4. For Spouses in cases of divorce, the date of the divorce.

5. For Children, until the end of the month in which the Child turns 26 years of age.

6. For all other Dependents, the end of the month in which the Dependent ceases to be eligible.

7. The end of the month during which the Group or Subscriber provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.

8. If the Subscriber has performed an act that constitutes fraud or made a misrepresentation of material fact in writing on his/her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber.

9. The date that the Group Contract; is terminated. If We terminate and/or decide to stop offering a particular class of group contracts, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Group and Subscribers at least 30 days prior written notice.

10. The Group has performed an act or practice that constitutes fraud or made a misrepresentation of material fact under the terms of the coverage.

11. The Group has failed to comply with a material plan provision relating to group participation rules. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.

12. The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.

13. The date there is no longer any enrollee who lives, resides, or works in Our Service Area.

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

If Your employer has 20 or more employees, see the Continuation of Coverage section of this Certificate for Your right to continuation of this coverage under COBRA.

Section XIV Extension of Benefits

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

Section XV Continuation of Coverage

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA.

Qualifying Events.

Pursuant to federal COBRA, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this Certificate in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g. a reduction in the number of hours of employment) You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your covered Children.

2. If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Divorce or legal separation from the Subscriber; or
    - Death of the Subscriber; or.
    - The Covered employee becoming entitled to Medicare.

3. If You are a covered Child, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Loss of covered Child status under the plan rules; Death of the Subscriber; or
    - The Covered employee becoming entitled to Medicare.

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

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

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

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

1. The date 18 months after the Subscriber's coverage would have terminated because of termination of employment; provided that the Subscriber or their dependents may continue for a total of 29 months if the Member is determined to be disabled under the United States Social Security Act.
2. If You are a covered Spouse or Child the date 36 months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the Subscriber's eligibility for Medicare, or the failure to qualify under the definition of "Children";
3. The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
4. The date You become entitled to Medicare;
5. The date to which Premiums are paid if You fail to make a timely payment; or
6. The date the Group Contract terminates. However, if the Group Contract is replaced with similar coverage, You have the right to become covered under the new Group Contract for the balance of the period remaining for Your continued coverage.

Section XVI General Provisions

1. Agreements between Us and Participating Providers.

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

2. Assignment.

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

3. Changes in This Certificate.

We may unilaterally change this Certificate upon renewal, if We give the Group 30 days' prior written notice.

4. Choice of Law.

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

5. Clerical Error.

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

6. Conformity with Law.

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

7. Continuation of Benefit Limitations.

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

8. Entire Agreement.

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

9. Fraud and Abusive Billing.

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

10. Furnishing Information and Audit.

The Group and all persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with certain information over the telephone for reasons like the following: to determine the level of care You need; so that We may certify care authorized by Your Provider, or make decisions regarding the Medical Necessity of Your care. The Group will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to Group enrollment at the Group's New York office.

11. Identification Cards.

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

12. Incontestability.

No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties.

13. Independent Contractors.

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

14. Input in Developing Our Policies.

Subscribers may participate in the development of Our policies. We welcome your input on policies that We have developed or you would like Us to initiate. If you wish to share any ideas with Us, we encourage you to write to Us at:

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

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

15. Material Accessibility.

We will give the Group, and the Group will give You ID cards, Certificates, riders, and other necessary materials.

16. More Information about Your Dental Plan.

You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information.

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or utilization review guidelines.
- Written application procedures and minimum qualification requirements for Providers.

17. Notice.

Any notice that We give You under this Certificate will be mailed to Your address as it appears in Our records or to the address of the Group. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to: Empire Blue Cross, P.O. Box 551, Minneapolis, MN 55440-0551.

18. Premium Refund.

We will give any refund of Premiums, if due, to the Group.

19. Recovery of Overpayments.

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

20. Renewal Date.

The renewal date for the Certificate is the anniversary of the effective date of the Group Contract of each year. This Certificate will automatically renew each year on the renewal date unless otherwise terminated by Us, as permitted by this Certificate, or by the Group upon 30 days' prior written notice to Us.

21. Right to Develop Guidelines and Administrative Rules.

We may develop or adopt standards that describe in more detail when We will or will not make payments under this Certificate. Those standards will not be contrary to the descriptions in this Certificate. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate.

22. Right to Offset.

If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

23. Service Marks.

Empire HealthChoice Assurance Inc. is an independent corporation organized under the New York Insurance Law. Empire also operates under licenses with Blue Cross and Blue Shield Association, which licenses Us to use the Blue Cross and/or Blue Shield service marks in a portion of New York State. Empire HealthChoice Assurance does not act as an agent of the Blue Cross and Blue Shield Association. Empire is solely responsible for the obligations created under this agreement.

