Member Contract and Other Legal Information

Excellus

A nonprofit independent licensee of the BlueCross BlueShield Association

Excellus

165 Court Street
Rochester, NY 14647

A nonprofit independent licensee of the BlueCross BlueShield Association

Dear Subscriber:

Welcome to Excellus BlueCross BlueShield.

This document contains your Member Certificate or Contract. We encourage you to read this document in its entirety. Please note that Riders, Endorsements or Disclosures that modify certain benefits and exclusions in the Member Certificate or Contract are located in the back of the document.

This is an important legal document. Please keep it in a safe place.

If you have any questions, please contact us at the telephone number on your identification card or visit us at www.excellusbcbs.com.

Customer Service
Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

Excellus

This is your

DENTAL BLUE OPTIONS CERTIFICATE OF COVERAGE

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

To
Group contract holder

This Certificate of Coverage ("Certificate") explains the benefits available to you under a Group Contract between Excellus Health Plan, Inc. (hereinafter referred to as “we”, “us”, “our”, or “the Plan”) and the group contract holder listed in the Group Contract. This Certificate is not a contract between you and us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

This Certificate offers each person the option to receive covered services on two benefit levels:

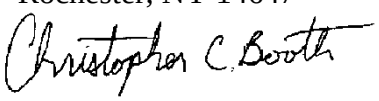
In-Network Benefits. In-Network Benefits are the highest level of coverage available. In-Network Benefits apply when your care is provided by Participating Providers. You should always consider receiving health care services first through the In-Network Benefits portion of this Certificate.

Out-of-Network Benefits. The Out-of-Network Benefits portion of this Certificate covers health care services described in this Certificate when you choose to receive the covered services from Non-Participating Providers. When you receive Out-of-Network Benefits, you will incur higher out-of-pocket expenses. In addition to increased Coinsurance, you will be responsible for paying any difference between the Allowable Expense and the Dentist’s charge.

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

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: 

Christopher C. Booth
President and Chief Executive Officer

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SECTION ONE - INTRODUCTION AND DEFINITIONS

1. **Your Coverage Under This Certificate.** Your employer or organization (referred to as the "group contract holder") has purchased a group health insurance contract from us. Under that contract we will provide the benefits described in this Certificate to members of the group, that is, to employees of the employer or to members of the organization and their covered dependents. However, this Certificate is not a contract between you and us. You should keep this Certificate with your other important papers so that it is available for your future reference.

2. **Definitions.**

   A. **Allowable Expense.** "Allowable Expense" means the maximum amount we will pay to a Dentist for the services or supplies covered under this Certificate, before any applicable Deductible and Coinsurance amounts are subtracted. The Allowable Expense is based on our Fee Schedule or the Dentist's actual charge, whichever is less.

   B. **Calendar Year.** The 12-month period beginning on January 1 and ending on December 31. However, if you were not covered under this Certificate for this entire period, Calendar Year means the period from the date you became covered until December 31.

   C. **Coinsurance.** A charge, expressed as a percentage of the Allowable Expense, that you must pay for certain dental services covered under this Certificate. You are responsible for the payment of any Coinsurance directly to the Dentist.

   D. **Deductible.** A charge, expressed as a fixed dollar amount, that you must pay once each Calendar Year before we will pay anything during that Calendar Year for the following services covered under this Certificate: Class II; Class IIA; and Class III. (There are special Deductible rules when you have other than individual coverage. See Section Three.)

   E. **Dentist.** Any duly licensed dentist or physician.

   F. **Effective Date.** The date your coverage under this Certificate begins. Coverage begins at 12:01 a.m. on the Effective Date.

   G. **In-Network Benefits.** In-Network Benefits are the highest level of coverage available. In-Network Benefits apply when your care is provided by Participating Providers.

   H. **Member.** Any Subscriber or eligible dependent who meets all applicable eligibility requirements, for whom the required premium payment has actually been received by us, and who is covered under this Certificate.

   I. **Non-Participating Provider.** A Dentist who does not have an agreement with us or our agent to provide dental services to Members.

   J. **Out-of-Network Benefits.** The Out-of-Network Benefits portion of this Certificate covers dental care services described in this Certificate when you choose to receive the covered services from Non-Participating Providers. When you receive Out-of-Network Benefits, you will incur higher out-of-pocket expenses. In addition to increased Coinsurance, you will be responsible for paying any difference between the Allowable Expense and the Dentist's charge.

   K. **Participating Provider.** A Dentist who has an agreement with us or our agent to provide dental services to Members.

L. **Service Area.** The geographic area in which we will provide benefits to our Members. Our Service Area consists of the following counties: Monroe; Wayne; Livingston; Seneca; Yates; Ontario; Steuben; Schuyler; Chemung; Tioga; Tompkins; Cortland; Broome; Cayuga; Onondaga; Oswego; Chenango; Madison; Delaware; Otsego; Herkimer; Montgomery; Fulton; Oneida; Lewis; Hamilton; Essex; Clinton; Franklin; St. Lawrence; and Jefferson.

M. **Subscriber.** The member of the group to whom this Certificate is issued.

N. **"We", "Us", "Our" or "The Plan" and "You", "Your" and "Yours".** Throughout this Certificate, Excellus Health Plan, Inc. will be referred to as "we", "us", "our" or "the Plan". The word "you", "your" or "yours" refers to you, the Subscriber. If other than individual coverage applies, then in most cases the word "you" also includes any family members who are covered under this Certificate.

3. **Alternative Benefit**s. All covered procedures are subject to Alternative Benefits. We will only provide benefits for the procedure carrying the lesser Allowable Expense, provided that procedure meets acceptable dental standards, subject to medical necessity. If the more expensive procedure is chosen by you or your Dentist and is not medically necessary, you must pay the difference between our payment and the amount billed by the Dentist.

4. **Predetermination Of Benefits.** We recommend a predetermination of benefits for any extensive treatment, such as periodontics or prosthetics. A description of planned treatment and expected charges should be sent to us before treatment is started. If there is a major change in the treatment, a revised predetermination of benefits is required. The expenses that will be covered will be determined by us and are subject to the Alternative Benefits provision in Paragraph 3 above. When there has not been a predetermination of benefits, we will determine what services will be covered at the time the claim is received. Predetermination of benefits does not guarantee payment and expires one year after the date of issue. The estimate of benefits payable may change based on the benefits, if any, for which a Member qualifies at the time services are completed.

5. **When Charges For Covered Services Are Incurred.** A charge for a covered service will be considered to be incurred: for an appliance or modification of an appliance, on the date the appliance is placed; for an inlay, crown or bridge, on the date the inlay, crown or bridge is seated; for root canal therapy, on the date the root canal is completed; and for all other services, on the date the service is rendered.

SECTION TWO - WHO IS COVERED

1. **Who Is Covered Under This Certificate.** Subject to the permissible eligibility rules of the group contract holder, you, the Subscriber to whom this Certificate is issued, are covered under this Certificate. If you selected other than individual coverage, the following members of your family may also be covered:

   A. Your spouse, unless you are divorced or your marriage has been annulled.

   B. Your unmarried children who are under 19 years of age and who are chiefly dependent on you for support.

   C. Any unmarried dependent child, regardless of age, who is incapable of self- sustaining employment because of mental retardation, mental illness, or developmental disability as defined in the New York Mental Hygiene Law, or because of physical handicap. The condition must have occurred before the child reached the age at which the child's coverage under this Certificate would otherwise have terminated. The child's disability must be certified by a physician. You must file an application in the form we approve to request that the child be included in your family coverage. We have the right to check whether a child is and continues to qualify under this paragraph. (See Section Eight for when coverage terminates.)

   We have the right to request, and have furnished to us, such proof as may be needed to determine eligibility status of a prospective Subscriber and all prospective dependents as they pertain to eligibility for coverage under this Certificate.

2. **Other Children Covered Under This Certificate.** In addition to your natural children, the following other children may also be covered under this Certificate if the child meets the above tests for children covered under this Certificate:

   A. A legally adopted child;

   B. A child chiefly dependent upon you for support and for whom you have been appointed the legal guardian by court order;

   C. A stepchild who is chiefly dependent upon you for support; and

   D. A child for whom you are the proposed adoptive parent and who is dependent upon you during the waiting period prior to the adoption becoming final.

   We have the right to request, and have furnished to us, such proof as may be needed to determine whether a child qualifies as a dependent for purposes of coverage under this Certificate.

3. **Newborn Child.** If you have a type of coverage that would cover a newborn, your newborn child will be covered at birth, provided you notify us within 30 days of the birth by completing the enrollment form to add the child to your coverage. If you are changing your type of coverage (for example from individual to family coverage) in order to cover the newborn child, you must complete the enrollment form to extend your coverage to include your child within 30 days of the birth. If you do not complete the form within 30 days of the birth, coverage of the child will not become effective until the next premium due date after we receive the application. If a child of yours who is covered under this Certificate gives birth, your newborn grandchild will not be covered (unless any of the criteria of Paragraph 2 above apply).

4. **Adopted Newborns.** If you have a type of coverage that will cover a newborn, or switch to a type of coverage that will cover a newborn, in accordance with Paragraph 3 above, we will cover a proposed adoptive newborn from the moment of birth if you (the proposed adoptive parent) take physical custody of the infant as soon as the infant is released from the hospital after birth and you file a petition within 30 days of the infant's birth pursuant to §115-C of the New York State Domestic Relations Law or a comparable provision when the child is adopted in another state. However, we will not provide coverage for the newborn if a notice of revocation of the adoption has been filed or one of the natural parents revokes consent to the adoption. If we provide coverage of an adopted newborn and notice of the revocation of the adoption is filed or one of the natural parents revokes their consent, we will be entitled to recover any sums paid by us for care of the adopted newborn.

