Dental Certificate of Coverage

Notice to persons 65 or older:
This Certificate provides limited benefits health insurance only. This coverage does not meet the minimum requirements for Medicare supplement, long-term care insurance, nursing home insurance only, home care insurance only, or nursing home and home care insurance in the State of New York. Purchase of this coverage may be unnecessary if you already have or intend to purchase Medicare supplement insurance or long term care insurance.

IMPORTANT NOTICE

This Certificate describes your dental benefits only. This Certificate does not provide hospital or medical benefit coverage. Each person covered under this Certificate must satisfy the copayments and any other applicable cost-sharing amounts set forth in the Summary of Benefits that is part of this Certificate.

The insurance evidenced by this certificate provides limited benefits health insurance only. It does NOT provide basic hospital, basic medical, major medical, Medicare supplement, long term care insurance, nursing home insurance only, home care insurance only, or nursing home and home care insurance as defined by the New York State Insurance Department.

Fedcap Rehabilitation Services, Inc.

Group Number 720419

Empire BlueCross BlueShield Complete Network

Empire BlueCross BlueShield Classic Dental Program

Empire BlueCross BlueShield
PO Box 810
Minneapolis, MN 55440-0810
(877)-606-3338

DENTAL CERTIFICATE OF COVERAGE

Welcome to Empire BlueCross BlueShield (“Empire”)! This Dental Certificate of Coverage (hereinafter "Certificate") has been prepared by Empire to help explain your dental care benefits. Please refer to this Certificate whenever you require Dental Services. It describes how to access dental care, what Dental Services are covered by Us, and what portion of the dental care costs you will be required to pay.

This Certificate of Coverage (“Certificate”) explains the benefits available to You under a Group Contract between Empire Blue Cross Blue Shield (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 other endorsements may be delivered with the Certificate or added thereafter.

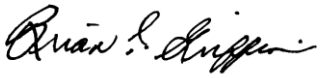
This Certificate should be read in its entirety. Since many of the provisions of this Certificate are interrelated, you should read the entire Certificate to get a full understanding of your coverage.

Many words used in the Certificate have special meanings. These words appear in capitals and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated. The Certificate also contains exclusions.

This Certificate supersedes and replaces any Certificate previously issued to you under the provisions of the Group Dental Contract.

Read your Certificate Carefully. The Certificate sets forth many of the rights and obligations between you and the Plan. Payment of benefits is subject to the provisions, limitations and exclusions of your Certificate. It is therefore important that you read your Certificate.

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



Brian Griffin
President and GM, Empire Blue Cross Blue Shield

Services provided by Empire HealthChoice Assurance, Inc.
a licensee of the Blue Cross and Blue Shield Association,
an association of independent Blue Cross and Blue Shield Plans.

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

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

Benefit Waiting Period - The period of continuous coverage under this Certificate that a Member must complete following his or her Effective Date before dental benefits are payable for Covered Services. No payment will be made for expenses incurred during the Benefit Waiting Period indicated in the Summary of Benefits.

Certificate - This Certificate issued by Empire Blue Cross Blue Shield, including the Schedule of Benefits and any attached riders. The Certificate explains the benefits available to You under the Group Contract.

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.

Completed - A service is completed when the final stage of a multiple stage/appointment procedure and all prior stages are finished or in the case of a dental appliance, when it has been permanently placed in the mouth. Benefits are payable once the final stage is completed or the appliance is permanently placed.

Coverage Year - The period of time that We pay benefits for Covered Services. The Coverage Year is listed in the Summary of Benefits. If your coverage ends earlier, the Coverage Year ends at the same time.

Coverage Year Maximum - The maximum dollar amount payable for Covered Services for each Member during each Coverage Year. If your benefit plan covers orthodontics, benefits for orthodontic services are not included in the Coverage Year Maximum, but are subject to a separate lifetime maximum. Refer to the **Summary of Benefits** for any Coverage Year Maximum or lifetime maximum amounts.

Covered Services - The medically necessary services paid for, arranged, or authorized 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.

Dental Service, **Dental Services**, **Dental Procedure and Dental Procedures** - The providing of dental care or treatment by a Dentist to a Member under this Certificate, provided that such care or treatment is a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dentist - A person who is licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry.

Dependent - The Subscriber's Spouse and Children.

Effective Date - The date that a Subscriber's coverage begins under this Certificate. A Dependent's coverage also begins on the Subscriber's Effective Date.

Group - The employer or party that has entered into a Group Dental Contract with the Plan.

Group Dental Contract (or Contract) - The Contract between the Plan and the Group. It includes this Certificate, your application, any supplemental application or change form. The final interpretation of any specific provision contained in this Certificate is governed by the Group Dental Contract.

Identification Card / ID Card - A card issued by the Plan, showing the Member's name, membership number, and occasionally coverage information.

Maximum Allowed Amount - The maximum amount of reimbursement Empire will pay for Covered Services provided by a Provider to a Member. You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or are subject to a Coinsurance. There are different levels of reimbursement for the Maximum Allowed Amount depending upon whether you elect to receive services from a Participating Dentist or a Non-Participating Dentist. The Maximum Allowed Amount will always be the lesser of the Maximum Allowed Amount or the Provider's billed charges.

