BENEFIT PLAN

Prepared for
Outten & Golden, LLP

DMO

What Your Plan Covers and How Benefits are Paid

Aetna Life Insurance Company
Certificate of Coverage

This Certificate of Coverage is part of the Group Policy between **Aetna** Life Insurance Company and the Policyholder

Prepared for:

Policyholder:	Outten & Golden, LLP
Policyholder number:	GP-0149284-A
Certificate:	1
Group policy effective date:	January 1, 2020
Plan name:	DMO
Plan effective date:	January 1, 2020
Plan issue date:	November 10, 2021
Plan revision effective date:	January 1, 2022

This is your

MANAGED DENTAL
CERTIFICATE OF COVERAGE

Issued by

Aetna Life Insurance Company

This Certificate of Coverage ("Certificate") explains the benefits available to You under a Group Contract between Aetna Life Insurance Company (hereinafter referred to as "We", "Us", or "Our") and the Group listed in the Group Policy. This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

In-Network Benefits. This Certificate only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers. Care Covered under this Certificate must be provided, arranged or authorized in advance by Your Primary Care Dentist and, when required, approved by Us. In order to receive the benefits under this Certificate, You must contact Your Primary Care Dentist before You obtain the services except for Emergency Dental Care described in the Dental Care and Covered Services provisions in the Schedule of Benefits section of this Certificate.

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

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

The insurance evidenced by this Certificate provides DENTAL insurance ONLY.

We are here to answer your questions. You can contact us by:

- Logging onto your secure member website at www.aetna.com
- Registering for our secure Internet access to reliable dental information, tools and resources

Online tools will make it easier for you to make informed decisions about your dental care, view claims, research care and treatment options, and access information.

You can also contact us by:

- Calling **Aetna** Member Services at 1-877-238-6200
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156

Your member ID card
You don't need to show an ID card. When visiting a **dentist**, just provide your name, date of birth and either your member ID or social security number. The dental office can use that information to verify your eligibility and benefits. Your member ID is located on the front of your digital ID card which you can view or print by going to the secure member website at www.aetna.com. If you don't have internet access, call us at 1-877-238-6200. You can also access your ID card when you're on the go. To learn more, visit us at www.aetna.com/mobile.

Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Edward C. Lee
Vice President and Corporate Secretary

TABLE OF CONTENTS

SECTION I

Definitions

Defined terms will appear capitalized throughout the Certificate.

Acute: The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

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

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

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

Calendar year: A period of 12 months beginning on January 1st and ending on December 31st.

Certificate: This Certificate issued by Aetna Life Insurance Company, including the Schedule of Benefits and any attached riders. The Certificate explains the benefits available to You under the Group Policy.

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

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

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

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

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

Dependents: The Subscriber's Spouse and Children.

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

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

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

General Dentist: A dentist licensed under Title 8 of the New York State Education Law (or other comparable state law, if applicable) who is not a Specialist.

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

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

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

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

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

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

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

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

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

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

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

Participating Provider: A Provider who has a contract with Us to provide health care services to You. A list of Participating Providers and their locations is available on Our website www.aetna.com or upon Your request to Us. The list will be revised from time to time by Us.

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

Plan Year: A calendar year ending on December 31 of each year.

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

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

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

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCD to a Specialist) in order to arrange for additional care for a Member**.**

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

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of: all counties within New York State.

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

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

Subscriber: The person to whom this Certificate is issued.

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

Us, We, Our: Aetna Life Insurance Company and anyone to whom We legally delegate performance, on Our behalf, under this Certificate.

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

You, Your: The Member.

SECTION II

How your coverage works

A. Your Coverage under this Certificate.

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

B. Covered Services.

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

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

C. Participating Providers.

To find out if a Provider is a Participating Provider:

- Check Our Provider directory, available at Your request;
- Call 1-877-238-6200; or
- Visit Our website at www.aetna.com

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

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

You will not have to submit claims for treatment received from network **providers**. Your network **provider** will take care of that for you. And we will directly pay the network **provider** for what the plan owes.

E. The Role of Primary Care Dentists.
This Certificate has; a gatekeeper, usually known as a Primary Care Dentist ("PCD"). This Certificate requires that You select a Primary Care Dentist ("PCD").

You may select any participating PCD who is available from the list of PCDs in the Network. Each Member may select a different PCD. Children covered under this Certificate may designate a participating PCD who specializes in pediatric care. In certain circumstances, You may designate a Specialist as Your PCD. See the Access to Care and Transitional Care section of this Certificate for more information about designating a Specialist. To select a PCD, visit Our website at www.aetna.com. If You do not select a PCD, We will assign one to You.