24. Severability.

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

25. Significant Change in Circumstances.

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

26. Subrogation and Reimbursement.

These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for Your injury, illness or other condition and We have provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to you under this Certificate. Subrogation means that We have the right, independently of you, to proceed directly against the other party to recover the benefits that We have provided.

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

We request that You notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by You for which we have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

27. Third Party Beneficiaries.

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

27. Time to Sue.

No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within 2 years from the date the claim was required to be filed.

28. Translation Services.

Translation services are available under this Certificate for non-English speaking Members. Please contact Us at the number on your ID card to access these services.

29. Venue for Legal Action.

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

30. Waiver.

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

31. Who May Change this Certificate.

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

32. Who Receives Payment under this Certificate.

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

33. Workers' Compensation Not Affected.

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

34. Your Dental Records and Reports.

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

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

We agree to maintain Your dental information in accordance with state and federal confidentiality requirements. However, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

Section XVII Schedule of Benefits

Dental Code and Procedure	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
D9430 Office Visit	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D0120 Periodic office exam	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D0140 Limited oral evaluation	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D0145 Oral evaluation for a patient under 3 years of age	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D0150 Comprehensive oral evaluation	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D0180 Comprehensive periodontal evaluation	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D0210 Intraoral radiographs complete series	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D0220 Intraoral periapical radiograph - first Radiographic image	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D0230 Intraoral periapical radiograph - each additional film	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D0240 Intraoral occlusal radiograph image	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D0270 Bitewing radiograph - single Radiographic image	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D0272 Bitewing radiograph - two Radiographic images	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D0273 Bitewing radiograph - four Radiographic images	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D0274 Vertical bitewings - 7 to 8 Radiographic images	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D0277 Panographic Radiographic image	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D0330 Cephalometric Radiographic image	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D0460 Pulp vitality test	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	

D0470 Diagnostic casts	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D1110 Prophylaxis (Adult)	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D1120 Prophylaxis (Child)	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D1206 Topical flouride varnish, therapeutic application for moderate to high	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D1208 Topical application of fluoride (excl. prophy)	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D1310 Nutritional counseling for control of dental disease	$0	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D1351 Sealant application	$10.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Limited to one time per twenty-four (24) month period per tooth with a maximum of two (2) times per tooth but only for primary molars, permanent premolars and permanent molars, for covered members under sixteen (16) years of age.
D1352 Preventive Resin Restoration	$15.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Limited to one time per twenty-four (24) month period per tooth with a maximum of two (2) times per tooth but only for primary molars, permanent premolars and permanent molars, for covered members under sixteen (16) years of age.
D1510 Space maintainer fixed unilateral (primary teeth)	$100.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D1515 Nutritional counseling for control of dental disease	$100.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D1550 Recementation of space maintainer	$30.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D1555 Removal of space maintainer, not by DDS who placed appliance	$15.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D2140 Amalgam 1 surface	$20.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D2150 Amalgam 2 surface	$30.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.

D2160 Amalgam 3 surface	$40.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D2161 Amalgam 4+ surface	$50.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D2330 Resin 1 surface anterior (including acid etch)	$50.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D2331 Resin 2 surface anterior (including acid etch)	$55.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D2332 Resin 3 surface anterior (including acid etch)	$60.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D2335 Resin 4 or more surface involving incisal angle	$75.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D2390 Resin based composite resin crown, anterior	$75.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D2391 Resin - One surface - posterior	$47.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D2392 Resin - Two surface - posterior	$65.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D2393 Resin - Three+ surface - posterior	$80.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D2394 Resin - Four surface - posterior	$100.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D2542 Onlay metallic - 2 surfaces	$400.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not.
D2543 Onlay metallic - 3 surfaces	$400.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was

			covered under this Certificate or not.
D2544 Onlay metallic - four or more surfaces	$400.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not.
D2710 Crown resin (laboratory)	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not.
D2720 Crown resin with high noble metal	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not.
D2721 Missing crown resin base metal and noble metal	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not.
D2740 Crown porcelain/ceramic substrate	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five

			(5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not.
D2750 Crown porcelain fused to high noble metal	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D2751 Crown porcelain fused to predominantly base metal	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D2752 Crown porcelain fused to noble metal	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D2783 Crown - 3/4 porcelain/ceramic (not facial veneers)	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance

			was provided was covered under this Certificate or not
D2790 Crown full cast for high noble metal	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D2791 Crown full cast for predominantly base metal	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D2792 Crown full cast noble metal	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D2910 Recement inlay	$20.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered in PCD office only
D2915 Recement cast or prefab post and core	$25.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered in PCD office only
D2920 Recement crown	$30.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D2930 Prefabricated stainless steel crown, primary	$80.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D2931 Prefabricated stainless steel crown, permanent	$62.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.