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 Dentist - A Dentist who has NOT signed a written provider service agreement agreeing to service the program identified in this Certificate. Empire will reimburse Non-Participating Dentists according to the Maximum Allowed Amount for Non-Participating Dentists, also referred to in this Certificate as the Table of Allowances. The Table of Allowances is different from the Maximum Allowed Amount reimbursed to Participating Dentists.

Open Enrollment - An enrollment period when any eligible Subscriber or Dependent of the Group may apply for this coverage.

Participating Dentist - A Dentist who has signed a written provider service agreement agreeing to service the program identified in this Certificate. The Dentist has agreed to accept Empire's Schedule of Maximum Allowable Charges as payment in full for Dental Services covered under this Certificate.

Plan (or We, Us, Our) - Empire BlueCross BlueShield; also referred to as "Empire".

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

Pretreatment Estimate - A written response from Empire to a request by a Member or Dentist to Empire in advance of a Dental Service being provided to determine the Member's benefits, estimate the Maximum Allowed Amount, and estimate the amount of the Member's financial liability. A Pretreatment Estimate is not a guaranty of benefits or a guaranty of payment of benefits.

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.

Schedule of Maximum Allowable Charges - A schedule of Maximum Allowed Amounts established by Empire for services rendered by Participating Dentists servicing this program.

Subscriber - The person to whom this Certificate is issued.

Table of Allowances - A schedule of fixed dollar Maximum Allowed Amounts established by Empire for services rendered by Non-Participating Dentists.

SUMMARY OF BENEFITS

The Summary of Benefits is a summary of the Deductibles, Coinsurance and other limits that apply when you receive Covered Services from a Provider. Please refer to the Covered Services section of this Certificate for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of this Certificate including any attachments or riders.

COVERAGE YEAR:	Calendar Year
DEPENDENT AGE LIMIT:	To the end of the month in which the child attains age 26.
BENEFIT WAITING PERIOD:	There are no benefit waiting periods.

DENTAL COVERED SERVICES

After you have satisfied the Deductible, We will pay benefits for Covered Services at the percentage or applicable amount listed in this Certificate up to the Maximum Allowed Amount for each completed Dental Service. The Maximum Allowed Amount is the maximum amount of reimbursement payable for each Dental Procedure. There are different levels of reimbursement for the Maximum Allowed Amount depending upon whether you elect to receive services from a Participating or a Non-Participating Dentist.

	Participating Dentist Plan Responsibility for Cost-Sharing	**Non-Participating Dentist Plan Responsibility for Cost-Sharing**
DIAGNOSTIC AND PREVENTIVE SERVICES*	100%	100%
BASIC RESTORATIVE SERVICES	80%	80%
ENDODONTIC SERVICES	80%	80%
PERIODONTAL SERVICES	80%	80%
ORAL SURGERY SERVICES	80%	80%
MAJOR RESTORATIVE SERVICES	50%	50%
PROSTHODONTIC SERVICES	50%	50%
ORTHODONTIC SERVICES*	50%	50%

*(Not subject to the Deductible)

DENTAL BENEFIT MAXIMUMS (combined for Participating and Non-Participating Dentists)

Coverage Year Maximum	$1500.00 per Member
Orthodontic Services Lifetime Maximum	$1500.00 per Member

Coverage Year Maximum. Your combined benefits, excluding orthodontics, are subject to the Coverage Year Maximum. We will not pay any benefit in excess of that amount during a Coverage Year.

Orthodontic Services Lifetime Maximum. Your orthodontic benefits are subject to the Orthodontic Services Lifetime Maximum. We will not pay any orthodontic benefits in excess of that amount during a Member's lifetime.

DEDUCTIBLES (combined for Participating and Non-Participating Dentist)

Per Member	$50.00
Per Family	$150.00

Deductible(s). You are responsible for satisfying the Deductible(s) before We pay for benefits. If 3 family Members satisfy their individual Deductible, the family Deductible will be met. Only charges that meet the definition of Maximum Allowed Amount will apply toward satisfaction of the Deductibles.

ELIGIBILITY AND ENROLLMENT

Who is Covered Under this Certificate. You, the Subscriber to whom this Certificate is issued, are covered under this Certificate. Members of Your family may also be covered depending on the type of coverage You selected.

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

i. Individual. If You selected individual coverage, then You are covered.
ii. Individual and Spouse. If You selected individual and Spouse coverage, then You and Your Spouse are covered.
iii. Parent and Child/Children. If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.
iv. Family. If you selected family coverage, then You and Your Spouse and Your child or children, as described below, are covered.

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.

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 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.

When Coverage Begins.
Coverage under this Certificate will begin as follows:

1. 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 60 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise, coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 60 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 60 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice, provided that You pay any additional Premium when due.

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 toward 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 continuation 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.

TERMINATION AND CONTINUATION

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 end of the month in 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. The date contribution for coverage under the Certificate is not made when due.

For extended eligibility, see Continuation of Coverage.

Continuation of Coverage (COBRA)

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;
    - 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.

Continuation Rights During Active Duty

Under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), 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 due to service in the uniformed services or upon becoming eligible for medical and dental care under federal health insurance by reason of their service. Call or write Your Group to find out if You are entitled to temporary continuation of coverage under USERRA.

The Group may charge up to 102% of the Group Premium for continued coverage. This does not apply if You or Your dependents serve less than 31 days.

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

1. The 24-month period beginning on the date on which the absence begins; or
2. The day after the date on which You or Your Dependent fail to apply for or return to a position of employment.