F. Services Not Requiring Referral from Your PCD.
Your PCD is responsible for determining the most appropriate treatment for Your dental care needs.

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

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

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

H. Out-of-Network Services.
We Cover the services of Non-Participating Providers. The services of Non-Participating Providers inside Our Service Area are not Covered except for Emergency Dental Care or unless specifically Covered in this Certificate. See the Schedule of Benefits section of this Certificate for the Non-Participating Provider services that are Covered. We Cover the services of Non-Participating Providers for Emergency Dental Care only.

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

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

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

We may base Our decision on a review of:

- Your dental records
- Our dental policies and clinical guidelines;
- Dental opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed dental literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of health care professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided
- They are provided in accordance with generally accepted standards of dental practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;

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

L. Important Telephone Numbers and Addresses.

- CLAIMS
  Aetna
  P.O. Box 14094
  Lexington, KY 40512-4094; Refer to the address on Your ID card
  (Submit claim forms to this address.)

- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
  1-800-558-0860; Call the number on Your ID card

- MEMBER SERVICES
  1-877-238-6200; Call the number on Your ID card
  (Member Services Representatives are available Monday – Friday 8:00 a.m. – 6:00 p.m.)

- OUR WEBSITE
  www.aetna.com

SECTION III

Access to Care and Transitional Care

A. Referral to a Non-Participating Provider.

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

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

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

C. Standing Referral to a Participating Specialist.

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

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

In order for You to continue to receive Covered Services for up to 90 days, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to Our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals; authorization, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

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

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

SECTION IV

Cost-Sharing Expenses and Allowed Amount

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

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

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

The Allowed Amount for Participating Providers will be the amount we have negotiated with the Participating Provider.

Services paid under your medical plan

- Your plan will not pay for amounts that were paid for the same services under a medical plan covering you. When a dental service is covered under both plans, we will figure the amount that would be payable under this plan if you did not have other coverage, then subtract what was paid by your medical plan. If there is any difference, this plan will pay it. If the amount paid by your medical plan is equal to or more than the benefit under this plan, this plan will not pay anything for the service.

SECTION V

Who Is Covered

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

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

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

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

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

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

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

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

Coverage shall continue for a Child who is a full-time student when the Child takes a medical leave of absence from school due to illness for a period of 12 months from the last day of attendance in school. However, coverage of the Child is not provided beyond the age at which coverage would otherwise terminate. To qualify for such coverage, We may require that the leave be certified as Medically Necessary by the Child's Physician who is licensed to practice in the state of New York.

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

D. When Coverage Begins.

Coverage under this Certificate will begin as follows:

1. If You, the Subscriber, elect coverage before becoming eligible, or within 31 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your Group.

2. If You, the Subscriber, do not elect coverage upon becoming eligible or within 31 days of becoming eligible for other than a special enrollment period, You must wait until the Group's next open enrollment period to enroll, except as provided below.

3. If You, the Subscriber, marry while covered, and We receive notice of such marriage and Premium payment within 31 days thereafter, coverage for Your Spouse and Child starts on the first day of the following month after We receive Your application. If We do not receive notice within 31 days of the marriage, You must wait until the Group's next open enrollment period to add Your Spouse or Child.

4. If You, the Subscriber, have a newborn or adopted newborn Child and We receive notice of such birth within 31 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise, coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 31 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. If You have individual or individual and Spouse coverage, You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within 31 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice, provided that You pay any additional Premium when due.

E. Special Enrollment Periods.
You, Your Spouse or Child can also enroll for coverage within 31 days of the loss of coverage in another group dental plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other group dental plan due to:

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

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

We must receive notice and Premium payment within 60 days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application. If You gain a Dependent or become a Dependent due to a birth, adoption, or placement for adoption, Your coverage will begin on the date of the birth, adoption or placement for adoption.

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

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

We must receive notice and Premium payment within 60 days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application.