5. **Persons Not Covered.** Individuals who do not either live, reside or work in our Service Area, except for children, are not covered under this Certificate.

6. **Types Of Coverage Other Than Individual Coverage.** We offer different types of coverage in addition to individual coverage:

   A. Family Coverage – If family coverage applies, then you, the Subscriber, and your spouse and your children as described above are covered.

   B. Spousal Coverage – If spousal coverage applies, then only you, the Subscriber, and your spouse as described above are covered.

   C. Child Coverage – If child coverage applies, then you, the Subscriber, and your child or children as described above are covered.

   D. Two-Person Coverage – If two-person coverage applies, then you, the Subscriber, and your spouse or one child as described above are covered. You may only select two-person coverage if your family unit consists of two people.

   The names of all persons covered under this Certificate must have been specified on the enrollment form for this Certificate or provided to us as described in Paragraph 9 below. No one else can be substituted for those persons. We have administrative rules to determine which types of coverage are available to members of your group. You are only entitled to the types of coverage for which we receive premium and that our records indicate is applicable. You may call us if you have any questions about which type of coverage applies to you.

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

   A. If you, the Subscriber, elect coverage before becoming eligible for coverage or within 30 days of becoming eligible, coverage begins at 12:01 a.m. on the date you become eligible.

   B. If you, the Subscriber, do not elect coverage upon becoming eligible or within 30 days of becoming eligible, you must wait until the group's next open enrollment period, except as provided in Paragraph 8 below. When you enroll during the next open enrollment period, coverage then begins at 12:01 a.m. on the date to which the open enrollment period applies.

   C. If you, the Subscriber, marry while covered, and we receive notice of such marriage within 30 days thereafter, coverage for your spouse starts at 12:01 a.m. on the date of your marriage. If we do not receive notice of the marriage within the 30-day period, your spouse must wait until the next open enrollment period for coverage. When your spouse is enrolled during the next open enrollment period, coverage for your spouse will start at 12:01 a.m. on the date to which the open enrollment period applies.

8. **When You Reject Initial Enrollment Or Elect Not To Enroll During Open Enrollment, But Do Not Need To Wait Until The Group's Next Open Enrollment Period To Enroll For Coverage.** If you, the Subscriber, reject initial enrollment under this Certificate, or elect not to enroll during a subsequent open enrollment, you may enroll for coverage if the following conditions are met:

   A. You or your spouse had coverage under another plan or contract when coverage was initially offered or at a subsequent open enrollment period; and

   B. Coverage was provided in accordance with continuation required by state or federal law and was exhausted; or coverage under the other plan or contract was terminated because you or your spouse lost eligibility for one or more of the following reasons:

      (1) Termination of employment;

      (2) Termination of the other plan or contract;

      (3) Death of the spouse;

      (4) Legal separation, divorce or annulment;

      (5) Reduction in the number of hours worked;

      (6) The employer or other group ceased its contribution toward the premium for the other plan or contract;

      (7) The dental coverage was in connection with HMO coverage, and you no longer live, work or reside in the HMO service area;

      (8) Cessation of dependent child status;

      (9) Benefits are no longer offered to similarly situated individuals (e.g., part-time employees);

      (10) The benefit maximum under the plan or contract has been reached; or

   C. You acquire a dependent due to birth, adoption, guardianship, placement for adoption or marriage, in which case you, the Subscriber, may enroll for individual coverage or for a type of coverage available to your group that will cover you and your eligible dependents.

   D. You apply for coverage under this Certificate within 30 days after: termination for one of the reasons set forth in Subparagraph B above; or acquisition of a dependent as set forth in Subparagraph C above.

   If you enroll for coverage pursuant to Subparagraphs A and B above, your coverage will begin at 12:01 a.m. on the date of the loss of coverage. If you enroll for coverage pursuant to Subparagraph C above, your coverage will begin at 12:01 a.m. on: the date of the birth, adoption, guardianship or placement for adoption; or on the first day of the month following the request for enrollment, when you are entitled to special enrollment based on marriage.

9. **Notification Of Change In Your Coverage.**

A. **To Add a Spouse or Child.** If you need to add a spouse or child to your coverage (other than a newborn child added under Paragraph 3 or 4 above), you must complete and return to us a form for this purpose and any requested documentation. The addition of a spouse or child will be effective as of the date of marriage, adoption or other event making the child eligible for coverage under Paragraph 2, if you return to us a completed application and requested documents within 30 days of the wedding, adoption or other event, and the applicable premium is paid. If you do not return a completed form and documentation within 30 days, your spouse or child will be added to your coverage after the next open enrollment period, so long as the applicable premium is paid.

B. **When Coverage of a Spouse or Child Terminates.** If you have other than individual coverage you should notify us of any event that affects your coverage, such as: your divorce, the death of your spouse or Medicare eligibility; or a child marrying, leaving school, reaching the age at which coverage terminates or otherwise experiencing an event that would normally result in termination of dependent coverage. We will provide you with a form for that purpose. If such change results in you seeking a different type of coverage at a lower premium (such as a switch to individual coverage), the form and requested documentation must be returned within 30 days of the event in order for the change in premium to be effective on the date of the event. If you do not return a completed form and any requested documentation within 30 days of the event, the change in premium will be effective as of the next premium due date after they are received. Nothing in this Subparagraph B is designed to affect the provisions of Section Eight governing terminations of coverage. This Subparagraph B only involves the effective date of changes in premiums due to terminations of coverage under Section Eight.

If you think there are reasons coverage of the person experiencing the change should continue, you must notify us of the reasons for the continuation of the coverage, on a form provided by us to you for that purpose upon your request, together with any requested documentation, no later than 30 days after the date dependent coverage would usually terminate.

SECTION THREE - COST SHARING EXPENSES

1. **Deductible.** Except where stated otherwise, each person covered under this Certificate must pay the first $50 of Allowable Expenses incurred for the following benefits under this Certificate during each Calendar Year: Class II; Class IIA; and Class III. If you have other than individual coverage, the Deductible applies to each person covered under this Certificate. However, after Deductible payments for any and all persons covered under this Certificate total $100 in a Calendar Year, no further Deductible will be required for any person covered under this Certificate for that Calendar Year. No more than $50 of any person's Allowable Expenses can be applied to the maximum limit of $100.

2. **Coinsurance.** Except where stated otherwise, after you have satisfied the annual Deductible, you will be responsible for a percentage of the Allowable Expense. The Coinsurance amounts you must pay are set forth in the section where the particular service is described. For example, if a service is covered at 80% of the Allowable Expense, your Coinsurance responsibility is 20% of the Allowable Expense.

3. **Additional Payments For Out-of-Network Benefits.** When you receive services from a Non-Participating Provider, in addition to the Coinsurance and the annual Deductible described above, you must also pay the amount, if any, by which the provider's actual charge exceeds the Allowable Expense. This means that the total of our coverage and your Deductible and Coinsurance may be less than the provider's actual charge.

4. **Annual Maximum.** The annual maximum aggregate amount we will pay under this Certificate for any individual is $1,000 for all of the following covered services: Class II; Class IIA; and Class III.

5. **Alternative Benefits.** As set forth in Section One, paragraph 3, if you or your Dentist choose a procedure that is not medically necessary and carries a higher Allowable Expense than another appropriate procedure, you will be liable for the difference between our payment and the amount billed by the Participating Provider or Non-Participating Provider.

SECTION FOUR - BENEFITS FOR DENTAL SERVICES

We will provide benefits under this Certificate for the services described below. The services must be provided by a Dentist. Benefits for some of these services are subject to a Deductible, as described in Section Three. Benefits for all services are subject to the limitations, exclusions and other terms and conditions of this Certificate.

1. **Preventive And Diagnostic Services (Class I).**

   A. **Clinical Oral Examinations.** We will provide coverage for an oral examination twice in any Calendar Year. We will also provide coverage for emergency oral examinations to treat pain; if an operative procedure is also provided on the same day, coverage for the emergency oral exam is included in the payment for the operative procedure.

   B. **Radiographs.**

      (1) **Full Mouth or Panoramic.** We will provide coverage for the following complete intra-oral x-rays once every 36 consecutive months: a complete series of bitewings (16 films); or a panoramic film. We will not provide coverage for periapical x-rays when performed on the same date as a complete series or a panoramic x-ray. When the total amount charged for individual periapical x-rays equals or exceeds the Allowable Expense for a complete series, benefits are limited to the Allowable Expense for a complete series.

      (2) **Bitewings.** We will provide coverage for up to a combination of four bitewing films in a Calendar Year. We will not provide coverage for bitewings provided in conjunction with a full mouth series.

      (3) **Diagnostic Radiographs and Photographs.** We will provide coverage for diagnostic x-rays and photographs. We will only provide coverage for photographs once in a Calendar Year.

      (4) **Facial Images.** We will provide coverage for facial images once in a Calendar Year.

   C. **Dental Prophylaxis, Including Cleaning, Scaling and Polishing.** We will provide coverage for prophylaxis twice in a Calendar Year. We will provide coverage for cleaning or scaling of teeth performed by a licensed dental hygienist if such treatment is rendered under the supervision and direction of a Dentist.