An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment unless an exclusion or waiting period would have been imposed under the health plan had coverage not been terminated.

1. This shall not apply to the coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

2. If You or Your Dependent's coverage under a health plan is terminated by reason of the person having become eligible for federal health insurance for former members of the uniformed services and their dependents, but subsequently do not commence a period of active duty under the order to active duty that established such eligibility because the order is canceled before such active duty commences, any exclusion or waiting period in connection with the reinstatement of coverage shall apply to the continued employment in the same manner as if You or Your Dependents had become reemployed upon such termination of eligibility.

DENTAL PROVIDERS AND CLAIMS PAYMENT

You do not have to select a particular Dentist to receive dental benefits. You have the freedom to choose the Dentist you want for your dental care. However, your Dentist choice can make a difference in the benefits you receive and the amount you pay. You may have additional out-of-pocket costs if your Dentist is a Non-Participating Dentist.

PAYMENTS ARE MADE BY EMPIRE WHEN THE COVERED DENTAL PROCEDURES HAVE BEEN COMPLETED. IN ORDER TO PROPERLY PROCESS A CLAIM, THE PLAN MAY BE REQUIRED TO ADD AN ADMINISTRATIVE POLICY LINE TO THE CLAIM. DUPLICATE CLAIMS PREVIOUSLY PROCESSED WILL BE DENIED.

This section describes how We determine the amount of reimbursement for Covered Services. Reimbursement for Dental Services rendered by Participating and Non-Participating Dentists is based on the Maximum Allowed Amount for the type of service performed. There may be different levels of reimbursement for the Maximum Allowed Amount depending upon whether you elect to receive services from a Participating or a Non-Participating Dentist.

The Maximum Allowed Amount is the maximum amount of reimbursement Empire will pay for Dental Services provided by a Dentist to a Member and which meet Our definition of a Covered Service. For Participating Dentists, the Maximum Allowed Amount will be reimbursed according to the Schedule of Maximum Allowable Charges. For Non-Participating Dentists, the Maximum Allowed Amount will be reimbursed according to the Table of Allowances.

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

When you submit a claim for Covered Services from a Dentist, We will evaluate the claim information and, among other things, determine the accuracy and appropriateness of the Dental Procedure. Applying these rules may affect Our determination of the Maximum Allowed Amount. For example, your Dentist may have submitted the claim using several procedure codes when there is a single procedure code that includes all or a combination of the procedures that were performed. When this occurs, Our payment will be based on a single Maximum Allowed Amount for the single procedure code rather than a separate Maximum Allowed Amount for each billed procedure amount.

When multiple procedures are performed on the same day by the same dental Provider or other dental Providers, We may reduce the Maximum Allowed Amount for those additional procedures, because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent a duplicate payment for a Dental Procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Dentist or a Non-Participating Dentist. There are different levels of reimbursement for the Maximum Allowed Amount depending upon whether you elect to receive services from a Participating Dentist or a Non-Participating Dentist.

Participating Dentists

A Participating Dentist is a Dentist who has signed a written provider service agreement agreeing to service the program identified in this Certificate. For Covered Services performed by a Participating Dentist, the Maximum Allowed Amount is based upon the lesser of the Dentist's actual charges or the Schedule of Maximum Allowable Charges. Because Participating Dentists have agreed to accept the Maximum Allowed Amount as payment in full for services, they should not send you a bill or collect for amounts above the agreed upon Maximum Allowed Amount. However, you may receive a bill or be asked to pay a portion of the Maximum Allowed Amount to the extent you have exhausted your coverage for the service, have not met your Deductible, have a Coinsurance, have received non-covered services, or have exceeded the dental benefit maximum as outlined in the Summary of Benefits. Please call Our Customer Service Department at (877) 606-3338 for help in finding a Participating Dentist or visit Our website at www.empireblue.com.

Non-Participating Dentists

Dentists who have NOT signed a written provider service agreement agreeing to service the program identified in this Certificate are considered Non-Participating Dentists. For Covered Services you receive from a Non-Participating Dentist, the Maximum Allowed Amount will be the lesser of the Dentist's actual charges or an amount based on Our Non-Participating Dentist fee schedule, referred to as the Table of Allowances, which We have established in Our discretion, and which We reserve the right to modify from time to time after considering one or more of the following: reimbursement amounts accepted by similar Providers contracted with Us, and other industry cost, reimbursement and utilization data. The Table of Allowances is different from the Maximum Allowed Amount reimbursed to Participating Dentists.

Unlike Participating Dentists, Non-Participating Dentists may send you a bill and collect for the amount of the Dentist's charge that exceeds the Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Non-Participating Dentist charges. This amount may be significant. Choosing a Participating Dentist will likely result in lower out of pocket costs to you. Please call Customer Service Department at (877) 606-3338 for help in finding a Participating Dentist or visit Our website at www.empireblue.com.

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

MEMBER COST SHARE

For certain Covered Services, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (Deductible and/or Coinsurance). Your cost share amount and out-of-pocket limits may vary depending on whether you received services from a Participating or Non-Participating Dentist. Specifically, you may pay higher cost sharing amounts or may have limits on your benefits when using Non-Participating Dentists. Please see the Summary of Benefits in this Certificate for your cost share responsibilities and limitations, or call Customer Service with any questions.

Payment of Benefits

You authorize Us to make payments directly to Participating Dentists for Covered Services. We also reserve the right to make payments directly to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, a Member's authorized custodian or designated representative. You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support order" as defined by ERISA or any applicable state law.