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

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists; or
2. For partners residing where registration does not exist, by:
   a. An alternative affidavit of domestic partnership. The affidavit must be notarized and must contain the following:
      - The partners are both 18 years of age or older and are mentally competent to consent to contract;
      - The partners are not related by blood in a manner that would bar marriage under the laws of the State of New York;
      - The partners have been living together on a continuous basis prior to the date of the application; and
      - Neither individual has been registered as a member of another domestic partnership within the last six (6) months
   b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
   c. Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
      - A joint bank account;
      - A joint credit card or charge card;
      - Joint obligation on a loan;
      - Status as an authorized signatory on the partner's bank account, credit card or charge card;
      - Joint ownership of holdings or investments;
      - Joint ownership of residence;
      - Joint ownership of real estate other than residence;
      - Listing of both partners as tenants on the lease of the shared residence;
      - Shared rental payments of residence (need not be shared 50/50);
      - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
      - A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
      - Shared household budget for purposes of receiving government benefits;
      - Status of one (1) as representative payee for the other's government benefits;
      - Joint ownership of major items of personal property (e.g., appliances, furniture);
      - Joint ownership of a motor vehicle;
      - Joint responsibility for child care (e.g., school documents, guardianship);

- Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
- Execution of wills naming each other as executor and/or beneficiary;
- Designation as beneficiary under the other's life insurance policy;
- Designation as beneficiary under the other's retirement benefits account;
- Mutual grant of durable power of attorney;
- Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
- Affidavit by creditor or other individual able to testify to partners' financial interdependence; or
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

SECTION VI

Dental Care

***

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

We Cover the following dental care services:

Covered dental services for Fixed Copayment Plans

In-network coverage

This listing of Covered Services applies to **covered services** provided by **primary care dentists** (**PCDs**) and other **in-network providers** upon **referral** from your **PCD**. The plan covers only the **covered services** listed below.

Primary Care Services	Limitations
Periodic oral evaluation - established patient	4 visits per year for all oral evaluations combined
Limited oral evaluation - problem focused	
Oral evaluation for a patient under 3 years of age and counseling with primary caregiver	
Comprehensive oral evaluation – new or established patient	
Detailed and extensive oral evaluation – problem focused, by report	
Re-evaluation - limited, problem focused	
Comprehensive periodontal evaluation - new or established patient	
Intraoral - complete series of radiographic images	1 set every 3 years
Intraoral - periapical image- first radiographic image	
Intraoral- periapical each additional radiographic image	
Intraoral - occlusal radiographic image	
Extra-oral image- first radiographic image	
Extra-oral posterior dental radiographic image	
Bitewing - single radiographic image	1 set every year
Bitewings - 2 radiographic images	
Bitewings - 3 radiographic images	
Bitewings - 4 radiographic images	

Vertical bitewings - 7 to 8 radiographic images	1 set every 3 years
Panoramic radiographic image	Frequency combined with Intraoral
Interpretation of diagnostic image by practitioner not associated with capture of the image, including report	
Diagnostic casts	
Accession of tissue, gross examination, preparation and transmission of written report	
Accession of tissue, gross and microscopic examination, preparation and transmission of written report	
Accession of tissue, gross and microscopic exam, including assessment of surgical margins for presence of disease, preparation & transmission of written report	
Panoramic radiographic image - image capture only	
Extra-oral posterior dental radiographic image - image capture only	
Intraoral - occlusal radiographic image - image capture only	
Intraoral - periapical radio graphic image - image capture only	
Intraoral - bitewing radiographic image - image capture only	
Intraoral - complete series of radiographic images - image capture only	
Prophylaxis – adult	2 visits per year
Prophylaxis – child	2 visits per year
Topical application of fluoride varnish if you are under age 16	1 treatment per year
Topical application of fluoride- excluding varnish if you are under age 16	
Oral hygiene instruction	
Sealant - per tooth, if you are under age 16	1 application every 3 years for permanent molars
Preventive resin restoration in a moderate to high risk caries patient – permanent tooth if you are under age 16	1 application every 3 years for permanent molars
Sealant repair - per tooth, if you are under age 16	For permanent bicuspids and molars combined frequency for all sealants
Caries arresting medicament application if you are under age 16 – per tooth	1 application every 3 years for permanent molars
Caries preventive medicament application - per tooth	

