American Family Life Assurance Company of New York

PARTICIPATING PROVIDER ORGANIZATION
CERTIFICATE OF COVERAGE FOR GROUP DENTAL INSURANCE

Issued by: American Family Life Assurance Company of New York
22 Corporate Woods Boulevard, Suite 2
Albany, New York 12211

Administrator: Aflac Benefits Solutions, Inc.
4211 W Boy Scout Blvd
Tampa, FL 33607

Claims Administrator: SKYGEN USA, LLC
W140, N8981 Lilly Rd
Menomonee Falls, WI 53051

About Your Insurance – This Certificate of Coverage ("Certificate") explains the benefits available to You under the Group Policy between American Family Life Assurance Company of New York (a stock company hereinafter called: We, Our, Us, or Aflac New York) and the Group listed in the Group Policy. This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

This Certificate offers Members the option to receive Covered Services on two benefit levels:

1. **In-Network Benefits.** In-network benefits are the highest level of coverage available. In-network benefits apply when a Member's care is provided by Participating Providers in Our Network. Members should always consider receiving dental care services first through the in-network benefits portion of this Certificate.
2. **Out-of-Network Benefits.** The out-of-network benefits portion of this Certificate provides coverage when a Member receives Covered Services from Non-Participating Providers. A Member's out-of-pocket expenses will be higher when out-of-network benefits are received. In addition to Cost-Sharing, a Member will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider's charge. See the Schedule of Benefits and Schedule of Covered Procedures sections of this Certificate for more information.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP POLICY. 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, Aflac New York's president and secretary signed this Certificate in Albany, New York, as of the Member's effective date of coverage.

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

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Section I
Schedule of Benefits

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Section II
Definitions

Defined terms will appear capitalized throughout the entire contract.

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. If Your Non-Participating Provider charges more than the Allowed Amount, You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements.

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 Us, including the Schedule of Benefits, Schedule of Covered Procedures, and any attached riders. The Certificate explains the benefits available to You under the Group Policy.

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 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, 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.

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.

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 policyholder.

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.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Maximum Reimbursement: the amount used to determine the maximum amount of charges of Covered Procedures to reimburse Participating Providers and Non-Participating Providers based on the plan that is issued. See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of the three types of Maximum Reimbursement.

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.

Network: The Providers We have contracted with to provide health care services to You.

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide health care services to You. You will pay more to see a Non-Participating Provider.

Participating Provider: A Provider who has a contract with Us to provide health care services to You. A list of Participating Providers and their locations is available on Our website at aflac.com or upon Your request to Us. 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: A calendar year ending on December 31 of each year.

Policy: The Policy entered into between Us and the Group and any riders attached to the Policy.

Policyholder: The Group to which the Group Master Policy has been issued as shown in the Schedule of Benefits.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, or device that the Covered Service, procedure, treatment plan, or device is Medically Necessary. We do not require Preauthorization for any Covered Services.

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

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 this Certificate.

Schedule of Benefits: The section of this Certificate that describes the Copayments, Deductibles, Coinsurance, and other limits on Covered Services.

Schedule of Covered Procedures: The section of this Certificate that describes the procedures that are Covered Services under this Certificate and the Waiting Period, Maximum Reimbursement, and other limits on such Covered Services.
Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse. Spouse also includes a domestic partner.

Subscriber: The person to whom this Certificate is issued.

UCR (Usual, Customary and Reasonable): The cost of a dental service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Us, We, Our: Aflac New York 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).

Waiting Period: The period of time starting on a Member's effective date before benefits for certain Services become payable.

You, Your: The Member.

Section III
How Your Coverage Works

Your Coverage under this Certificate.
Your employer or other party (referred to as the "Group") has purchased a Group dental insurance Policy 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/or 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.

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 for in-network coverage;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in this Certificate; and
- Received while Your Certificate is in force.

Participating Providers.
To find out if a Provider is a Participating Provider:

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

The Provider directory will give You the following information about Our Participating Providers:

- Name, address, and telephone number;
- Specialty;
- Board certification (if applicable);
- Languages spoken; and
- Whether the Participating Provider is accepting new patients.