Once a Provider gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

THE MEMBER IS RESPONSIBLE FOR DIRECTLY PAYING A NON-PARTICIPATING DENTIST. WHEN SERVICES ARE OBTAINED FROM A NON-PARTICIPATING DENTIST, ANY BENEFITS PAYABLE UNDER THE GROUP CONTRACT ARE PAID DIRECTLY TO THE MEMBER.

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; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling (877) 606-3338. Completed claim forms should be sent to:

Empire BlueCross BlueShield
PO Box 810
Minneapolis, MN 55440-0810
(877) 606-3338

Proof of Claim

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-day period, You must submit it as soon as reasonably possible.

Claims should be submitted to:

Empire BlueCross BlueShield
PO Box 810
Minneapolis, MN 55440-0810
(877) 606-3338

Claims for Covered Services provided to a Member will be processed within thirty (30) days of the date the claim is received by Us for electronic claims and forty-five (45) days for paper claims unless Our obligation to pay the Claim is not reasonably clear or where there is evidence of suspected fraud. In all events, we will pay undisputed claims within 45 days. Before the end of the initial thirty (30) day period, We will send the Member written notice of the reason(s) for any delay and to request any additional required information. If the time to process a claim is extended because the Member or dentist has not submitted requested information, the time period requirements for claim processing will be tolled from the date the notice of requested information is sent to the Member until the date We receive the Member's response. We will make a claim decision within fifteen (15) days after receipt of the requested information. Members should submit the requested information within forty-five (45) days of receipt of the request.

In the event We do not pay a claim within 30 days of receipt of complete proof of loss for electronic claims and within 45 days of receipt of complete proof of loss for claims submitted in paper format, We will pay interest at the rate required by law on the benefits due under the terms of this Certificate.

Member Documentation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other program to the extent such reimbursement is permitted by applicable law or regulation.

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.

Explanation of Benefits

After you receive dental care, you will often receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- total amounts charged for services/supplies received;
- the amount of the charges satisfied by your coverage;
- the amount for which you are responsible (if any);
- general information about your Appeals rights and for ERISA plans, information regarding the right to bring an action after the Appeals process.

COVERED SERVICES

Pretreatment Estimate
(Estimate of Benefits)

IT IS RECOMMENDED, BUT NOT REQUIRED, THAT A PRETREATMENT ESTIMATE BE SUBMITTED TO EMPIRE PRIOR TO TREATMENT IF YOUR DENTAL TREATMENT INVOLVES MAJOR RESTORATIVE, PERIODONTICS, PROSTHETICS OR ORTHODONTIC CARE (SEE DESCRIPTION OF COVERAGES), TO ESTIMATE THE MAXIMUM ALLOWED AMOUNT. THE PRETREATMENT ESTIMATE IS A VALUABLE TOOL FOR BOTH THE DENTIST AND YOU. SUBMITTING A PRETREATMENT ESTIMATE ALLOWS THE DENTIST AND YOU TO KNOW WHAT REIMBURSEMENT IS AVAILABLE TO YOU BEFORE BEGINNING TREATMENT. THE PRETREATMENT ESTIMATE WILL OUTLINE YOUR RESPONSIBILITY TO THE DENTIST WITH REGARD TO COINSURANCE, DEDUCTIBLES AND NON-COVERED SERVICES. THIS WILL ALLOW THE DENTIST AND YOU TO MAKE ANY NECESSARY FINANCIAL ARRANGEMENTS BEFORE TREATMENT BEGINS. THIS PROCESS DOES NOT DETERMINE WHETHER THE TREATMENT IS NECESSARY FOR YOU. THE ESTIMATED MAXIMUM ALLOWED AMOUNT IS BASED ON YOUR CURRENT ELIGIBILITY AND CONTRACT BENEFITS IN EFFECT AT THE TIME OF THE COMPLETED SERVICE. SUBMISSION OF OTHER CLAIMS OR CHANGES IN ELIGIBILITY OR THE CONTRACT MAY ALTER FINAL PAYMENT. THIS IS NOT A GUARANTEE OF BENEFITS.

After the examination, your Dentist will establish the dental treatment to be performed. If the dental treatment necessary involves major restorative, periodontics, prosthetics or orthodontic care, you should submit a claim form to Empire outlining the proposed treatment. Empire will determine if the proposed treatment is covered and estimate the Maximum Allowed Amount, including your responsibility for Coinsurance, Deductibles and non-covered services.

A statement will be sent to you and your Dentist estimating the amount of the Maximum Allowed Amount, including the amount that you will owe. This statement will be sent within thirty (30) days of the date the estimate request was received by Us for electronic submissions and forty-five (45) days for paper submissions. These estimates will be subject to your continuing eligibility and the Group Contract remaining in effect. If claims for other completed Dental Services are received and processed prior to the completion date of the proposed treatment, this may reduce Empire's estimated Maximum Allowed Amount for the proposed treatment and increase your obligation to the Dentist.

TO AVOID ANY MISUNDERSTANDING OF THE MAXIMUM ALLOWED AMOUNT OR THE AMOUNT THAT YOU WILL OWE, ASK YOUR DENTIST ABOUT HIS OR HER PARTICIPATION STATUS AND IF THEY HAVE AGREED TO SERVICE THIS DENTAL PROGRAM PRIOR TO RECEIVING DENTAL CARE.