Space maintainer - fixed - unilateral - per quadrant	Only when needed to preserve space resulting from premature loss of deciduous teeth; includes all adjustments within 6 months after installation
Space maintainer - fixed - bilateral - per quadrant	Only when needed to preserve space resulting from premature loss of deciduous teeth; includes all adjustments within 6 months after installation
Mandibular	
Maxillary	
Space maintainer - removable - unilateral - per quadrant	Only when needed to preserve space resulting from premature loss of deciduous teeth; includes all adjustments within 6 months after installation
Space maintainer - removable - bilateral - per quadrant	Only when needed to preserve space resulting from premature loss of deciduous teeth; includes all adjustments within 6 months after installation
Mandibular	
Maxillary	
Re-cement or re-bond space maintainer - maxillary	
Re-cement or re-bond space maintainer - mandibular	
Removal of fixed unilateral space maintainer - per quadrant	
Removal of fixed bilateral space maintainer - maxillary	
Removal of fixed bilateral space maintainer - mandibular	
Distal shoe space maintainer– fixed – unilateral, per quadrant	
Amalgam – 1 surface, primary or permanent	
Amalgam – 2 surfaces, primary or permanent	
Amalgam – 3 surfaces, primary or permanent	
Amalgam – 4+ surfaces, primary or permanent	
Resin-based composite – 1 surface, anterior	
Resin-based composite – 2 surfaces, anterior	
Resin-based composite – 3 surfaces, anterior	
Resin-based composite – 4+ surfaces or involving incisal angle, anterior	

Resin-based composite crown, anterior	
Resin-based composite – 1 surface, posterior	
Resin-based composite – 2 surfaces, posterior	
Resin-based composite – 3 surfaces, posterior	
Resin-based composite – 4+ surfaces, posterior	
Inlay – metallic - 1 surface	
Inlay – metallic - 2 surfaces	
Inlay – metallic - 3 or more surfaces	
Onlay – metallic - 2 surfaces	
Onlay – metallic - 3 surfaces	
Onlay - metallic – 4 or more surfaces	
Inlay, porcelain/ceramic – 1 surface	
Inlay, porcelain/ceramic – 2 surfaces	
Inlay, porcelain/ceramic – 3 or more surfaces	
Onlay, porcelain/ceramic – 2 surfaces	
Onlay, porcelain/ceramic – 3 surfaces	
Onlay, porcelain/ceramic – 4 or more surfaces	
Inlay, resin based composite – 1 surface	
Inlay, resin based composite – 2 surfaces	
Inlay, resin based composite – 3 or more surfaces	
Onlay, resin based composite – 2 surfaces	
Onlay, resin based composite – 3 surfaces	
Onlay, resin based composite – 4 or more surfaces	
Crown – resin-based composite, indirect	
Crown – 3/4 resin-based composite, indirect	
Crown – resin with predominantly base metal	
Crown – resin with noble metal	
Crown – porcelain/ ceramic	
Crown – porcelain fused to predominantly base metal	
Crown – porcelain fused to noble metal	
Crown – porcelain fused to titanium and titanium alloys	
Crown – 3/4 cast predominantly base metal	
Crown – 3/4 cast noble metal	
Crown – 3/4 cast porcelain/ceramic	

Crown – full cast predominantly base metal	
Crown – full cast noble metal	
Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	
Re-cement or re-bond indirectly fabricated or prefabricated post and core	
Re-cement or re-bond crown	
Reattachment of tooth fragment, incisal edge or cusp	
Prefabricated porcelain/ceramic crown – primary tooth	
Prefabricated stainless steel crown – primary tooth	
Prefabricated stainless steel crown - permanent tooth	
Protective restoration	
Interim therapeutic restoration – primary dentition	
Core buildup, including any pins	
Pin retention – per tooth	
Post & core in addition to crown, indirectly fabricated	
Each additional indirectly fabricated post	
Prefabricated post & core in addition to crown	
Each additional prefabricated post	
Additional procedures to customize a crown to fit under an existing partial denture framework	
Resin infiltration of incipient smooth surface lesions if you are under age 16	1 application every 3 years
Pulp cap – direct-excluding final restoration	
Pulp cap – indirect -excluding final restoration	
Therapeutic pulpotomy -excluding final restoration	
Pulpal debridement, primary and permanent teeth	
Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	
Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	

Pulpal therapy (resorbable filling) – posterior, primary tooth -(excluding final restoration)	
Endodontic therapy, anterior tooth - (excluding final restoration)	
Endodontic therapy, premolar tooth- (excluding final restoration)	
Treatment of root canal obstruction; non-surgical access	
Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	
Internal root repair of perforation defects	
Surgical repair of root resorption - anterior	
Surgical repair of root resorption - premolar	
Surgical repair of root resorption - molar	
Periodontal scaling and root planing, 4 or more teeth per quadrant	4 separate quadrants every 2 years
Periodontal scaling and root planing – 1-3 teeth per quadrant	4 per site every 2 years
Scaling in presence of generalized moderate or severe gingival inflammation– full mouth, after oral evaluation	2 treatments per year combined with prophylaxis
Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per lifetime
Periodontal maintenance- following surgical therapy	2 per year
Unscheduled dressing change (by someone other than treating dentist or their staff)	
Complete denture – maxillary	Relines/Rebases/Adjustments <u>are not</u> separately eligible within 6 months of placement of the denture
Complete denture – mandibular	Relines/Rebases/Adjustments <u>are not</u> separately eligible within 6 months of placement of the denture
Immediate denture – maxillary	Relines/rebases/adjustments are separately eligible within 6 months of placement of the immediate denture
Immediate denture – mandibular	Relines/rebases/adjustments are separately eligible within 6 months of placement of the immediate denture
Maxillary partial denture – resin base - (including any conventional clasps, rests and teeth)	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the denture
Mandibular partial denture – resin base- (including any conventional clasps, rests and teeth)	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the denture