   D. **Topical Fluoride Treatments (Office Procedure).** We will provide coverage for topical fluoride treatments twice in a Calendar Year for Members under 16 years of age.

   E. **Palliative Emergency Treatment.** We will provide coverage for emergency care you receive from a Dentist that is designed only to relieve your dental pain until corrective treatment can be provided.

   F. **Sealants.** We will provide coverage for the topical application of sealants on un-restored, permanent molars once in any 36 consecutive months for Members under 16 years of age.

   G. **Space Maintainers.** We will provide coverage for space maintainers for Members under 16 years of age. This includes coverage for adjustment and re-cementation within six months after placement.

   H. **Payments for Class I Benefits.** Benefits are covered at 100% of the Allowable Expense.

2. **Basic Services (Class II).**

   A. **Amalgam and Composite Restorations.** We will provide coverage for amalgam and composite restorations for treatment of cavities. Restorations including multiple surfaces will, for the purpose of providing benefits, be combined; and benefits will be provided according to the number of surfaces treated. Benefits for each surface are allowed once in 12 consecutive months.

   B. **Oral Surgery.** We will provide coverage for simple extractions. Coverage for local anesthesia, routine pre and post operative procedures, sutures and suture removal are included in our Allowable Expense for the surgery; and we will not provide additional benefits for such services.

   C. **Payments For Class II Benefits.** Benefits are covered at 50% of the Allowable Expense, after Deductible.

3. **Basic Restorative Services (Class IIA).**

   A. **Oral Surgery.** We will provide coverage for oral surgery, consisting of: surgical extractions, including removal of impacted teeth; odontogenic cysts, lesions and biopsies; tooth re-implantation; tooth transplantation and alveoplasty. Coverage for local anesthesia, routine pre and post operative procedures, sutures and suture removal are included in our Allowable Expense for the surgery; and we will not provide additional benefits for such services. Benefits for extraction of impacted wisdom teeth include coverage for IV sedation.

   B. **Endodontics.**

      (1) **Pulp Caps.** Coverage for direct and indirect pulp caps rendered in conjunction with a restoration is included in the Allowable Expense for the restorative procedure; and we will not provide additional benefits for such services.

      (2) **Pulpotomy.** We will provide coverage for therapeutic pulpotomy once per tooth, except when performed in conjunction with root canal therapy.

      (3) **Root Canal Treatment.** We will provide coverage for root canal therapy, including: anesthesia; opening and drainage of pulp chambers and canals; removal of pulp tissue and instrumentation of canals; application of medications; radiographs taken during the course of active treatment; and culture and sensitivity examinations.

         (a) Our coverage for root canal therapy includes the following: any related diagnostic and/or palliative treatment provided during, or 30 days before or after, root canal therapy; and temporary re-cementation of crowns/bridges.

         (b) We will provide coverage for root canal treatment provided up to 30 days after termination of your coverage under this Certificate for a tooth opened while coverage was in effect.

      (4) **Apicoectomy.** We will provide coverage for apicoectomy, including: sutures; suture removal; treatment plan; anesthesia; application of medications; treatment radiographs; and routine post-operative treatment.

      Our coverage includes benefits for any diagnostic and/or palliative treatment related to the apicoectomy that is rendered during, or 30 days before or after, the apicoectomy or retrograde filling.

(5) **Hemisection.** We will provide coverage for hemisection, including: sutures; suture removal; treatment plan; anesthesia; application of medications; treatment radiographs; and routine post-operative treatment.

C. **Periodontic Services.**

(1) **Periodontic Surgical Services.** We will provide coverage for the following periodontic surgical services once in any quadrant in any consecutive 36-month period: gingivectomy; osseous surgery; and gingival flap procedures. When more than one of these surgical procedures is rendered at the same time, we will only pay for the most inclusive procedure.

(2) **Periodontic Adjunctive Services.** We will provide coverage for periodontic adjunctive services consisting of periodontal scaling and root planing (per quadrant) once per quadrant in any consecutive 24-month month period. When periodontal scaling and root planing are provided on the same day as a prophylaxis, we will only pay for the most inclusive procedure.

(3) **Periodontal Maintenance.** We will provide coverage for periodontal maintenance (periodontal prophylaxis) twice per Calendar Year after active therapy and/or surgical treatment. Periodontal scaling performed in presence of gingival inflammation and/or full mouth debridement is not considered active treatment.

D. **Payments For Class IIA Benefits.** Benefits are covered at 50% of the Allowable Expense, after Deductible.

4. **Major Restorative Services (Class III).**

A. **Removable and Fixed Prosthodontics.** Benefits will be provided for the following removable and fixed prosthodontics: full and partial dentures; and fixed bridgework. The following benefit limitations apply:

(1) We will only provide benefits for the replacement of a denture, partial denture or fixed bridgework for which benefits were provided under this Certificate with another denture, partial denture or fixed bridge: when the existing prosthetic was placed more than five years ago; and cannot be made serviceable.

Benefits for the upgrading from a partial denture to fixed bridgework are limited to the Allowable Expense for a partial denture.

Benefits for replacement of bilateral or multiple missing teeth in the same arch are limited to the Allowable Expense for the partial denture.

(2) We will not provide coverage for denture replacement made necessary by reason of loss or theft.

(3) We will only provide benefits for adjustments, re-cementation or repairs to full or partial dentures or bridges when the adjustment, re-cementation or repair is performed more than six months after the initial insertion of the prosthesis.

(4) Benefits for denture reline or rebases are limited to one in a 36-month period and must occur at least six months after initial placement.

(5) Benefits for temporary partial stayplate dentures (flipper) are limited to the replacement of extracted anterior teeth.

(6) Benefits for the following are included in the Allowable Expense for the major procedure: tooth preparation; temporary bridges; bases; impressions; anesthesia; preparation of the gingival tissue; or other services that are components of a complete procedure.

(7) Removal of part of a root (hemisection) does not qualify as a tooth extraction when determining benefits in connection with installation of removable or fixed prosthetics.

(8) A bridge in conjunction with a partial denture in the same arch is considered optional and benefits are limited to the Allowable Expense for a partial denture.

(9) The following in connection with a denture, partial denture or bridge are limited to the Allowable Expense for a standard procedure: precision or semi-precision attachments; athletic mouth guards; special techniques or personalized restoration.

(10) We will not provide benefits for a denture, partial denture or bridge or the fitting thereof: that was ordered while the Member was not covered under this Certificate; or that was ordered while the Member was covered under this Certificate, but finally installed or delivered to such Member more than 30 days after termination of coverage under this Certificate.

B. **Inlays/Onlays and/or Crowns.** We will provide coverage for inlays/onlays and/or crowns only when teeth cannot be restored by a filling. Our coverage for these restorations includes all necessary: bases; pulp medications; liners; gingival preparation; impressions; temporary crowns; finishing; and occlusal adjustments. The following benefit limitations apply:

(1) When an inlay/onlay or crown is used to replace an existing filling in the absence of decay, we will only provide benefits that are based on the Allowable Expense for an amalgam or composite filling. When an inlay/onlay or crown is not used to replace an existing filling, we will only provide benefits for an inlay/onlay or crown that is medically necessary to treat a tooth due to severe decay and/or fracture.

(2) We will only provide benefits for the replacement of an inlay/onlay or crown with another inlay/onlay or crown if more than five years have elapsed since the last placement.

(3) We will only provide coverage for plastic or stainless steel crowns for Members under16 years of age.

(4) We will only provide benefits for re-cementation that is performed more than six months after the initial insertion.

(5) We will not provide benefits for an inlay/onlay or crown or the fitting thereof: that was ordered while the Member was not covered under this Certificate; or that was ordered while the Member was covered under this Certificate, but finally installed more than 30 days after termination of coverage under this Certificate.

C. **Payments For Class III Benefits.** Benefits are covered at 50% of the Allowable Expense, after Deductible.

SECTION FIVE - EXCLUSIONS

In addition to the exclusions and limitations described in other sections of this Certificate, we will not provide coverage for the following:

1. **Anesthesia.** We will not provide coverage for the following forms of anesthesia: local; regional block; Trigem division block; local analgesia; intravenous sedation; and non-intravenous conscious sedation.

2. **Bonding.** We will not provide coverage for bonding and/or splinting of teeth.

3. **Care By More Than One Provider.** In the event a Member transfers from the care of one Dentist to that of another Dentist during the course of treatment, or if more than one Dentist renders services for one dental procedure, we will not provide coverage for more than the amount we would have provided if one Dentist rendered the service.

4. **Cosmetic Services.** We will not provide coverage for dental services that are primarily for cosmetic or aesthetic purposes and are not medically necessary.

5. **Court Ordered Services.** We will not provide coverage for any dental service or care (including evaluation, testing, and/or treatment) that is ordered by a court, or that is required by a court as a condition of parole or probation, unless:

   A. The service or care would be covered under this Certificate in the absence of a court order;

   B. Our procedures have been followed to authorize the service or care; and

   C. Our dental director determines, in advance, that the service or care is medically necessary and covered under the terms of this Certificate.

   This exclusion applies to special dental reports, including those not directly related to treatment, e.g., reports on certification examinations and reports prepared in connection with litigation.

6. **Criminal Behavior.** We will not provide coverage for any dental service or care related to the treatment of an accident or condition arising out of your participation in a felony. The felony will be determined by the law of the state where the criminal behavior occurred.