You will be responsible for payment of any Deductibles and Coinsurance amounts and any dental treatment that is not a Covered Service under this Certificate or that exceeds benefit maximums.

The Plan covers the following Dental Procedures when they are performed by a licensed Dentist and when necessary and customary as determined by the standards of generally accepted dental practice. The benefits under this Certificate shall be provided whether the Dental Procedures are performed by a duly licensed physician or a duly licensed Dentist, if otherwise covered under this Certificate, provided that such Dental Procedures can be lawfully performed within the scope of a duly licensed Dentist.

The Plan shall be entitled to request and receive, to such extent as may be lawful, from any treating Dentist, or from hospitals in which a Dentist's care is provided, such information and records relating to a Member as may be required to pay claims. Also, the Plan may require that a Member be examined by a dental consultant retained by Empire in or near the Member's place of residence. Empire and the Plan shall hold such information and records confidential.

Empire does not determine whether a service submitted for payment or benefit under this Certificate is a Dental Procedure that is dentally necessary to treat a specific condition or restore dentition for an individual. The Plan evaluates Dental Procedures submitted to determine if the procedure is a Covered Service. Your coverage includes a preset schedule of Dental Services that are eligible for coverage under this policy. Other Dental Services may be recommended or prescribed by your Dentist including those that offer you an enhanced cosmetic appearance or services that are more frequent than what is covered under this policy. While these services may be prescribed by your Dentist, they may not be a Covered Service under this policy or they may be a service where Empire provides a payment allowance for a service that is part of an Optional Treatment Plan. If this Certificate provides for a payment allowance that is part of an Optional Treatment Plan, you may apply the payment to the services you elected to receive. Services that are not covered under this policy or exceed the frequency of plan benefits do not imply that the service is or is not necessary to treat your specific dental condition. You are responsible for Dental Services that are not Covered Services under this policy.

Some procedures are an integral part of another completed service that is covered by the Plan. Such integral services must be billed by the dentist as part of the Covered Service in order to be covered. If a Non-Participating Dentist bills an integral service separate from the related Covered Service, you may be responsible for the separately billed procedure and are required to pay the dentist directly for those procedures.

ONLY those services listed below are Covered Services under this Certificate. Deductibles and Dental Benefit Maximums are listed under the Summary of Benefits. Covered Services are subject to the limitations within the Benefits, Exclusions and Limitations sections described below. For estimates of Covered Services, please see the "Pretreatment Estimate" section of this Certificate.

Services for the replacement of an existing restoration/appliance may be subject to the contract limitation that applied to the initial service performed if the replacement/retreatment is needed within the coverage limitation period that applied to the initial service. For example: A tooth that had a filling performed on it 1 year ago, may now require a crown placement. The crown would not be covered if performed within the filling frequency limitation.

DIAGNOSTIC & PREVENTIVE SERVICES

Oral Evaluations - An evaluation (checkup or exam) is covered 2 times per calendar year.

NOTE: Comprehensive oral evaluations will be benefited 1 time per dental office, subject to the 2 times per calendar year limitation. Any additional comprehensive oral evaluations performed by the same dental office will be benefited as a periodic oral evaluation and will be subject to the 2 times per calendar year limitation.

Radiographs (X-rays)

- Bitewings - Covered at 1 series of bitewings per 12-month period.
- Full Mouth (Complete Series) or Panoramic - Covered 1 time per 36-month period.
- Periapical(s) - 4 single x-rays are covered per 12-month period.
- Occlusal - Covered at 2 series per 24-month period.

Dental Cleaning

- Prophylaxis - Any combination of this procedure or periodontal maintenance (see Periodontics section) is covered 2 times per calendar year.

  Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

  NOTE: A prophylaxis performed on a Member under the age of 14 will be reimbursed as a child prophylaxis. A prophylaxis performed on a Member age 14 or older will be reimbursed as an adult prophylaxis.

Fluoride Treatment (Topical application of fluoride) - Covered 1 time per 12-month period for dependent children through the age of 18.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered 1 time per 24-month period for permanent first and second molars of eligible dependent children through the age of 15.

Enhanced benefit for Members who are enrolled in the Anthem Care Management program

Enhanced dental benefits are available for any member enrolled in the Anthem Care Management program who is in active management with an Anthem Care Manager for the following conditions cancer with chemotherapy, head and neck cancer with chemotherapy and/or radiation, solid organ transplant, bone marrow transplant, cardiac conditions (e.g. valve conditions). The enhanced benefits include a maximum of three of the following procedures:

- Prophylaxis; or
- Periodontal maintenance

Please note enrollment alone does not qualify you for the benefit. You must be in active management of your care with an Anthem Care Manager.

BASIC RESTORATIVE SERVICES

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Permanent Basic Restorations - Covered when there has been loss of tooth structure due to decay or fracture of a permanent or primary tooth. Coverage for amalgam or composite restorations is available for 1 surface per 24-month period.

- **Amalgam (silver) Restorations**
- **Composite (white) Resin Restorations** - Benefits for posterior (back teeth) composite resin restorations are available at the same level that applies to amalgams (silver fillings) and are subject to the same surface limitations and allowances. The Member is responsible for any difference in cost between the Maximum Allowed Amount for the amalgam (silver filling) and the Maximum Allowed Amount for the composite (white filling), plus any Deductible and/or Coinsurance for the Covered Service.