Participating and Non-Participating Providers are available nationwide.

The Role of Primary Care Dentists.
This Certificate does not have a gatekeeper, usually known as a Primary Care Dentist ("PCD").

Access to Providers and Changing Providers.
Sometimes Providers in Our Provider directory are not available. You should call the Provider to make sure he or she is a Participating Provider and is accepting new patients.

To see a Provider, call his or her office and tell the Provider that You are an Aflac New York 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.
If We do not have a Participating Provider for certain provider types in the county in which You live or in a bordering county that is within approved time and distance standards, We will approve an authorization to a specific Non-Participating Provider until You no longer need the care or We have a Participating Provider in Our network that meets the time and distance standards and Your care has been transitioned to that Participating Provider. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

Out-of-Network Services.
We Cover the services of Non-Participating Providers. See the Schedule of Covered Procedures section of this Certificate for the Non-Participating Provider services that are Covered. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to in-network and out-of-network services.

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

Pre-Determination/Pre-Treatment Estimates.
We allow You to request and obtain an estimate of coverage. You or 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.

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 medical 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.

Medical Necessity.
We Cover certain benefits described in this Certificate as long as the dental service, procedure, treatment, test, device, or supply (collectively, "service") is Medically Necessary (e.g., cosmetic surgery). 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;
- Dental opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed dental literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of health care professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

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;

See the Utilization Review and External 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.

Important Telephone Numbers and Addresses.

- CLAIMS
  American Family Life Assurance Company of New York
  Aflac Claims
  PO Box 2015
  Milwaukee, WI 53201
  (Submit claim forms to this address.)

  DVClaimsIntake@aflac.com
  (Submit electronic claims to this email address.)

- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
  American Family Life Assurance Company of New York
  Regulatory Compliance Dept.
  Attn: Grievance & Appeals Coordinator
  1932 Wynnton Rd
  Columbus, GA 31999
  Phone: 800-992-3522

- MEMBER SERVICES
  Call the number on Your ID card.
  (Member Services Representatives are available Monday – Friday 8:00 a.m. – 8:00 p.m.)

- OUR WEBSITE
  aflac.com

SECTION IV
Cost-Sharing Expenses and Allowed Amount

Deductible.

Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Certificate for Covered in-network and out-of-network Services during each Plan Year before We provide coverage. If You have other than individual coverage, the individual Deductible applies to each person covered under this Certificate. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year. However, after Deductible payments for persons covered under this Certificate collectively total the Maximum Amount per Family shown in the Schedule of Benefits section of this Certificate in a Plan Year, no further Deductible will be required for any person covered under this Certificate for that Plan Year.

Cost-Sharing amounts incurred with Participating Providers and Non-Participating Providers accumulate to the Deductible.

Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Deductible.

The Deductible runs from January 1 to December 31 of each calendar year.

Copayments.
There are no Copayments for Covered Services under this Certificate.

Coinsurance.
Except where stated otherwise, after You have satisfied the Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your in-network or out-of-network benefit as shown in the Schedule of Benefits section of this Certificate. **You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.**

In-Network Annual Maximum.
This Certificate has an in-network annual maximum for in-network non-orthodontic benefits. When Members receiving dental care have met the in-network annual maximum for non-orthodontic in-network Covered Services in the Schedule of Benefits section of this Certificate, no more benefits will be payable for that Member for the remainder of that Plan Year. If You have other than individual coverage, the individual in-network annual maximum for dental care benefits applies to each person covered under this Certificate. Once a person within a family meets the individual in-network annual maximum for dental care, no more benefits for services will be payable for that person.

Out-of-Network Annual Maximum.
This Certificate has an out-of-network annual maximum for out-of-network non-orthodontic benefits. Once You have met the out-of-network annual maximum for non-orthodontic out-of-network Covered Services in the Schedule of Benefits section of this Certificate, no more benefits will be payable for the remainder of that Plan Year. If You have other than individual coverage, the individual out-of-network annual maximum applies to each person covered under this Certificate. Once a person within a family meets the individual out-of-network annual maximum, no more benefits will be payable for that person.