7. **Free Care.** We will not provide coverage for any service or care that is furnished to you without charge, or that would have been furnished to you without charge if you were not covered under this Certificate. This exclusion applies even if a charge for the service or care is billed. When service or care is furnished to you by your spouse, brother, sister, mother, father, son or daughter; or the spouse of any of them; we will presume that the service or care would have been furnished without charge. You must prove to us that a service or care would not have been furnished without charge.

8. **Grafting Procedures.** We will not provide coverage for grafting procedures.

9. **Implants.** We will not provide coverage for implants or services related to implants.

10. **Military Service-Connected Conditions.** We will not provide coverage for any service or care related to any military service-connected disability or condition, if the Veterans Administration (VA) has the responsibility to provide the service or care.

11. **No-Fault Automobile Insurance.** We will not provide coverage for any service or care for which benefits are available under mandatory no-fault automobile insurance, until you have used up all of the benefits of the mandatory no-fault policy. 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. We will provide benefits for services covered under this Certificate when you have exceeded the maximum benefits of the no-fault policy. Should you be denied benefits under the no-fault policy because it has a deductible, we will provide coverage for the services covered under this Certificate, up to the amount of the deductible. We will not provide benefits even if you bring a lawsuit against the person who caused your injury and even if you receive money from that lawsuit and you have repaid the medical expenses you received payment for under the mandatory automobile no-fault coverage.

12. **Non-Covered Service.** We will not provide coverage for any service or care that is not specifically described in this Certificate as a covered service; or that is related to service or care not covered under this Certificate; even when a Participating Provider considers the service or care to be medically necessary and appropriate.

13. **Oral Hygiene Programs.** We will not provide coverage for training or supplies used for: dietary counseling; tobacco counseling; oral hygiene; or plaque control programs.

14. **Procedures To Increase Vertical Dimension.** We will not provide coverage for procedures, restorations and appliances to increase vertical dimension or to restore occlusion.

15. **Replacement Of Prosthetic Devices.** We will not provide coverage for replacement of a lost, missing or stolen prosthetic device. We will not provide coverage for replacement of a prosthetic device for which benefits were provided under this Certificate unless the existing prosthetic was placed more than five years ago and cannot be made serviceable.

16. **Services Charged By Other Providers.** We will not provide coverage for services of Dentists if fees or charges therefore are claimed by hospitals, clinical laboratories or other institutions.

17. **Services Starting Before Coverage Begins.** If you are receiving care on the Effective Date of your coverage under this Certificate, we will not provide benefits for any service or care you receive:

    A. Prior to the Effective Date of your coverage under this Certificate; or

    B. That is continuing dental treatment (such as crowns, bridgework, or dentures, or root canal therapy) that began before the Effective Date of this Certificate and continues after the Effective Date until you have satisfied any applicable waiting period in Section Six.

18. **Special Charges.** We will not provide coverage for charges billed to you for telephone consultations, missed appointments, new patient processing, interest, copies of provider records, or completion of claim forms.

19. **Temporomandibular Joint.** We will not provide coverage for appliances, therapy, surgery or any services rendered for what we determine in our sole judgment is for the medical treatment of the temporomandibular joint.

20. **Unlicensed Provider.** We will not provide coverage for any service or care that is provided or prescribed by an unlicensed provider; or that is outside the scope of licensure of the duly-licensed provider rendering the service or care.

21. **Workers' Compensation.** We will not provide coverage for any service or care for which benefits are provided under a workers' compensation or similar law.

SECTION SIX - WAITING PERIODS

There are no waiting periods under this Certificate.

SECTION SEVEN - COORDINATION OF BENEFITS

This section applies only if you also have other group dental benefits coverage with another plan.

1. **When You Have Other Health Benefits.** It is not unusual to find yourself covered by two health insurance contracts, plans or policies ("plans") providing similar benefits both issued through or to groups. When that is the case and you receive an item of service that would be covered by both plans, we will coordinate benefit payments with any payment made under the other plan. One company will pay its full benefit as the primary plan. The other company will pay secondary benefits if necessary to cover all or some of your remaining expenses. This prevents duplicate payments and overpayments. The following are considered to be a health insurance plan:

   A. Any group or blanket insurance contract, plan or policy, including HMO and other prepaid group coverage, except that blanket school accident coverage or such coverage offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance contract, plan or policy;

   B. Any self-insured or noninsured plan, or any other plan arranged through any employer, trustee, union, employer organization, or employee benefit organization;

   C. Any Blue Cross, Blue Shield, or other service type group plan;

   D. Any coverage under governmental programs, or any coverage required or provided by any statute. However, Medicaid and any plan whose benefits are, by law, excess to those of any private insurance plan or other non-governmental plan shall not be considered health insurance policies; and

   E. Medical benefits coverage in group and individual mandatory automobile "no-fault" and traditional "fault" type contracts.

2. **Rules To Determine Payment.** In order to determine which plan is primary, certain rules have been established. The first of the rules listed below which applies shall determine which plan shall be primary:

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

   B. If you are covered under one plan as an employee, subscriber or member and you are only covered as a dependent under the other plan, the plan which covers you as an employee will be primary; or

   C. Subject to the provisions regarding separated or unmarried parents below, if you are covered as a child under both plans, the plan of the parent whose birthday (month and date) falls earlier in the year is primary. If both parents have the same birthday, the plan that covered the parent longer is primary. If the other plan does not have the rule described immediately above, but instead has a rule based on gender of a parent and, as a result, the plans do not agree on which shall be primary, then the father's plan will be primary.

      There are special rules for a child of separated or unmarried parents:

      (1) If the terms of a court decree specify which parent is responsible for the health care expenses of the child, and that parent's plan has actual knowledge of the court decree, then that parent's plan shall be primary.

(2) If no such court decree exists or if the plan of the parent designated under such a court decree as responsible for the child's health care expenses does not have actual knowledge of the court decree, benefits for the child are determined in the following order:

(a) First, the plan of the parent with custody of the child;

(b) Then, the plan of the spouse of the parent with custody of the child;

(c) Finally, the plan of the parent not having custody of the child.

D. If you are covered under one of the plans as an active employee, neither laid-off nor retired, or as the dependent of such an active employee, and you are covered as a laid-off or retired employee or a laid-off or retired employee's dependent under the other plan, the plan covering you as an active employee will be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the plans do not agree on which shall be primary, this rule shall be ignored.

E. If none of the above rules determine which plan shall be primary, then the plan that has covered you for the longest time will be primary.

3. **Payment Of The Benefit When This Plan Is Secondary.** When this plan is secondary, the benefits of this plan will be reduced so that the total benefits payable under the other plan and this plan do not exceed your expenses for an item of service. However, we will not pay more than we would have paid if we were primary.

   We count as actually paid by the primary plan any items of expense that would have been paid if you had made the proper and timely claim. We will request information from that plan so we can process your claims. If the primary plan does not respond within 30 days, we will assume its benefits are the same as ours. If the primary plan sends the information after 30 days, we will adjust our payment, if necessary.

   Although it is not a requirement of this section, when you have coverage under more than one health plan, you can help to maximize the benefits available to you by following the rules and protocols of both the primary and secondary plans.

4. **Right To Receive And Release Necessary Information.** We have the right to release or obtain information that we believe necessary to carry out the purpose of this section. We need not tell you or obtain anyone's consent to do this except as required by Article 25 of the New York General Business Law. We will not be legally responsible to you or anyone else for releasing or obtaining this information. You must furnish to us any information that we request. If you do not furnish the information to us, we have the right to deny payments.

5. **Payments To Others.** We may repay to any other person, insurance company or organization the amount which it paid for your covered services and which we decide we should have paid. These payments are the same as benefits paid.

6. **Our Right To Recover Overpayment.** In some cases we may have made payment even though you had coverage under another plan. Under these circumstances, it will be necessary for you to refund to us the amount by which we should have reduced the payment we made. We also have the right to recover the overpayment from the other health benefits plan if we have not already received payment from that other plan. You must sign any document that we deem necessary to help us recover any overpayment.

SECTION EIGHT - TERMINATION OF YOUR COVERAGE

Described below are the reasons why your coverage under this Certificate may terminate.

All terminations are effective on the date specified.

1. **Termination Of The Group Contract.** This Certificate is provided under the terms of the Group Contract between us and the group contract holder. The Group Contract is effective for one year and will automatically be renewed each year unless it is terminated as set forth below.

   A. The group contract holder terminates the Group Contract pursuant to its terms. In this case, your coverage will terminate on the date the group contract holder terminates;

   B. We do not receive premium payment from the group contract holder as of the date the premium was due. In this case, your coverage will end on the date to which the premium has been paid;

   C. The group contract holder has committed fraud or made an intentional misrepresentation of material fact under the terms of the Group Contract. In this case, your coverage will terminate 30 days from the date we provide notice to you;

   D. The group contract holder no longer qualifies as a group. We have certain administrative rules that describe our requirements for group contract holders. Our rules are consistent with New York State law and regulations governing health insurance. If you have a question about the rules that apply to your group contract holder, you may contact us and we will explain them to you.