Space Maintainers - Covered 1 time per lifetime on eligible dependent children through the age of 16 for extracted primary posterior (back) teeth.

The repair or replacement of a lost/broken appliance is not a Covered Service.

Basic Tooth Extractions

- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Restorative cast post and core build-up, including pins and posts - See benefit coverage description under Complex or Major Restorative Services.

ENDODONTIC SERVICES (NERVE OR PULP TREATMENT)

Completed Endodontic Therapy on Primary Teeth - Covered 1 time per tooth per lifetime.

- Pulpal Therapy
- Therapeutic Pulpotomy

Completed Endodontic Therapy on Permanent Teeth - Covered 1 time per tooth per lifetime.

- Root Canal Therapy

PERIODONTAL SERVICES (GUM & BONE TREATMENT)

Periodontal Maintenance - A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Any combination of this procedure and dental cleanings (see Diagnostic and Preventive section) is covered 2 times per calendar year.

Basic Non Surgical Periodontal Care - Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning - Covered 1 time per 36 months if the tooth has a pocket depth of 4 millimeters or greater.
- Full mouth debridement - Covered 1 time per lifetime.

Complex Surgical Periodontal Care - Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services under this plan.

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - LIMITATION: Covered on natural teeth only.

One complex surgical periodontal benefit is covered per 36-month period per single tooth or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

ORAL SURGERY SERVICES (TOOTH, TISSUE, OR BONE REMOVAL)

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of 3rd molars are covered if the removal is associated with symptoms or oral pathology.

Surgical Reduction of Fibrous Tuberosity - Covered 1 time per 6-month period.

Intravenous Conscious Sedation, IV Sedation and General Anesthesia - Covered when performed in conjunction with complex surgical service.

Temporomandibular Joint Disorder (TMJ)
Dental treatment that is considered surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder, including splints.

MAJOR RESTORATIVE SERVICES (CROWNS, INLAYS AND ONLAYS)

Services performed to restore lost tooth structure as a result of decay or fracture

Gold foil restorations - Benefits are available at the same level that applies to amalgams (silver fillings) and are subject to the same surface limitations and allowances. The Member is responsible for any difference in cost between the Maximum Allowed Amount for the amalgam (silver filling) and the Maximum Allowed Amount for the gold foil restoration, plus any Deductible and/or Coinsurance for the Covered Service.

Inlays - Benefits are available at the same level that applies to amalgams (silver fillings) and are subject to the same surface limitations and allowances. The Member is responsible for any difference in cost between the Maximum Allowed Amount for the amalgam (silver filling) and the Maximum Allowed Amount for the inlay, plus any Deductible and/or Coinsurance for the Covered Service.

Pre-fabricated or Stainless Steel Crown - Covered 1 time per 60-month period for eligible Dependent children through the age of 18.

Onlays and/or Permanent Crowns - Covered 1 time per 7 year period per tooth for Members age 12 and older if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that an amalgam or composite restoration cannot be used to restore the tooth.

Porcelain/ceramic substrate onlays/crowns - Benefits are available up to the Maximum Allowed Amount for a porcelain to noble metal crown. The Member is responsible for any difference in cost between the Maximum Allowed Amount for the Covered Service and the cost of the optional treatment, plus any Deductible and/or Coinsurance for the Covered Service.

Implant Crowns - See Prosthetic Services.

Recement Inlay, Onlay and Crowns - Covered 6 months after initial placement.

Crown Repair - Covered 1 time per 12-month period per tooth when the submitted narrative from the treating dentist supports the procedure.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface - Covered 1 time per 7 year period when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

PROSTHODONTIC SERVICES (DENTURES, PARTIALS, AND BRIDGES)

THE REPLACEMENT OF TEETH THAT WERE MISSING PRIOR TO BECOMING A MEMBER UNDER THIS PLAN WILL BE COVERED AFTER THE MEMBER HAS BEEN CONTINUOUSLY COVERED UNDER THIS PLAN FOR TWELVE (12) MONTHS OR MORE

Tissue Conditioning - Covered 1 time per 24-month period.

Recement Fixed Prosthetic - Covered 1 time per 12-month period.

Reline and Rebase - Covered 1 per 24-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) - Covered 1 per 6-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge); and
- when the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments - Covered 2 times per 12-month period:

- when the denture is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the denture.

Partial and Bridge Adjustments - Covered 2 times per 24-month period:

- when the partial or bridge is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the partial or bridge.

Completed Removable Prosthetic Services (Dentures and Partials) - Covered 1 time per 7 year period:

- for Members age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if 7 years have elapsed since the last benefited removable prosthetic appliance (denture or partial) and the existing denture or partial needs replacement because it cannot be repaired or adjusted.

Completed Fixed Prosthetic Services (Bridge) - Covered 1 time per 7 year period:

- for Members age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if no more than 3 teeth are missing in the same arch;
- a natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- no other missing teeth in the same arch that have not been replaced with a removable partial denture;
- if none of the individual units of the bridge has been benefited previously as a crown or cast restoration in the last 7 years;
- if 7 years have elapsed since the last benefited removable prosthetic appliance (bridge) and the existing bridge needs replacement because it cannot be repaired or adjusted.

If there are multiple missing teeth, a removable partial denture is covered if it is the least costly course of treatment. Any additional optional benefits are subject to the contract limitations of those services.

Other Complex Surgical Procedures - Covered when necessary to prepare for dentures.