Your Additional Payments.
When You receive Covered Services from a Non-Participating Provider, in addition to the applicable Copayments, Deductible and Coinsurance described in the Schedule of Benefits and Schedule of Covered Procedures sections of this Certificate, You must also pay the amount, if any, by which the Non-Participating Provider's actual charge exceeds Our Allowed Amount. This means that the total of Our coverage and any Cost-Sharing amounts You pay may be less than the Non-Participating Provider's actual charge.

When You receive Covered Services from a Participating or Non-Participating Provider, We will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services You received. Sometimes, applying these rules will change the way that We pay for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. For example, Your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. We will make one inclusive payment in that case, rather than a separate payment for each billed code.

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.

Unless the Policyholder has selected an In-Network Only plan, the Allowed Amount for Non-Participating Providers is based on the type of Maximum Reimbursement in the plan that is issued and will be the lesser of:

For an Allowable Charge (AC) plan:
- the Provider's charge.
- a rate based on information provided by a third party vendor, which may reflect one or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable Providers' fees and costs to deliver care.

For a Maximum Allowable Charge (MAC) plan:
- the Provider's charge.
- the FAIR Health rate at 30th percentile.

The type of Maximum Reimbursement for a Covered Procedure is shown in the Schedule of Covered Procedures.

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.

We reserve the right to negotiate a lower rate with Non-Participating Providers.

SECTION V
Who Is Covered

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:

- **Individual.** If You selected individual coverage, then You are covered.
- **Individual and Spouse.** If You selected individual and Spouse coverage, then You and Your Spouse are covered.
- **Individual and Children.** If You selected individual and Children coverage, then You and Your Child or Children, as described below, are covered.
- **Individual and Family.** If You selected individual and 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 day the Child turns 26 years of age. Foster children and grandchildren are not 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 qualifies 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:

- 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.
- 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.
- If You, the Subscriber, marry while covered, and We receive notice of such marriage and Premium payment within 30 days thereafter, coverage for Your Spouse and Child starts on the first day of the following month after the date of the 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 or Child.
- 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 Subscriber or Subscriber 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, provided that You pay any additional Premium when due.

Special Enrollment Periods.
You, Your Spouse or Child can also enroll for coverage within 31 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:

- Termination of employment;
- Termination of the other group dental plan;
- Death of the Spouse;
- Legal separation, divorce or annulment;
- Reduction of hours of employment;
- Employer contributions towards the group dental plan were terminated for You or Your Dependent's coverage; or
- A Child no longer qualifies for coverage as a Child under the other group dental plan.

You, Your Spouse or Child can also enroll 31 days from exhaustion of Your COBRA coverage or if You gain a Dependent or become a Dependent through marriage, birth, adoption, or placement for adoption.

We must receive notice and Premium payment within 31 days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application. If You gain a Dependent or become a Dependent due to a birth, adoption, or placement for adoption, Your coverage will begin on the date of the birth, adoption or placement for adoption.

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

- You or Your Spouse or Child loses eligibility for Medicaid or a state child dental plan; or
- 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. Your coverage will begin on the first day of the following month after We receive Your application.

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:

- Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months, where such registry exists; or
- For partners residing where registration does not exist, by:
    - An alternative affidavit of domestic partnership. The affidavit must be notarized and must contain the following:
        - The partners are both 18 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 the laws of the State of New York;
        - The partners have been living together on a continuous basis prior to the date of the application; and
        - Neither individual has been registered as a member of another domestic partnership within the last six months
    - Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
    - 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 and benefit maximums that may apply. Below are descriptions of various dental care services. **Please check the Schedule of Covered Procedures to verify which dental benefits are available to You, as well as any day or visit limitations**.

Description of dental care services:

- **Emergency Dental Care -** emergency dental treatment required to alleviate pain and suffering caused by dental disease or trauma. Emergency Dental Care is not subject to Our Preauthorization.

- **Preventive & Diagnostic Dental Care –** routine dental services and procedures provided in the office of a dentist which evaluate oral health status and help to prevent oral disease from occurring, including dental examinations, visits and consultations; prophylaxis; space maintainers; and preventive topical fluoride application.

- **Endodontics -** routine endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.