      When your group contract holder no longer meets our requirements, we will notify you. Your coverage will terminate 30 days from the date we provide notice to you;

   E. The group contract holder fails to comply with a material plan provision relating to employer contribution or group participation rules, as permitted under section 4235 of the Insurance Law. In this case, your coverage will terminate 30 days from the date we provide notice to you;

   F. The group contract holder no longer has any enrollee living, residing or working in New York State. In this case, your coverage will terminate 30 days from the date we provide notice to you;

   G. Any reason approved by the New York State Superintendent of Insurance and authorized by the Health Insurance Portability and Accountability Act of 1996, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act. In this case, your coverage will terminate 30 days from the date we provide notice to you;

   H. If we terminate the entire class of contracts to which this Certificate belongs. In this case, your coverage will terminate 90 days from the date we provide notice to you; or

   I. If we withdraw from the applicable market through which you obtained coverage under this Certificate, and we cease offering any products in that market. In this case, your coverage will terminate six months from the date we provide notice to you.

2. **Termination Of Your Coverage Under This Certificate.** In the following instances, the Group Contract will continue in force, but your coverage under this Certificate will be terminated:

   A. You choose to terminate your coverage. You must give the group contract holder 30 days' written notice. Your coverage will terminate on the date to which your premium is paid;

B. You are no longer a member of the group. Your coverage will terminate on the date to which your premium is paid if you are no longer a member of the group;

C. You committed fraud in applying for coverage or in filing a claim under this Certificate. Your coverage will terminate 30 days from the date we provide notice to you;

D. Any reason approved by the Superintendent of Insurance. In this case, your coverage will terminate 30 days from the date we provide notice to you. A copy of the reason for the termination of your coverage will be provided to you upon request;

E. On your death or the death of the Subscriber. Your coverage under this Certificate will automatically terminate on the date after your death or the death of the Subscriber;

F. Termination of the Subscriber's marriage. If the Subscriber becomes divorced, or the Subscriber's marriage is annulled, coverage of the Subscriber's spouse under this Certificate will automatically terminate on the date of the divorce or annulment; or

G. Termination of coverage of a child. Coverage of a Subscriber's child under this Certificate will terminate on the date the child no longer qualifies as a dependent under Section Two of this Certificate or, if later, the next premium due date after we receive notice of termination.

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

Under New York State law, if you lose coverage because of termination of employment of membership in the class or classes eligible for coverage, you may continue coverage for yourself and your eligible dependents subject to the following conditions:

A. You are not entitled to Medicare; and you are not covered under or eligible for other group coverage that does not exclude or limit coverage for pre-existing conditions;

B. You must request continued coverage within 60 days after the later of: the date of termination; or the date you are given notice of continuation by the group. If you wish continuation under Subparagraph D. (4) below, you must notify the group within 60 days after a determination that you were disabled under the Social Security Act at the time of termination of employment or membership or within the first sixty days of continuation coverage;

C. You must pay the premium (not more frequently than monthly) when due. The first payment is due within 60 days after the later of the date coverage would otherwise terminate or the date you are given notice of continuation by the group. The premium cannot exceed 102% of the group's premium rate;

D. Coverage will terminate at the earliest of the following:

(1) The date 18 months after your coverage would have terminated because of termination of employment or membership;

(2) The date to which premiums are paid if you fail to make a timely payment;

(3) If you are an eligible dependent, the date 36 months after coverage would have terminated due to: death of the employee or member; divorce or legal separation, the employee or member's eligibility for Medicare; failure to qualify under the definition of “children”;

(4) The date 29 months after coverage would have otherwise terminated because of termination of employment or membership if the employee or member is determined to have been disabled under the Social Security Act at the time of termination of employment or membership or at any time during the first sixty days of continuation coverage. However, if the employee or member is no longer disabled, coverage will terminate at the later of the date in Subparagraph D. (1) above; or the month that begins more than 31 days after determination that the employee or member is no longer disabled; or

(5) The date the group no longer provides coverage to any of its employees or members.

SECTION NINE - GENERAL PROVISIONS

1. **No Assignment.** You cannot assign any benefits or monies due under the Group Contract or this Certificate to any person, corporation or other organization. Any assignment by you will be void. Assignment means the transfer to another person or to an organization of your right to the services provided under this Certificate or your right to collect money from us for those services.

2. **Notice.** Any notice that we give to you under this Certificate will be mailed to your address as it appears on our records or to the address of the group contract holder. If you have to give us any notice, it should be mailed to: 165 Court Street, Rochester, NY 14647.

3. **Your Dental Records.** In order to provide your coverage under this Certificate, it may be necessary for us to obtain your dental records and information from Dentists who treated you. Our actions to provide that coverage include processing your claims, reviewing grievances 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. When you become covered under this Certificate, you automatically give us permission to obtain and use those records for those purposes.

   We agree to maintain that information in accordance with state and federal confidentiality requirements. However, you automatically give us permission to share that 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.

4. **Who Receives Payment Under This Certificate.** Payments under this Certificate for service provided by a Participating Provider will be made directly by us to the provider. If you receive services from a Non-Participating Provider, we reserve the right to pay either you or the provider.

5. **Time To File Claims.** Claims for services under this Certificate must be submitted to us for payment within 12 months after you receive the services for which payment is being requested.

6. **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 twenty four months from the date you received the service for which you want us to pay.

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

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

9. **Recovery Of Overpayments.** On occasion a payment will be made when you are not covered, for a service which 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.

10. **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 owed to us. 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.

11. **Continuation Of Benefit Limitations.** Some of the benefits under this Certificate are limited to a specific number of services per Calendar Year or other time period. You will not be entitled to any additional benefits if your contract status should change during the Calendar Year or other time period. For example, if your coverage status changes from dependent to Subscriber, all benefits previously utilized when you were a dependent will be applied toward your new status as a Subscriber.

12. **Subrogation.** In the event that you suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident, and we pay benefits as a result of that injury or illness, we will be subrogated and succeed to the right of recovery against the party responsible for your illness or injury to the extent of the benefits we have paid.

    Duty to Cooperate with Us - Possible Penalties for Failure to Cooperate. Under certain circumstances, we are also entitled to be reimbursed for the benefits we have paid from a settlement or a judgment you receive from the party responsible for your illness or injury. This and other penalties which apply under certain circumstances are noted below. Those circumstances are:

    A. The settlement or judgment you receive from the party responsible for your illness or injury specifically identifies or allocates monetary sums directly attributable to expenses for which we have paid benefits; or

    B. You fail to cooperate with us in proceeding against the party responsible for your illness or injury to recover the benefits we have paid. We will pay all expenses associated with a legal action instituted on our initiative.

    The penalty for failing to cooperate under Subparagraph B above is that you will be responsible to repay to us the amount of the benefits we have paid. We agree to invoke Subparagraph B only when your illness or injury caused by a third party results in our expenditure on your behalf of an amount exceeding $500 under this coverage. In any of these provisions where we must give our prior written consent, we agree not to unreasonably withhold our prior consent and we agree to waive all penalties under these provisions if we do not give or withhold our prior consent within 30 days from the date you or your legal representative seeks prior consent in writing from us.

13. **Who May Change This Certificate.** The Certificate may not be modified; amended; or changed, except in writing, and signed by our Chief Operating Officer (COO) or a person designated by the COO. No employee; agent; or other person is authorized to interpret; amend; modify; or otherwise change the Certificate in a manner that expands or limits the scope of coverage; or the conditions of eligibility; enrollment; or participation, unless in writing and signed by the COO or person designated by the COO.

14. **Changes In This Certificate.** We may unilaterally change this Certificate upon the group's renewal, if we give the group contract holder 44 days' prior notice.

15. **Renewal Date.** The renewal date for the Certificate is January 1 of each year. This Certificate will automatically renew each year on the renewal date unless otherwise terminated by us or the group contract holder as permitted by the Certificate or by you upon 30 days' prior written notice to the group contract holder.

16. **Agreements Between The Plan 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 health benefits program.

17. **Material Accessibility.** We will give the group contract holder, and the group contract holder will give Members, identification cards, Certificates, Riders and other necessary materials.

18. **Refund.** We will give any refund of premiums, if due, to the group contract holder.

19. **Notice Of Claim.** Claims for services under this Certificate 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, social security number, and supporting dental records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information.

20. **Identification Cards.** Identification cards are issued by us for identification only. Possession of any identification card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits the Member's premiums must be paid in full at the time that the services are sought to be received. Coverage under this Certificate may be terminated by us if the Member allows another person to wrongfully use the identification cards.

21. **Right To Develop Guidelines And Administrative Rules.** We may develop or adopt standards that describe in more detail when we will make or will not make payments under this Certificate. If you have a question about the standards that apply to a particular benefit, you may contact us and we will explain the standards or send you a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this Certificate.

22. **Furnishing Information And Audit.** The group contract holder 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 information over the telephone for reasons like the following: to allow us to determine the level of care you need; or so that we may certify care authorized by your Dentist. The group contract holder 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 contract holder's New York office.

23. **Enrollment; ERISA.** The group contract holder further will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages and social security numbers of all group members covered under this Certificate, and any other information required to confirm their eligibility for coverage. The group contract holder will provide us with the enrollment form including your name, address, age, and social security number and to advise us in writing when you are to be added to or subtracted from our list of covered persons, on a monthly basis, on or before the same date of the month as the effective date the group's contract with us. If the group contract holder fails to so advise us, the group contract holder will be responsible for the cost of any claims paid by us as a result of such failure. In no event will retroactive additions to or deletions from coverage be made for periods in excess of 30 days.