Maxillary partial denture – cast metal framework with resin denture bases-(including any conventional clasps, retentive/clasping materials, rests and teeth)	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the denture
Mandibular partial denture – cast metal framework with resin denture bases-(including any conventional clasps, retentive/clasping materials, rests and teeth)	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the denture
Immediate maxillary partial denture – resin base-(including any conventional clasps, retentive/clasping materials, rests and teeth)	Relines/rebases/adjustments are separately eligible within 6 months of placement of the immediate denture
Immediate mandibular partial denture – resin base-(including any conventional clasps, retentive/clasping materials, rests and teeth)	Relines/rebases/adjustments are separately eligible within 6 months of placement of the immediate denture
Immediate maxillary partial denture – cast metal framework with resin denture bases-(including any conventional clasps, retentive/clasping materials, rests and teeth)	Relines/rebases/adjustments are separately eligible within 6 months of placement of the immediate denture
Immediate mandibular partial denture – cast metal framework with resin denture bases-(including any conventional clasps, retentive/clasping materials, rests and teeth)	Relines/rebases/adjustments are separately eligible within 6 months of placement of the immediate denture
Maxillary partial denture – flexible base -(including retentive/clasping materials, rests and teeth)	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the immediate denture
Mandibular partial denture – flexible base-(including retentive/clasping materials, rests and teeth)	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the immediate denture
Immediate maxillary partial denture – flexible base (including any clasps, rests and teeth)	
Immediate mandibular partial denture – flexible base (including any clasps, rests and teeth)	
Removable unilateral partial denture – one piece cast metal -(including retentive/clasping materials, rests and teeth)	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the denture
Mandibular	
Maxillary	

Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests and teeth) – per quadrant	
Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests and teeth) – per quadrant	
Adjust complete denture – maxillary	Adjustment is not separately eligible within 6 months of placement of the denture
Adjust complete denture – mandibular	Adjustment is not separately eligible within 6 months of placement of the denture
Adjust partial denture – maxillary	Adjustment is not separately eligible within 6 months of placement of the denture
Adjust partial denture – mandibular	Adjustment is not separately eligible within 6 months of placement of the denture
Repair broken complete denture base, maxillary	
Repair broker complete denture base, mandibular	
Replace missing or broken teeth – complete denture (each tooth)	
Repair resin denture base, maxillary	
Repair resin denture base, mandibular	
Repair cast framework, maxillary	
Repair cast framework, mandibular	
Repair or replace broken clasp - per tooth	
Replace broken teeth – per tooth	
Add tooth to existing partial denture	
Add clasp to existing partial denture - per tooth	
Replace all teeth and acrylic on cast metal framework (mandibular)	
Replace all teeth and acrylic on cast metal framework (maxillary)	
Rebase complete maxillary denture	Rebase is not separately eligible within 6 months of placement of the denture
Rebase complete mandibular denture	Rebase is not separately eligible within 6 months of placement of the denture
Rebase maxillary partial denture	Rebase is not separately eligible within 6 months of placement of the denture
Rebase mandibular partial denture	Rebase is not separately eligible within 6 months of placement of the denture
Rebase hybrid prosthesis	Rebase is not separately eligible within 6 months of placement of the denture
Reline complete maxillary denture (direct)	Reline is not separately eligible within 6 months of placement of the denture
Reline complete mandibular denture (direct)	Reline is not separately eligible within 6 months of placement of the denture