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis - per site
- Surgical reduction of osseous tuberosity

Implant Supported Fixed and Removable Prosthetic (Crowns, Bridges, Partials and Dentures) - A restoration that is retained, supported and stabilized by an implant. Implants and related services are NOT covered.

LIMITATION: This procedure receives an optional treatment benefit equal to the least expensive professionally acceptable treatment. The additional fee is the patient's responsibility. For example: A single crown to restore one open space will be given the benefit of a Fixed Partial Denture Pontic (one unit). The optional benefit is subject to all contract limitations on the Covered Service.

Coverage is provided for the least expensive professionally acceptable treatment.

Coverage for congenitally missing teeth is available once the Member has been continuously covered under this Plan for 12 months or more.

ORTHODONTICS

TREATMENT NECESSARY FOR THE PREVENTION AND CORRECTION OF MALOCCLUSION OF TEETH AND ASSOCIATED DENTAL AND FACIAL DISHARMONIES.

Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.

Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.

Comprehensive (complete) Treatment - Full treatment includes all records, appliances and visits.

Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.

Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.

Other Complex Surgical Procedures

- Surgical exposure of impacted or unerupted tooth for orthodontic reasons
- Surgical repositioning of teeth

Treatment in progress (appliances placed prior to eligibility under this plan) will be benefited on a pro-rated basis.

Eligible Dependent children are covered from the age of 8 through the age of 18.

EXCLUSIONS - Coverage is NOT provided for:

1. Monthly treatment visits that are inclusive of treatment cost;
2. Repair or replacement of lost/broken/stolen appliances;
3. Orthodontic retention/retainer as a separate service; and
4. Retreatment and/or services for any treatment due to relapse.

Orthodontic Payments: Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. The Member must have continuous eligibility under the plan in order to receive ongoing orthodontic benefit payments.

Benefit payments are made in equal amounts: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or until the lifetime maximum benefits are exhausted (see Benefit Maximums in the Summary of Benefits).

Before treatment begins, the treating dentist should submit a Pre-treatment Estimate. An Estimate of Benefits form will be sent to you and your dentist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the dentist should submit the Estimate of Benefit form with the date of placement and his/her signature. After benefit and eligibility verification by the Plan, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be issued to you and your dentist. This again will serve as the claim form to be submitted 6 months from the date of appliance placement.

EXCLUSIONS

This section indicates items which are excluded and are not considered Covered Services. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services. This list of exclusions is in no way a limitation upon, or a complete listing of, such items considered to be Non-Covered Services.

Coverage is NOT provided for:

1. Dental services for which a Member would be entitled to receive benefits under the federal Medicare program or other governmental program (except Medicaid).
2. Dental services if benefits for such services are provided under any state or federal Worker's Compensation, employer's liability or occupational disease law.
3. Dental or health care services or supplies that are medical in nature, including Hospital or prescription drug charges.
4. Experimental or investigational treatments are not covered. However, We shall cover an experimental or investigational treatment approved by an external appeal agent in accordance with this Certificate. 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 costs of services required to provide treatment to you according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Certificate for non-experimental or non-investigational treatments provided in such clinical trial.
5. Analgesia, analgesic agents, nitrous oxide, prescription drug charges, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care.
6. Dental services performed for cosmetic purpose, including cosmetic surgery and services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents, tooth bonding and veneer covering of the teeth.
7. Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, abrasion and abfraction, realignment of teeth, periodontal splinting and gnathologic recordings.
8. Guided tissue regeneration.
9. Case presentations, office visits and consultations.
10. Incomplete treatment (e.g. patient does not return to complete treatment) or interim/temporary services (e.g. temporary restorations and temporary removable/fixed prosthetic appliances).
11. Corrections of congenital conditions during the first 12 months of continuous coverage under this plan.
12. Athletic mouth guards, occlusal guards and adjustments, enamel microabraision and odontoplasty.
13. Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.
14. Crown lengthening.
15. Tests, laboratory and adjunctive charges, including but not limited to, bacteriologic tests, cytology sample collection, pulp vitality tests, diagnostic tests/casts, cone beam images and oral hygiene instructions.
16. Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.

17. Sedative filling, base or liner used under a restoration.
18. Anatomical crown exposure, surgical exposure of impacted/unerupted teeth or the surgical repositioning of teeth.
19. Complex endodontic services, including intentional reimplantation, apicoectomy, root amputation, apexification, retrograde fillings and hemisection.
20. Procedures used to prepare, repair or place materials in the root canal, including removal of pulpal debridement, pulp cap, resorbable or non-resorbable fillings, root canal obstruction and internal root repair of perforation defects.
21. Amalgam or composite restorations placed for preventive or cosmetic purposes.
22. Dental treatment necessary due to service in the Armed Forces or auxiliary units.
23. 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.
24. Dental services necessary due to war, declared or undeclared.
25. Services performed due to service in the Armed Forces or auxiliary units.
26. Services not listed in this Certificate as being Covered.
27. Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.
28. Implant maintenance or repair to an implant or implant abutment.
29. Brush biopsy.

Optional Treatment Plans

In all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Member and the Dentist. However, the benefits payable hereunder will be made for the applicable percentage of the least costly course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Member.

GENERAL PROVISIONS

Form or Content of 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.

Relationship of Parties (Plan - Participating Dentists)

The relationship between the Plan and Participating Dentists is an independent contractor relationship. Participating Dentists are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Participating Dentists.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Participating Dentist or in any Participating Dentist's facilities.