    The group contract holder may also have additional responsibilities as the "plan administrator" as defined by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The "plan administrator" is the group contract holder, or a third party appointed by the group contract holder. We are not the ERISA plan administrator.

24. **Reports And Records.** We are entitled to receive from any provider of services to Members, information reasonably necessary to administer this Certificate subject to all applicable confidentiality requirements as defined in the General Provisions Section of this Certificate. By accepting coverage under this Certificate, the Member, for himself or herself, and for all covered dependents covered hereunder, authorizes each and every provider who renders services to a Member hereunder to:

    A. Disclose all facts pertaining to the care, treatment and physical condition of the Member to us or a medical, dental, or mental health 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;

    B. Render reports pertaining to the care, treatment and physical condition of the Member to us, or a medical, dental, or mental health professional, that we may engage to assist us in reviewing a treatment or claim; and

    C. Permit copying of the Member's records by us.

25. **Service Marks.** Excellus Health Plan, Inc., is an independent corporation organized under the Insurance Law of New York State. Excellus also operates under licenses with the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans, which licenses Excellus to use the Blue Cross and Blue Shield service marks in a portion of New York State. Excellus does not act as an agent of the Blue Cross and Blue Shield Association. Excellus is solely responsible for the obligations created under this agreement.

26. **Utilization Review.** We have developed a process to review rendered health services to determine whether the services were medically necessary. This review process is called Utilization Review. All services are subject to retrospective review to determine if they were medically necessary.

    A. **Retrospective Reviews.** If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and provide notice to you and your provider within 30 calendar days of receipt of the claim. If we need additional information, we will request it within 30 calendar days. You or your provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to you and your provider within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day time period. When we determine that a service is not medically necessary, the case will be referred to a clinical peer reviewer.

    B. **Notice of Adverse Determination.** A notice of adverse determination (notice that a service is not medically necessary) will include the reasons, including clinical rationale, for our determination. The notice will also advise you of your right to appeal our determination, give instructions for requesting an external appeal and for initiating an external appeal and specify that you may request a copy of the clinical review criteria used to make the determination. The notice will specify additional information, if any, needed for us to review an appeal. We will send notices of determination to you or your designee and to your health care provider.

    If, prior to making an adverse determination, no attempt was made to consult with the provider who recommended the service at issue, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. If the adverse determination is upheld, a notice of adverse determination will be given to the provider, by telephone and in writing.

C. **Internal Appeals of Adverse Determinations.** You, your designee and, in retrospective review cases, your health care provider, may request an internal appeal of an adverse determination, either by phone, in person 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 include the name, address and phone number of the person handling your appeal and, if necessary, inform you of any additional information needed before a decision can be made. A clinical peer reviewer who is in the same or similar specialty as the provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the appeal.

We will decide internal appeals related to retrospective reviews within 60 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you or your designee (and your health care provider if he or she requested the review) within two business days after the determination is made, but no later than 60 calendar days after receipt of the appeal request.

D. **Notice of Determination of Internal Appeal.** The notice of determination of your internal appeal will indicate that it is a "final adverse determination" and will include the clinical rationale for our decision. It will also explain your rights to an external appeal, together with a description of the external appeal process and the time frames for initiating an external appeal. We will send notices of determination to you or your designee and to your health care provider.

27. **External Appeal.**

A. **External Appeal in General.** You have the right to an "external appeal" of certain coverage determinations made by us. An external appeal is an independent review of a coverage determination by a third party known as an External Appeal Agent. External Appeal Agents are certified by the State, and may not have a prohibited affiliation with any health insurer, health maintenance organization (HMO), medical facility, or health care provider associated with the appeal. "Requested service" or "requested services" refers to the service or services for which you are requesting coverage.

You may request an external appeal only if the requested service is a covered service under this Certificate.

B. **Coverage Determinations Subject to External Appeal.** This subparagraph describes the general conditions for external appeal.

In general, you may not request an external appeal unless we have issued a "final adverse determination" of your request for coverage through the first level of the internal appeal process. You may ask us to agree to an external appeal even though you have not obtained a final adverse determination through the first level of the internal appeal process; however, we have no obligation to agree to your request. If we do agree, we will send you a letter stating that we have agreed to an external appeal even though you have not obtained a final adverse determination.

To be eligible for external appeal, the final adverse determination issued through the first level of the internal appeal process must be based on a determination that the requested service is not medically necessary. You do not have the right to an external appeal of any other determinations, even if those other determinations affect your coverage.

C. **Conditions for External Appeals of Determinations of Medical Necessity.** You may request an external appeal of a final adverse determination of medical necessity issued through the first level of the internal appeal process if you meet the conditions of this subparagraph and the general requirements of Subparagraph B above. The provisions of this subparagraph apply only to external appeal of medical necessity determinations.

To request external appeal under this subparagraph, the final adverse determination must indicate that the requested service is not medically necessary. Subparagraph E below provides information on requesting an external appeal.

D. **Effect of the External Appeal Agent's Decision; Coverage.** The decision of the External Appeal Agent is binding on both parties. If the External Appeal Agent decides in our favor, we will not cover the requested service. If the external appeal agent decides in your favor, we will treat the service as medically necessary and provide coverage subject to all other conditions of this Certificate.

We will not provide coverage for any service that is not a covered service under this Certificate. In addition, this subparagraph does not alter any cost-sharing responsibilities as otherwise provided for in this Certificate.

E. **Requesting an External Appeal.** If you meet the conditions described above, you may request an external appeal by filing a standard external appeal request form with the New York State Insurance Department. If the requested service has already been provided to you, your Dentist may file an appeal on your behalf. We will send a standard request form to you when we have made a final adverse determination at the first level of the internal appeal process. You or your Dentist may obtain additional standard request forms at any time from the State Insurance Department, the Department of Health, or by contacting us.

You must file your request for an external appeal with the State Insurance Department within 45 days of receiving a final adverse determination as a result of the first level appeal process, or within 45 days of receiving a letter from us waiving the internal review process. We do not have the authority to grant extensions of this deadline.

Additional internal appeals may be available to you which are optional. However, regardless of whether you participate in additional internal appeals, your application for external appeal must be filed with the New York State Department of Insurance within 45 days from your receipt of the notice of final adverse determination from a first level internal appeal in order to be eligible for review by an external appeal agent.

You may be charged a fee of up to $50 to request an external appeal, which may be waived if we determine that paying the fee is a financial hardship. The fee is returned if your external appeal is successful.

If you do not understand any part of the external appeal process or if you have questions regarding your right to external appeal, you may contact us, the State Insurance Department, or the Department of Health.

Excellus

DOMESTIC PARTNER RIDER FOR CALIFORNIA RESIDENTS

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider adds coverage for domestic partners to your Contract, Certificate or Group Health Plan, including any affected Riders thereto (hereinafter collectively "Health Plan"). All of the terms, conditions and limitations of the Health Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **California Residency Required.** This Rider only applies to residents of the State of California. You, the Subscriber, are only entitled to cover your domestic partner as described in this Rider if you reside in California.

2. **Who are Domestic Partners?** Domestic partners are two persons who are registered as domestic partners, which means they have filed a "Declaration of Domestic Partnership" with the California Secretary of State. You are eligible to register as domestic partners if you meet the following criteria: you are both 18 years of age or older; you are unrelated by blood in a way that would bar marriage in the State of California; you reside together; you are persons of the same sex, or one or both of you is over the age of 62; and neither of you is married to someone else or is in a domestic partnership with someone else.

3. **Domestic Partner Coverage.** Coverage of your, the Subscriber's, domestic partner will become effective and terminate according to the provisions in your Health Plan that apply to coverage of the Subscriber's spouse. All of the terms of your Health Plan that apply to a spouse will apply to your domestic partner, except that according to federal law, domestic partners are not eligible for continuation of coverage under COBRA.

4. **New Contract After Termination of Coverage May Not Contain the Benefits of this Rider.** The new contract to which you may be entitled if your coverage under your Health Plan ends may not include any of the benefits of this Rider.

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: Christopher C. Booth

Christopher C. Booth
President and Chief Executive Officer

Excellus

This is your

DENTAL IMPLANT RIDER

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider adds certain benefits for dental implants to your Dental Certificate of Coverage. All of the terms, conditions and limitations of the Certificate to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **Dental Implants (Class III).** We will provide coverage for dental implants to replace missing teeth, including: the implant; abutment; and crown (fixed or removeable). Coverage for anesthesia, routine pre and post operative procedures, impressions, sutures and suture removal are included in our Allowable Expense for dental implant surgical procedures; and we will not provide additional benefits for such services. We will only provide benefits for replacement of an implant when more than ten years have elapsed since the last placement.

2. **Predetermination Of Benefits.** We recommend a predetermination of benefits for implant services. A description of planned treatment and expected charges should be sent to us before treatment is started. If there is a major change in the treatment, a revised predetermination of benefits is required. The expenses that will be covered will be determined by us. When there has not been a predetermination of benefits, we will determine what services will be covered at the time the claim is received. Predetermination of benefits does not guarantee payment and expires one year after the date of issue. The estimate of benefits payable may change based on the benefits, if any, for which a Member qualifies at the time services are completed.

3. **Benefits.** Benefits are covered as set forth in the "Payments For Class III Services" provision in your Certificate.