- **Restorative Services –** services to repair and/or replace natural tooth structure damaged or loss by disease or injury. Restorative services include: minor restorative services, such as amalgam (silver) fillings and composite resin (tooth colored) fillings; and major restorative services such as crowns and onlays, used when teeth cannot be restored with amalgam or resin fillings.

- **Periodontics –** limited, non-surgical periodontic services and periodontic surgical services necessary for treatment related to hormonal disturbances, drug therapy, or congenital defects; periodontic services in anticipation of, or leading to orthodontics or cosmetic orthodontics that are otherwise Covered under this Certificate.

- **Prosthodontics –** services and appliances that replace missing natural teeth, such as:
  - Removable complete or partial dentures, for Members 15 years of age and above;
  - Additional services including insertion of identification slips, repairs, relines and rebases and treatment of cleft palate; and
  - Interim prosthesis for Members five to 15 years of age.
  - Implants or implant-related services.

  Fixed bridges when required:
  - For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth;
  - For cleft palate stabilization; or
  - Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

- **Oral Surgery -** non-routine oral surgery, such as partial and complete bony extractions, tooth re-implantation, tooth transplantation, surgical access of an unerupted tooth, mobilization of erupted or malpositioned tooth to aid eruption, and placement of device to facilitate eruption of an impacted tooth; oral surgery in anticipation of, or leading to orthodontics that are otherwise Covered under this Certificate.

- **Orthodontics –** orthodontic services used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

SECTION VII
Limitations and Exclusions

No coverage is available under this Certificate for the following:

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 Appeal sections of this Certificate unless medical information is submitted.

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, except for Emergency Dental Care.

Experimental or Investigational Treatment.
We do not Cover any health care service, procedure, treatment, or device that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights

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

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

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).

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

No-Fault Automobile Insurance.
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This Exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

Services Not Listed.
We do not Cover services that are not listed in this Certificate's Schedule of Covered Procedures as being Covered.

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.

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

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

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

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.

SECTION VIII
Claim Determinations

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.

Notice of Claim.
Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on Your ID card or visiting Our website at aflac.com. If requested claim forms are not provided to You within 15 days of Our receipt of the request, You will meet the proof of loss requirements if We are given written proof of the nature and extent of the loss. Completed claim forms should be sent to the address in the How Your Coverage Works section of this Certificate. You may also submit a claim to Us electronically by sending it to the email address in the How Your Coverage Works section of this Certificate.

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

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.

Claim Determinations.
Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our Claim determination procedure applies to contractual benefit denials. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures 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.

Pre-Service Claim Determinations.

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

- **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 period. Written notice will follow within three (3) calendar days of the decision.

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 deny the claim in whole or in part. 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 if We deny the claim in whole or in part.

Payment of Claims.
Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 15 days of Our determination that payment is due but no later than 30 days of receipt of the claim (when submitted through the internet or e-mail) or 45 days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

SECTION IX
Grievance Procedures

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.

Filing a Grievance.
You can contact Us 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.

You may ask that We send You electronic notification of a Grievance or Grievance Appeal determination instead of notice in writing or by telephone. You must tell Us in advance if You want to receive electronic notifications. To opt into electronic notifications, call the number on Your ID card or visit Our website. You can opt out of electronic notifications at any time.

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

Expedited/Urgent Grievances:	72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or a treatment that has not yet been provided.)	15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 45 calendar days of receipt of all necessary information.

Grievance Appeals.
If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal in writing. However, urgent Appeals may be filed by phone. 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:	72 hours of receipt of Your Appeal.
Pre-Service Grievances: (A request for a service or 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.

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, You may also contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Ave., 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400; or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION X
Utilization Review

Utilization Review.
We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place 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.

You may ask that We send You electronic notification of a Utilization Review determination instead of notice in writing or by telephone. You must tell Us in advance if You want to receive electronic notifications. To opt into electronic notifications, call the number on Your ID card or visit Our website. You can opt out of electronic notifications at any time.

Concurrent Reviews.
- **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee), by telephone and in writing, within one

business day of receipt of all necessary information. If We need additional information, We will request it within one 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), by telephone and in writing, within one business day of Our receipt of the information or, if We do not receive the information, within the earlier of 15 calendar days of receipt of part of the requested information or 15 calendar days of the end of the 45-day period.