Reline maxillary partial denture (direct)	Reline is not separately eligible within 6 months of placement of the denture
Reline mandibular partial denture (direct)	Reline is not separately eligible within 6 months of placement of the denture
Reline complete maxillary denture (indirect)	Reline is not separately eligible within 6 months of placement of the denture
Reline complete mandibular denture (indirect)	Reline is not separately eligible within 6 months of placement of the denture
Reline maxillary partial denture (indirect)	Reline is not separately eligible within 6 months of placement of the denture
Reline mandibular partial denture (indirect)	Reline is not separately eligible within 6 months of placement of the denture
Soft liner for complete or partial removable denture - indirect	Reline is not separately eligible within 6 months of placement of the denture
Interim partial denture (including retentive/clasping materials, rests, and teeth),-maxillary	Eligible when replacing anterior teeth
Interim partial denture (including retentive/clasping materials, rests, and teeth),-mandibular	Eligible when replacing anterior teeth
Tissue conditioning, maxillary	Tissue conditioning is not separately eligible within 6 months of placement of the denture
Tissue conditioning, mandibular	Tissue conditioning is not separately eligible within 6 months of placement of the denture
Abutment supported porcelain/ceramic crown	
Abutment supported porcelain fused to metal crown (predominantly base metal)	
Abutment supported porcelain fused to metal crown (noble metal)	
Abutment supported cast metal crown (predominantly base metal)	
Abutment supported cast metal crown (noble metal)	
Implant supported porcelain/ceramic crown	
Abutment supported retainer for porcelain/ceramic fixed partial denture	
Abutment supported retainer for porcelain fused to metal fixed partial denture (predominantly base metal)	
Abutment supported retainer for porcelain fused to metal fixed partial denture (noble metal)	
Abutment supported retainer for cast metal fixed partial denture (predominantly base metal)	

Abutment supported retainer for cast metal fixed partial denture (noble metal)	
Implant supported retainer for ceramic fixed partial denture	
Re-cement or re-bond implant/abutment supported crown	
Re-cement or re-bond implant/abutment supported fixed partial denture	
Implant /abutment supported removable denture for edentulous arch – maxillary	
Implant /abutment supported removable denture for edentulous arch – mandibular	
Implant /abutment supported removable denture for partially edentulous arch – maxillary	
Implant /abutment supported removable denture for partially edentulous arch – mandibular	
Implant /abutment supported fixed denture for edentulous arch – maxillary	
Implant /abutment supported fixed denture for edentulous arch – mandibular	
Implant /abutment supported fixed denture for partially edentulous arch – maxillary	
Implant /abutment supported fixed denture for partially edentulous arch – mandibular	
Implant supported crown – porcelain fused to predominantly base alloys	
Implant supported crown – porcelain fused to noble alloys	
Implant supported crown – porcelain fused to titanium and titanium alloys	
Implant supported crown – predominantly base alloys	
Implant supported crown – noble alloys	
Implant supported crown – titanium and titanium alloys	
Abutment supported crown – porcelain fused to titanium and titanium alloys	
Implant supported retainer – porcelain fused to predominantly base alloys	
Implant supported retainer for fixed partial denture – porcelain fused to noble alloys	
Implant supported retainer – porcelain fused to titanium and titanium alloys	
Implant supported retainer for metal fixed partial denture – predominantly base alloys	

Implant supported retainer for metal fixed partial denture – noble alloys	
Implant supported retainer for metal fixed partial denture – titanium and titanium alloys	
Pontic – indirect resin based composite	
Pontic – cast predominantly Base metal	
Pontic – cast noble metal	
Pontic – porcelain fused to predominantly base metal	
Pontic – porcelain fused to noble metal	
Pontic – porcelain fused to titanium and titanium alloys	
Pontic – porcelain/ceramic	
Pontic – resin with predominantly base metal	
Pontic – resin with noble metal	
Retainer – cast metal for resin-bonded fixed prosthesis	
Retainer – porcelain/ceramic for resin-bonded fixed prosthesis	
Resin retainer – for resin bonded fixed prosthesis	
Retainer inlay – porcelain/ceramic, 2 surfaces	
Retainer inlay – porcelain/ceramic, 3 or more surfaces	
Retainer inlay – cast predominantly base metal, 2 surfaces	
Retainer inlay – cast predominantly base metal, 3 or more surfaces	
Retainer inlay – cast noble metal, 2 surfaces	
Retainer inlay – cast noble metal, 3 or more surfaces	
Retainer onlay – porcelain/ceramic, 2 surfaces	
Retainer onlay – porcelain/ceramic, 3 or more surfaces	
Retainer onlay – cast predominantly base metal, 2 surfaces	
Retainer onlay – cast predominantly base metal, 3 or more surfaces	
Retainer onlay – cast noble metal, 2 surfaces	
Retainer onlay – cast noble metal, 3 or more surfaces	