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, New York 14647

By: Christopher C. Booth

Christopher C. Booth
President and Chief Executive Officer

Excellus

DENTAL BLUE OPTIONS ALLOWABLE EXPENSE RIDER

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider changes the Allowable Expense definition in your dental Certificate of Coverage. All of the terms, conditions and limitations of the Certificate to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

Allowable Expense. Under this Rider, the subparagraph entitled "Allowable Expense" in the Introduction and Definitions Section of your Certificate is hereby deleted in its entirety and replaced with the following:

Allowable Expense. "Allowable Expense" means the maximum amount we will pay to a Dentist for the services or supplies covered under this Certificate, before any applicable Deductible and Coinsurance amounts are subtracted. We determine our Allowable Expense as follows:

We assign a fee schedule amount to dental services or procedures based upon our review of market factors such as consumer demand, consumer price sensitivity, and competitive price point in the geographic location. In the absence of a set fee schedule amount, we will determine the Allowable Expense amount taking into consideration the type of covered service and the average fee schedule amount for similar covered services.

When used in this Rider, the term "Network Area" includes the following counties: Monroe; Wayne; Livingston; Seneca; Yates; Ontario; Steuben; Schuyler; Chemung; Tioga; Tompkins; Cortland; Broome; Cayuga; Onondaga; Oswego; Chenango; Madison; Delaware; Otsego; Herkimer; Montgomery; Fulton; Oneida; Lewis; Hamilton; Essex; Clinton; Franklin; St. Lawrence; and Jefferson.

The Allowable Expense for covered services performed by Participating and Non-Participating Providers will be the lower of: the amount listed on our fee schedule; or the Dentist's charge.

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, New York 14647

By: Christopher C. Booth

Christopher C. Booth
President and Chief Executive Officer

Excellus

RIDER FOR DEPENDENT CHILD COVERAGE

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider adds certain benefits for dependent children to your Certificate of Coverage. All of the terms, conditions and limitations of the Certificate to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **Covered Dependent Children.** If you selected other than individual coverage, the following members of your family may also be covered: your unmarried children who are under 26 years of age and who are chiefly dependent on you for support. Coverage continued until the end of the month in which the dependent no longer qualifies.

2. **New Contract After Termination Of Coverage May Not Contain The Benefits Of This Rider.** The new contract to which you may be entitled if your coverage under your Certificate ends may not include any of the benefits of this Rider.

EXCELLUS HEALTH PLAN, INC.
doing business as

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165 Court Street
Rochester, New York 14647

By: Christopher C. Booth

Christopher C. Booth
President and Chief Executive Officer

Excellus

RIDER FOR DOMESTIC PARTNER COVERAGE

Issued by

EXCELLUS HEALTH PLAN, INC.
A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider adds certain benefits for domestic partners to your Certificate of Coverage. All of the terms, conditions and limitations of the Certificate to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **Domestic Partners.** A Domestic Partner, as defined below, will be considered an eligible dependent for coverage under your Certificate. We will not cover more than one domestic partner for each Member at any one time. Your domestic partner must be 18 years of age or older, unmarried and unrelated by marriage or blood in a way that would bar marriage. You must reside together in a committed relationship and have been each others sole domestic partner for six months. In order to prove the existence of a domestic partnership for purposes of determining eligibility for coverage, all of the following criteria must be met:

   A. **Economic Interdependence.** The partners must be economically interdependent upon each other. This may be proven by:

      (1) Registration as the Members domestic partner, if living in a city or county providing for registration as domestic partners, and provision of a copy of the appropriate certificate to the group contract holder; or

      (2) Submission to the group contract holder of a signed affidavit, in a form acceptable to us, confirming an existing and established relationship of intended future duration that involves economic interdependency.

   B. **Proof of Cohabitation.** The partners must prove that they are cohabitating. Cohabitation may be proven by presenting documentation, such as drivers licenses or tax returns, demonstrating that the partners are living together.

   C. **Other Indicia.** At least two other indicia of a domestic partnership must be provided:

      (1) A joint bank account.

      (2) A joint credit or charge card.

      (3) A joint obligation on a loan.

      (4) Status as authorized signatory on the partners bank account, credit card or charge card.

      (5) Joint ownership or holding of investments.

      (6) Joint ownership of residence.

      (7) Joint ownership of real estate other than residence.

      (8) Listing of both partners as tenants on the lease of the shared residence.

(9) Shared rental payments of residence (need not be shared 50/50).

(10) Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence.

(11) A common household and shared household expenses (e.g., grocery bills, utility bills, telephone bills), which need not be shared 50/50.

(12) Shared household budget for purposes of receiving government benefits.

(13) Status of one as representative payee for the others government benefits.

(14) Joint ownership of major items of personal property (e.g., appliances, furniture).

(15) Joint ownership of a motor vehicle.

(16) Joint responsibility for child-care (e.g., school documents, guardianship).

(17) Shared child-care expenses (e.g., baby-sitting, day care, school bills), which need not be shared 50/50.

(18) Execution of wills naming each other as executor or beneficiary.

(19) Designation as beneficiary under the others retirement benefits account.

(20) Mutual grant of durable power of attorney.

(21) Affidavit by creditor or other individual able to testify to partners financial interdependence.

(22) Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

D. **When Coverage of a Domestic Partner Becomes Effective.** If you have two-person or family coverage and we have determined in our sole judgment that a domestic partnership exists, your domestic partner will be covered under your Certificate as of the signed affidavit date as long as you notify us within 30 days of the signed affidavit date. If we do not receive notice of the domestic partnership within the 30-day period, your domestic partner must wait until the next open enrollment period for coverage. When your domestic partner is enrolled during the next open enrollment period, coverage for your domestic partner will start at 12:01 a.m. on the date to which the open enrollment period applies.

If you have single coverage and you enter into a domestic partnership, coverage of your new dependent(s) will be effective as of the signed affidavit date as long as you notify us within 30 days of the signed affidavit date and we have received the completed change of coverage form. If we do not receive notice of the domestic partnership within the 30-day period and have received a completed change of coverage form, your new dependent(s) must wait until the next open enrollment period for coverage. When your new dependent(s) are enrolled during the next open enrollment period, coverage will start at 12:01 a.m. on the date to which the open enrollment period applies.

E. **Notification Of Change In Your Coverage.** If the domestic partnership terminates, you must notify the group contract holder of the change in your status in order to change your coverage to two-person or individual coverage. We will provide you with a form for that purpose. If such change results in your seeking a different type of coverage at a lower premium (such as a switch to individual coverage), the form and requested documentation must be returned within 30 days of the event in order for the change in premium to be effective on the date of the event. If you do not return a completed form and any requested documentation within 30 days of the event, the change in premium will be effective as of the next premium due date after they are received. Nothing in this Subparagraph

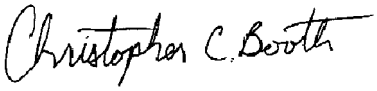
E is designed to affect the provisions of your Certificate governing terminations of coverage. This Subparagraph E only involves the effective date of changes in premiums due to terminations of domestic partner coverage.

If you think there are reasons coverage of the person experiencing the change should continue, you must notify us of the reasons for the continuation of coverage, on a form provided by us to you for that purpose, together with any requested documentation, no later than 60 days after the date the coverage would usually terminate.

2. **New Contract After Termination Of Coverage May Not Contain The Benefits Of This Rider.** The new contract to which you may be entitled if your coverage under your Certificate ends may not include any of the benefits of this Rider.

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, New York 14647

By: 

Christopher C. Booth
President and Chief Executive Officer

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please refer to the enclosed document for ways to reach us.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 1-315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Attention: If you speak English free language help is available to you. Please refer to the enclosed document for ways to reach us.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.

注意：如果您说中文，我们可为您提供免费的语言协助。
请参见随附的文件以获取我们的联系方式。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. В приложенном документе содержится информация о том, как ими воспользоваться.

Atansyon: Si ou pale Kreyòl Ayisyen gen èd gratis nan lang ki disponib pou ou. Tanpri gade dokiman ki nan anvlòp la pou jwenn fason pou kontakte nou.

주목해 주세요: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. 연락 방법은 동봉된 문서를 참조하시기 바랍니다.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Per sapere come ottenerla, consultate il documento allegato.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך ביטע רעפערירט צום בייגעלייגטן דאקומענט צו זען אופנים זיך צו פארבינדן מיט אונז.

নজর দিন: যদি আপনি বাংলা ভাষায় কথা বলেন তাহলে আপনার জন্য সহায়তা উপলভ্য রয়েছে। আমাদের সঙ্গে যোগাযোগ করার জন্য অনুগ্রহ করে সংযুক্ত নথি পড়ুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Patrz załączony dokument w celu uzyskania informacji na temat sposobów kontaktu z nami.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. يرجى الرجوع إلى الوثيقة المرفقة لمعرفة كيفية الوصول إلينا.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Consultez le document ci-joint pour savoir comment nous joindre.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے زبان کی مفت مدد دستیاب ہے۔ ہم سے رابطہ کرنے کے طریقوں کے لیے منسلک دستاویز ملاحظہ کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may maaari kang kuning libreng tulong sa wika. Mangyaring sumangguni sa nakalakip na dokumento para sa mga paraan ng pakikipag-ugnayan sa amin.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Δείτε το έγγραφο που εσωκλείεται για πληροφορίες σχετικά με τους διαθέσιμους τρόπους επικοινωνίας μαζί μας.

Kujdes: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Drejtojuni dokumentit bashkëlidhur për mënyra se si të na kontaktoni.