Your Participating Dentist's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Participating Dentists and Non-Participating Dentists. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

Not Liable for Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Certificate does not give anyone any claim, right, or cause of action against the Plan based on what a Provider of dental care, services or supplies, does or does not do.

Identification Card

Your Identification Card identifies the dental program in which you are enrolled. When you receive care from a Participating or Non-Participating Dentist, you must show your Identification Card. Possession of an Identification Card confers no right to services or other benefits under this Certificate. To be entitled to such services or benefits you must be a Member on whose behalf all applicable Premiums under this Certificate have been paid. If you receive services or other benefits to which you are not then entitled under the provisions of this Certificate you will be responsible for the actual cost of such services or benefits.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the Plan, disability of a significant part of a Participating Dentist's personnel or similar causes that prevent the provision of services under this Certificate, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan shall render services provided under this Certificate insofar as practical, and according to its best judgment; but the Plan shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Employer Premiums

Your employer is responsible for paying a monthly Premium by the first day of the month for which coverage is purchased. We will allow employers a 31 day grace period to pay monthly Premiums, except for the first month's Premium. During this grace period, coverage will continue unless We receive a written notice of termination from your employer. We will notify your employer at least 30 days prior to terminating the Group Contract for non-payment of a monthly Premium.

Coordination of Benefits

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

A. Definitions.

1. **"Allowable expense"** is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.
2. **"Plan"** is other group health coverage with which We will coordinate benefits. The term "plan" includes:
   - Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
   - Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
   - Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.
3. **"Primary plan"** is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).
4. **"Secondary plan"** is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment.

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

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.
2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.

3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.
4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health 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; and
    - If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.
5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

C. Effects of Coordination.

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

D. Right to Receive and Release Necessary Information.

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

E. Our Right to Recover Overpayment.

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

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

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

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

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

Rules to Determine Order of Payment

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

- If the other plan does not have a provision similar to this one, then the other plan will be primary.
- If the Subscriber receiving benefits is the Member and is only covered as a dependent under the other plan, this Certificate will be primary.
- If a Dependent child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer shall be primary. 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 father's plan shall be primary.
- If a Dependent child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents which establishes financial responsibility for the child's health care expenses:
    - the plan of the parent who has custody (the custodial parent) shall be primary;
    - if the custodial parent has remarried, and the child is also covered as a dependent under the step-parent's plan, the custodial parent's plan shall pay first, the step-parent's plan second and the non-custodial parent's plan third;
    - If a court decree between the parents specifies which parent is to be responsible for the child's health care expenses, then that parent's plan shall be primary if that plan has actual knowledge of that decree.
- If the Subscriber is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the dependent of such an active employee or member, and is also covered under another plan as a laid-off or retired employee or as the dependent of such a laid-off or retired employee or member, the plan which covers him as an active employee, or as the dependent of such an active employee or member, shall be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the plans do not agree on which shall be primary, this rule shall be ignored.
- If none of the above rules determines which plan shall be primary, the plan which covered the Subscriber for the longer period of time shall be primary.

When this Plan is secondary, the benefits of this Plan will be reduced so that the total benefits paid by the Primary Plan(s) and this Plan will not exceed the allowable expenses. Also, the amount We pay or provide will not be more than the amount We would pay or provide if We were primary. "Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

Relationship of Parties (Group-Member-Plan)

Neither the Group nor any Member is the agent or representative of the Plan. The Group is fiduciary agent of the Member. The Plan's notice to the Group will constitute effective notice to the Member. It is the Group's duty to notify the Plan of eligibility data in a timely manner. The Plan is not responsible for payment of Covered Services of Members if the Group fails to provide the Plan with timely notification of Member enrollments or terminations.

Conformity with Law

Any provision of this Certificate which is in conflict with the laws of the state in which the Group Dental Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Modifications

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

Legal Action

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 three (3) years from the date the claim was required to be filed.

Acknowledgement of Understanding

By accepting this Certificate, you expressly acknowledge your understanding that this Certificate constitutes a benefit plan provided by Empire, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. Empire is not contracting as the agent of the Blue Cross and Blue Shield Association. You also acknowledge that you have not accepted this Certificate based upon representations by any person other than Empire, and that no person, entity or organization other than Empire will be held accountable or liable to you for any of Empire's obligations created under this Certificate. These acknowledgements in no way create any additional obligations whatsoever on the part of Empire other than those set forth in this Certificate.

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 (877) 606-3338 or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of urgent care. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 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 in writing within the following timeframes:

Expedited/Urgent Grievances:	72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or a treatment that has not yet been provided.)	30 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	60 calendar days of receipt of Your Grievance.

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

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

Authorized Representative
You may authorize another person to represent you and with whom you want Us to communicate regarding specific claims or an appeal. However, no authorization is required for your treating dentist to make a claim or appeal on your behalf. The authorization form must be in writing, signed by you, and include all the information required in Our Individual Authorization form. This form is available at Our web site or by calling Customer Service Department at (877) 606-3338. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

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 איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם. אויף אייער קארטל 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.

EMPIRE DENTAL

FOR CLAIMS AND ELIGIBILITY
Empire BlueCross BlueShield Dental Claims
PO Box 810
Minneapolis, MN 55440-0810
877-606-3338

FOR APPEALS
PO Box 1122
Minneapolis, MN 55440-1122

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