Retainer crown – indirect resin based composite	
Retainer crown – resin with predominantly base metal	
Retainer crown – resin with noble metal	
Retainer crown – porcelain/ceramic	
Retainer crown – porcelain fused to predominantly base metal	
Retainer crown – porcelain fused to noble metal	
Retainer crown – 3/4 cast predominantly base metal	
Retainer crown – 3/4 cast noble metal	
Retainer crown – 3/4 porcelain/ceramic	
Retainer crown – full cast predominantly base metal	
Retainer crown – full cast noble metal	
Re-cement or re-bond fixed partial denture	
Pediatric partial denture, fixed	
Extract, coronal remnants – deciduous tooth	
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	
Removal of impacted tooth – soft tissue	
Palliative (emergency) treatment of dental pain – minor procedure	
Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	For second opinions only
Consultation with a medical health care professional	
Cleaning and inspection of removable complete denture, maxillary	
Cleaning and inspection of removable complete denture, mandibular	
Cleaning and inspection of removable partial denture, maxillary	
Cleaning and inspection of removable partial denture, mandibular	

Occlusal guard, by report	1 every 3 years
Hard appliance, full arch	
Soft appliance, full arch	
Hard appliance, partial arch	
Repair and/or reline of occlusal guard	
Occlusal guard adjustment	Adjustments are not eligible within 6 months of the placement of the appliance
Full mouth rehabilitation, per unit (6 or more covered units of crowns and/or pontics under one treatment plan)	

Specialty Care Services	Limitations
Endodontic therapy, molar (excluding final restoration)	
Retreatment of previous root canal therapy – anterior	
Retreatment of previous root canal therapy – premolar	
Retreatment of previous root canal therapy – molar	
Apicoectomy – anterior	
Apicoectomy – bicuspid (first root)	
Apicoectomy – molar (first root)	
Apicoectomy – each additional root	
Surgical repair of root resorption - anterior	
Surgical repair of root resorption - premolar	
Surgical repair of root resorption - molar	
Retrograde filling – per root	
Root amputation – per root	
Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	
Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	
Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	
Gingivectomy or gingivoplasty, 4 or more contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years
Gingivectomy or gingivoplasty, 1-3 contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years
Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	
Gingival flap procedure, including root planing, 4 or more contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years

Gingival flap procedure, including root planing, 1-3 contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years
Apically positioned flap	
Clinical crown lengthening – hard tissue	
Osseous surgery (including elevation of a full thickness flap and closure),4 or more contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years
Osseous surgery (including elevation of a full thickness flap and closure), 1-3 contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years
Surgical revision procedure, per tooth	
Pedicle soft tissue graft procedure	
Autogenous connective tissue graft procedure (including donor and recipient surgical sites), first tooth, implant or edentulous tooth position	
Non-autogenous connective tissue graft (including recipient site and donor material), first tooth, implant, or edentulous tooth position in graft	
Combined connective tissue and pedicle graft, per tooth	
Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth, implant, or edentulous tooth position in graft	
Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant, or edentulous tooth position in same graft site	
Autogenous connective tissue graft procedure (including donor and recipient surgical sites), each additional contiguous tooth, implant or edentulous tooth position in same graft site	
Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material), each additional contiguous tooth, implant or edentulous tooth position in same graft site	
Add metal substructure to acrylic full denture (per arch)	
Removal of impacted tooth – partially bony	

Removal of impacted tooth – completely bony	
Removal of impacted tooth – completely bony, with unusual surgical complications	
Removal of residual tooth roots -cutting procedure	
Coronectomy - intentional partial tooth removal	
Exposure of an unerupted tooth	
Mobilization of erupted or malpositioned tooth to aid eruption	
Placement of device to facilitate eruption of impacted tooth	
Incisional biopsy of oral tissue – hard (bone, tooth)	
Incisional biopsy of oral tissue – soft	
Exfoliative cytological sample collection	
Alveoloplasty in conjunction with extractions, 4 or more teeth or tooth spaces, per quadrant	
Alveoloplasty in conjunction with extractions, 1 to 3 teeth or tooth spaces, per quadrant	
Alveoloplasty not in conjunction with extractions, 4 or more teeth or tooth spaces, per quadrant	
Alveoloplasty not in conjunction with extractions, 1 to 3 teeth or tooth spaces, per quadrant	
Incision and drainage of abscess – intraoral soft tissue	
Incision and drainage of abscess – intraoral soft tissue - complicated	
Buccal/ labial frenectomy (frenulectomy)	
Lingual frenectomy (frenulectomy)	
Frenuloplasty	
Evaluation for deep sedation or general anesthesia	
Deep sedation/general anesthesia, first 15 minutes	
Deep sedation/general anesthesia – each 15 minute increment	
Intravenous moderate (conscious) sedation/analgesia, first 15 minutes	
Intravenous moderate (conscious) sedation/analgesia, each 15 minute increment	