B-5495

THE NEW YORK CONSUMER GUIDE TO HEALTH INSURERS

The New York Consumer Guide to Health Insurers
evaluates the performance of HMOs and other insurers.

TO OBTAIN YOUR FREE COPY, WRITE TO:

New York State Department of Financial Services
Publications Unit
Agency Building One, 5th Floor
Albany, New York 12257

Or e-mail your request to:
Publicat@dfs.ny.gov

Guides are also available through the
New York State Department of Financial Service's Website:
www.dfs.ny.gov

Please send a copy of the current *New York Consumer Guide to Health Insurers* to:

NAME: _____

ADDRESS: _____

CITY/STATE: _____

ZIP CODE: _____

165 Court Street
Rochester, New York 14647

A nonprofit independent licensee of the BlueCross BlueShield Association

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

This notice takes effect April 14, 2003.

OUR COMMITMENT TO YOUR PRIVACY

We understand that medical information about you and your health is personal. We are committed to safeguarding your protected health information (PHI).

PHI is any information that can identify you as an individual and your past, present or future physical or mental health condition.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. The law requires us to:

- make sure that PHI that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to PHI about you; and
- follow the terms of the notice that is currently in effect.

OUR LEGAL DUTY

We **(Excellus BlueCross BlueShield)** are required by applicable federal and state laws to maintain the privacy of your PHI. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning PHI. We must follow the privacy practices that are described in this notice while it is in effect, including notification should there be a breach of your unsecured PHI.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to our health plan subscribers at the time of the change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the contact information at the end of this notice.

Uses and Disclosures of Nonpublic Personal Information

Nonpublic Personal Information is information you give us on your enrollment form, claim forms, premium payments etc. For example: names, member identification number, social security number, addresses, type of health care benefits, payment amounts, etc.

We will not give out your nonpublic personal information to anyone unless we are permitted to do so by law or have received a signed authorization form from the member. You may revoke this authorization in writing by completing an authorization cancellation form at any time. This revocation will not affect any actions we took in reliance on your authorization before your authorization cancellation form was processed.

Uses and Disclosures of Medical Information

The following categories describe different purposes for which we use and disclose PHI. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. If we need to use or disclose your PHI in any other way, we will obtain your signed authorization before our use or disclosure. You may revoke this authorization in writing by completing an authorization cancellation form at any time. This revocation will not affect any actions we took in reliance on your authorization before your authorization cancellation form was processed.

Treatment: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may disclose PHI to doctors or hospitals involved in your care. For example, we may disclose your medications to an emergency room physician so that he/she can avoid dangerous drug interactions. This allows providers to manage, coordinate and administer treatment.

Payment: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may use and disclose PHI to collect premiums, to determine our responsibility to pay claims or to notify members and providers of our claim determinations. We may disclose PHI to providers to assist them in their billing and collection efforts. We may also disclose PHI to other insurance companies to coordinate the reimbursement of health insurance benefits. For example, we may disclose PHI to an automobile no-fault insurance company to determine responsibility for claim payment. Also, if you have health insurance through another insurance company, we may disclose PHI to that other health insurance company in order to determine which company holds the responsibility for your claims.

Healthcare Operations: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may use and disclose PHI for purposes of performing our healthcare operations. Our healthcare operations include using PHI to determine premiums, to conduct quality assessment and improvement activities, to engage in care coordination or case management, to determine eligibility for benefits. For example, we may use or disclose PHI when working with accreditation agencies that monitor and evaluate the quality of our benefit programs.

To You: We must disclose your PHI to you, as described in the Individual Rights section of this notice, below. We may also use and disclose PHI to tell you about recommended possible treatment options or alternatives or to tell you about health related benefits or services that may be of interest to you.

To Family and Friends: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** If you agree or, if you are unable to agree when the situation, (such as medical emergency or disaster relief), indicates that disclosure would be in your best interest, we may disclose PHI to a family member, friend or other person. In an emergency situation, we will only disclose the minimum amount necessary.

To Our Business Associates: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** A business associate is defined as someone that assists us in managing our business. For example, a professional that reviews the quality of our products and services. We may disclose PHI to another company that helps us manage our business. For example, we may disclose PHI to a company that performs case reviews to ensure our members receive quality care. These business associates are required to sign a confidentiality agreement with us that limits their use or disclosure of the PHI they receive.

To Plan Sponsors: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** A plan sponsor is defined as the employer or employee organization that establishes and maintains the employee's benefit plan. If you are enrolled in a group health plan, we may disclose PHI to the plan sponsor to permit the plan sponsor to perform plan administrative functions. For example, the cost analysis of the benefit program. Before PHI is disclosed to your plan sponsor, we will receive certification from the plan sponsor that appropriate amendments have been made to group health plan document(s) and the plan sponsor agrees to limit their use or disclosure of this information to plan administration functions only.

Research: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** We may use or disclose PHI for research purposes in limited circumstances. For example, a research project may involve comparing the health and recovery of all members who received one medication to those who received another medication for the same condition. All research projects are required to obtain special approval.

Coroners, Medical Examiners and Funeral Directors: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** We may release PHI to a coroner or medical examiner, to identify a deceased person or determine the cause of death. We may also release PHI about deceased members to funeral directors in order for the funeral directors to carry out their duties.

Organ Donation: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** If you are an organ donor, we may release PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, to facilitate organ or tissue donation and transplantation. This may include a living donor as well as a deceased donor.

Public Health and Safety: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** We may disclose PHI to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose PHI to a government agency authorized to oversee the healthcare system or government programs or its contractors, and to public health authorities for public health purposes.

Victims of Abuse, Neglect or Domestic Violence: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** We may disclose PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

Required by Law: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** We may use or disclose PHI when we are required to do so by law. For example, we must disclose PHI to the U.S. Department of Health and Human Services upon request to determine whether we are in compliance with federal privacy laws.

Process and Proceedings: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** We may disclose PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may disclose PHI to law enforcement officials.

Law Enforcement: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** We may disclose PHI to a law enforcement official investigating a suspect, fugitive, material witness, crime victim or missing person. We may disclose PHI of an inmate or other person in lawful custody of a law enforcement official or correctional institution under certain circumstances.

Military and National Security: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** We may disclose to the military, PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials medical information required for lawful intelligence, counterintelligence, and other national security activities.

Marketing and Fundraising: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** To the extent we use PHI for marketing or fundraising purposes, you will be contacted by us and have the right to opt out of receiving these communications from us and our use of your information for such purposes.

Genetic Nondiscrimination Act (GINA): **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** We will not disclose your PHI containing genetic information for underwriting purposes. GINA expressly prohibits the use or disclosure of genetic information for these purposes.

Breach of Unsecured Information: **We will notify you should there be a breach of unsecured information.** We are required to notify you if there is any acquisition, access, use, or disclosure of your unsecured PHI that compromises the security or privacy of your PHI.

Psychotherapy Information: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** Should it be applicable that your psychotherapy notes be included in an appropriate use or disclosure of information, in most instances, we are required to obtain your authorization for the release of this information.

Individual Rights

Access: You have the right to inspect and/or copy your PHI, with limited exceptions such as information a licensed health care professional, exercising professional judgment, determines that providing access is reasonably likely to endanger the life, physical safety or cause someone substantial harm. You may contact us using the telephone number on the back of your identification card to obtain a form to be completed and returned to us. If you request copies, we reserve the right to charge you a reasonable fee for each copy, plus postage if the copies are mailed to you.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your PHI. The list will not include disclosures we made for the purpose of treatment, payment, healthcare operations, disclosures made with your authorization, or certain other disclosures. To request a disclosure accounting you may contact us using the telephone number on the back of your identification card to obtain a form to be completed and returned to us. The request may not exceed a six year time period. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your PHI, a description of the PHI we disclosed and the reason for the disclosure. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. As permitted by law, we will not honor these requests, as it prohibits us from administering your benefits.

Confidential Communication: You have the right to request that we communicate with you confidentially about your PHI. We will honor a request to communicate to an alternative location if you believe you would be endangered if we do not communicate to the alternative location. We must accommodate your request if it is reasonable and specifies the alternative location. To request a form to be completed and returned to us, you may contact us using the telephone number on the back of your identification card.

Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or if we determine the information is accurate. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be attached to the information you wanted amended. You may contact us using the telephone number on the back of your identification card to obtain a form to be completed and returned to us.

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the contact information at the end of this notice to obtain this notice in written form.

Safeguards

It is our policy to keep all information about you confidential in all settings. It is so important to us that we take the following steps:

- our employees sign an agreement to follow our Code of Business Conduct;
- our employees are required to complete our privacy training program;
- we have implemented the necessary sanctions for violation of our privacy practices;
- we have a privacy oversight committee that reviews our privacy practices;
- we have a security coordinator to detect and prevent security breaches;
- all computer systems that contain personal information have security protections; and
- we randomly check provider offices on a routine basis to ensure that medical records are kept in secure locations.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the contact information at the end of this notice.

If you are concerned that we may have violated your privacy rights, as described above, or you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI or to have us confidentially communicate with you at an alternative location, you may complain to us using the contact information at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Rights or Questions:

Contact Office: Customer Care

Phone: Please call the telephone number on your identification card.

Privacy Complaints:

Contact Office: Privacy Officer

Address: 333 Butternut Dr.
Dewitt, NY 13214-1803

Phone: 1-866-584-2313

E-mail: privacy.officer@excellus.com

Excellus

165 Court Street, Rochester, New York 14647