D2940 Sedative filling	$20.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D2950 Crown buildup, including any pins	$90.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D2952 Post and core in addition to crown (Indirect Fab)	$140.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D2954 Prefabricated post and core in addition to crown	$115.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D3110 Pulp cap - direct (excluding final restoration)	$15.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D3120 Pulp cap - indirect (excluding final restoration)	$15.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D3220 Therapeutic pulpotomy (excluding final restoration)	$50.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D3310 Root canal - anterior	$210.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D3320 Root canal - bicuspid	$310.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D3330 Root canal - molar	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care.
D3346 Retreatment of previous root canal therapy - anterior	$300.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D3347 Retreatment of previous root canal therapy - bicuspid	$400.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D3348 Retreatment of previous root canal therapy - molar	$480.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care.
D3410 Apicoectomy/periradicular surgery - anterior	$175.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care.
D3421 Apicoectomy/periradicular surgery - bicuspid	$120.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care.
D3425 Apicoectomy/periradicular surgery - molar	$180.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care.
D3426 Apicoectomy/periradicular surgery - (add root)	$120.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care.
D3430 Retrograde filling (per tooth, per root)	$80.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care.
D4210 Gingivectomy or gingivoplasty (per quadrant)	$180.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care.

			Surgical periodontal procedures are limited to one (1) time in a thirty-six (36) month period, but no more than twice in a lifetime per quadrant.
D4211 Gingivectomy or gingivoplasty (per tooth)	$90.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care. Surgical periodontal procedures are limited to one (1) time in a thirty-six (36) month period, but no more than twice in a lifetime per quadrant.
D4240 Gingival flap procedure (4+ teeth)	$250.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care. Surgical periodontal procedures are limited to one (1) time in a thirty-six (36) month period, but no more than twice in a lifetime per quadrant.
D4241 Gingival flap proc - per quad (1-3 teeth)	$120.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care. Surgical periodontal procedures are limited to one (1) time in a thirty-six (36) month period, but no more than twice in a lifetime per quadrant.
D4245 Apically positioned flap	$250.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care. Surgical periodontal procedures are limited to one (1) time in a thirty-six (36) month period, but no more than twice in a lifetime per quadrant.
D4260 Osseous surgery, flap entry & closure (4+ teeth)	$400.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care. Surgical periodontal procedures are limited to one (1) time in a thirty-six (36) month period, but no more than twice in a lifetime per quadrant.

D4261 Osseous surgery per quad (1-3 teeth)	$380.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care. Surgical periodontal procedures are limited to one (1) time in a thirty-six (36) month period, but no more than twice in a lifetime per quadrant.
D4270 Pedicle soft tissue graft procedure	$300.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Surgical periodontal procedures are limited to one (1) time in a thirty-six (36) month period, but no more than twice in a lifetime per quadrant.
D4273 Subepithelial connective tissue graft, per tooth	$155.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Surgical periodontal procedures are limited to one (1) time in a thirty-six (36) month period, but no more than twice in a lifetime per quadrant.
D4275 Soft tissue allograft	$250.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Surgical periodontal procedures are limited to one (1) time in a thirty-six (36) month period, but no more than twice in a lifetime per quadrant.
D4341Periodontal scaling & root planing - 4+ teeth, per quad	$80.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D4342 Periodontal scaling & root planing - 1-3 teeth, per quad	$50.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D4355 Full mouth debridement	$75.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D4910 Periodontal maintenance	$60.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5110 Complete denture upper (maxillary)	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not

D5120 Complete denture lower (mandibular)	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D5130 Immediate denture upper (maxillary)	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D5140 Immediate denture lower (mandibular)	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D5211 Upper Partial (maxillary) denture resin base, including conventional clasps & rests	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D5212 Lower Partial (mandibular) denture resin base, including conventional clasps & rests	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date

			on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D5213 Upper Partial (maxillary) denture cast metal framework with resin base including conventional clasps & rests	$600.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D5214 Lower Partial (mandibular) denture cast metal framework with resin base including conventional clasps & rests	$600.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D5410 Adjust complete denture (maxillary) No charge within 6 months of placement	$25.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5411 Adjust complete denture (mandibular) No charge within 6 months of placement	$25.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5421 Adjust partial denture (maxillary) No charge within 6 months of placement	$25.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5422 Adjust partial denture (mandibular) No charge within 6 months of placement	$25.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5510 Repair broken complete denture base	$50.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5520 Replace missing/broken teeth - complete denture (each tooth)	$50.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5610 Repair resin denture base	$60.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5620 Repair cast framework, partial denture	$60.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.