- **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 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 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 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 period.

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 in writing within 15 calendar days of the earlier of Our receipt of all or part of the requested 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.

Reconsideration.
If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For concurrent reviews, the reconsideration will take place within one 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.

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. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is (1) a Physician or (2) a health care professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

Standard Appeal.

- **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within the earlier of 30 calendar days of receipt of the information necessary to conduct the Appeal or 60 days of receipt of the Appeal. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two 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 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 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 business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

Full and Fair Review of an Appeal.
We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connection with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

Appeal Assistance.
If You need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Ave., 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or email cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION XI
External Appeal

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

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

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 the “Your Right to an External Appeal” paragraph above and Your attending Physician must certify that Your condition or disease is one for which:

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

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

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

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

The External Appeal Process.
You have four 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 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 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 additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two 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 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

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

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

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 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.

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 coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
  - Dental benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
  - Dental benefits coverage of a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.
- **"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.

Rules to Determine Order of Payment.
The first of the rules listed below that applies will determine which plan will be primary:
- If the other plan does not have a provision similar to this one, then the other plan will be primary.
- If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.
- 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.
- 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; and
  - 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.

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

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.

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.

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.

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:
- If this Certificate is primary, as defined in this section, We will pay benefits first.
- If this Certificate is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer.
- 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:

- 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.
- The date on which the Subscriber ceases to meet the eligibility requirements as defined by the Group.
- 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.
- For Spouses in cases of divorce, the date of the divorce.
- For Children, until the day the Child turns 26 years of age.
- 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.
- 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. However, if the Subscriber makes a misrepresentation of material fact in writing on his or her enrollment application We will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Certificate. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

- The date that the Group Policy is terminated. If We decide to stop offering a particular class of group policies, 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.
- The Group has performed an act or practice that constitutes fraud or made a misrepresentation of material fact under the terms of the coverage.
- The Group has failed to comply with a material plan provision relating to group participation rules. We will provide written notice to the Group at least 30 days prior to when the coverage will cease.
- 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 Subscribers at least 30 days prior to when the coverage will cease.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.
See the Continuation of Coverage section of this Certificate for Your right to continuation of this coverage under COBRA or USERRA.

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.

- 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.
- 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.
- 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:

- The date coverage would otherwise terminate; or
- 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:

- 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;
- 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";
- The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
- The date You become entitled to Medicare;
- The date to which Premiums are paid if You fail to make a timely payment; or
- The date the Group Policy terminates. However, if the Group Policy is replaced with similar coverage, You have the right to become covered under the new Group Policy 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:
- The 24-month period beginning on the date on which the absence begins; or
- 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.
- 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.
- 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.

SECTION XVI
General Provisions

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.

Assignment.
You cannot assign any benefits under this Certificate to any person, corporation, or other organization. Any assignment of benefits by You will be void and unenforceable. Assignment means the transfer to another person, corporation or organization of Your right to the services provided under this Certificate. However, You may request Us to make payment for services directly to Your Provider instead of You.

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

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

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.

Conformity with Law.
Any term of this Certificate which conflicts 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.

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.

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

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 such as 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.

Identification Cards.
Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID 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.

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.

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.

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

Notice.
Any notice that We give You under this Certificate will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery or to the address of the Group. If notice is delivered to You electronically, You may also request a copy of the notice from Us. 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 the address on Your ID card.

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

Recovery of Overpayments.
On occasion a payment may 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.

Renewal Date.
The renewal date for this Certificate is January 1 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.

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.

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.

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

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.

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 New York General Obligations Law Section 5-335, 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.

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.

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 two years from the date the claim was required to be filed.

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

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.

Who May Change this Certificate.
This Certificate may not be modified, amended, or changed, except in writing and signed by Our president and secretary or other person designated by Our 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 Our president and secretary or other person designated by Our president.

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 the Subscriber or the Provider regardless of whether an assignment has been made.

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.

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, except as prohibited by state or federal law, 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, to the extent permitted under state or federal law, 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 Covered Procedures

<Schedule of Covered Procedures will be inserted here.>