D5630 Repair or replace broken clasp, partial denture	$70.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5640 Replace broken teeth - per tooth, partial denture	$60.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5650 Add tooth to existing partial denture	$60.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5660 Add clasp to existing partial denture	$70.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5710 Rebase complete maxillary denture	$225.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5711 Rebase complete mandibular denture	$225.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5720 Rebase maxillary partial denture	$225.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5721 Rebase mandibular partial denture	$225.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5730 Reline maxillary denture (chairside)	$115.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5731 Reline mandibular denture (chairside)	$115.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5740 Reline maxillary partial denture (laboratory)	$115.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5741 Reline mandibular partial denture (laboratory)	$115.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5750 Reline complete maxillary denture (laboratory)	$190.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5751Reline complete mandibular denture (laboratory)	$190.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5760 Reline maxillary partial denture (laboratory)	$190.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D5761 Reline mandibular partial denture (laboratory)	$190.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D6210 Pontic cast high noble metal	$450.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance

			was provided was covered under this Certificate or not
D6211 Pontic cast predominantly base metal	$450.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D6212 Pontic cast noble metal	$450.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D6240 Pontic porcelain fused to high noble metal	$450.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D6241 Pontic porcelain fused to predominantly base metal	$450.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered in PCD office only Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D6242 Pontic porcelain fused to noble metal	$450.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.

			Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D6245 Pontic porcelain/ceramic	$400.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D6545 Retainer - cast metal for resin bonded fixed prosthesis	$100.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D6548 retainer poercelain/ceramic	$100.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D6720 Crown resin with high noble metal	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance

			was last supplied whether such appliance was provided was covered under this Certificate or not
D6721 Crown resin with base metal	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D6722 Crown resin with noble metal	500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D6740 Crown - porcelain ceramic	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D6750 Crown porcelain fused to high noble metal	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not

D6751 Crown porcelain fused to predominantly base metal	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D6752 Crown porcelain fused to noble metal	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D6780 Crown 3/4 cast high noble metal	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D6790 Crown full cast high noble metal	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D6791 Crown full cast predominantly base metal	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date

			on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D6792 crown full cast noble metal	$500.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only. Limited to once every five (5) years. Said five (5) year period will be measured from the date on which the existing restoration or appliance was last supplied whether such appliance was provided was covered under this Certificate or not
D6930 Recement fixed partial denture	$40.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D7111 Coronal remnant - deciduous tooth	$10.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D7140 Extraction, erupted or exposed tooth/root	$35.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D7210 Surgical removal of erupted tooth	$75.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D7220 Removal of impacted tooth - soft tissue	$90.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D7230 Removal of impacted tooth - partial bony	$150.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care.
D7240 Removal of impacted tooth - complete bony	$200.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care.
D7241 Removal of impacted tooth - complete bony/unusual complication	$225.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care.
D7250 Surgical removal of residual tooth roots	$75.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care.
D7251 Coronectomy	$120.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care.
D7280 Surgical exposure of impacted/unerupted tooth for ortho reasons	$120.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care.
D7285 Biopsy of oral tissue - hard (bone, tooth)	$100.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.

D7286 Biopsy of oral tissue - soft (all others)	$85.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D7310 Alveoloplasty in conjunction with extractions (4+ teeth)	$80.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D7311 Alveoloplasty in conjunction with extractions-1-3 teeth	$48.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D7320 Alveoloplasty not in conjunction with extractions (4+ teeth)	$110.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D7321 Alveoloplasty not in conjunction with extraction - 1-3 teeth	$50.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D7510 Incision & drainage of abscess (intraoral soft tiss)	$60.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D7511 Incision & drainage of abscess-intraoral soft tiss	$72.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D7960 Frenectomy, frenulectomy, frenotomy	$125.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D7963 Frenuloplasty	$125.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered by PCD only.
D9110 Palliative treatment minor procedures	$50.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
D9220 General anesthesia (first 30 minutes)	$175.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care. Documented medical need is required. Election with absence of documentation will not be covered in PCD or specialist office.
D9221 General anesthesia (additional 15 minutes)	$80.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care. Documented medical need is required. Election with absence of documentation will not be covered in PCD or specialist office.
D9241Intravenous conscious sedation/analgesia - first 30 minutes	$175.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care. Documented medical need is required. Election with absence of documentation will not be covered in PCD or specialist office.

D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes	$80.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care. Documented medical need is required. Election with absence of documentation will not be covered in PCD or specialist office.
D9310 Consultation - other than practitioner providing treatment	$75.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Referral is required from PCD for Specialist care.
D9940 Occlusal guard, by report	$125.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Orthodontic Care (braces) initial exam, insertion of appliance, and treatments	$2,000.00	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Limited to a 24 month treatment plan per lifetime.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Albanian
Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD:711).

Bengali
বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আপনার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন।
(TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Greek
Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Urdu
آپ کو اپنی زبان میں مفت ان معلومات اور مدد کےحصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔ (TTY/TDD:711)

Yiddish
רופט די מעמבער באדינונגען נומער אויף אייער קארטל איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם. פאר הילף (TTY/TDD:711)

It’s important we treat you fairly
That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.