Infiltration of a sustained release therapeutic when provided as part of an eligible dental service	
Occlusal adjustment – limited	
Occlusal adjustment – complete	

General Plan limitations:

- **Copayment** amounts for crowns and pontics are per unit.
- Fees for dentures and partial dentures include relines, rebases, and adjustments within 12 months after installation. Fees for relines and rebases include adjustments within 12 months after installation. Specialized techniques and characterizations are not eligible.
- Inlays, onlays, labial veneers and crowns (excludes temporary crowns) are covered only:
  - As treatment for decay or acute traumatic **injury**
  - When teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge.

  (Limited to 1 per tooth every 5 years. See the *Replacement rule.*)

- **Restorative services:** Multiple restorations on 1 surface are considered as a single restoration. (Limited to 1 per tooth every 5 years.)
- There is an extra charge for **eligible dental services** that use high noble metals (ex. gold or titanium).

General anesthesia and sedation are **covered benefits** when part of a covered surgical procedure.

Alternate treatment rule
Sometimes there are several ways to treat a dental problem, all of which provide acceptable results.

If a charge is made for a non-covered service but a **covered service** would have provided acceptable results, then your plan will pay a benefit for the **covered service**.

If a charge is made for a **covered service** but a different **covered service** would have provided acceptable results and is less expensive, then your plan will pay a benefit based upon the least expensive **covered service**.

You should review the differences in the cost of alternate treatment with your **dental provider**. Of course, you and your **dental provider** can still choose the more costly treatment method. You are responsible for any charges in excess of what your plan will cover.

Coverage for dental work begun before you are covered by the plan

Your plan does not cover dental work that began before you were covered by the plan. This means that the following dental work is not covered:

- An appliance, or modification of an appliance, if an impression for it was made before you were covered by the plan
- A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before you were covered by the plan
- Root canal therapy, if the pulp chamber for it was opened before you were covered by the plan

Late entrant rule
The plan does not cover services and supplies given to a person age 5 or older if that person did not enroll in the plan during one of the following:

- The first 31 days the person is eligible for this coverage
- Any period of open enrollment agreed to by the policyholder and us

This does not apply to charges incurred for any of the following:

- After the person has been covered by the plan for 12 months
- As a result of **injuries** sustained while covered by the plan
- Diagnostic and preventive services such as exams, cleanings, fluoride, and images (orthodontia related services are not included)

Orthodontic treatment rule
Orthodontic treatment is covered on the date the appliance is initially inserted.

The following are not considered **orthodontic treatment**:

- The installation of a space maintainer
- A surgical procedure to correct malocclusion

This benefit does not cover charges for the following:

- Replacement of broken appliances
- Re-treatment of orthodontic cases
- Changes in treatment necessitated by an accident
- Maxillofacial surgery
- Myofunctional therapy
- Treatment of cleft palate
- Treatment of micrognathia
- Treatment of macroglossia
- Lingually placed direct bonded appliances and arch wires (i.e. “invisible braces”)

The plan will not cover the charges for an orthodontic procedure if an active appliance for that procedure was installed before you were covered by the plan.

Comprehensive **orthodontic treatment** is limited to a:

- **Lifetime maximum** of 24 months of active; usual and customary **orthodontic treatment** on permanent dentition; plus an extra 24 months of post-treatment retention.
- **Lifetime maximum** of one full course of active, usual and customary **orthodontic treatment**, plus post-treatment retention.

Orthodontic limitation for late enrollees
The plan will not cover the charges for an orthodontic procedure for which an active appliance for that procedure has been installed within the 2 year period starting with the date you became covered by the plan. This limit applies only if you do not become enrolled in the plan within 31 days after you first become eligible.

Replacement rule
Some **covered services** are subject to your plan's replacement rule. The replacement rule applies to replacements of, or additions to existing:

- Crowns
- Inlays
- Onlays
- Veneers
- Complete dentures
- Removable partial dentures
- Fixed partial dentures (bridges)
- Other prosthetic services

These **covered services** are covered only when you give us proof that:

- While you were covered by the plan:
  - You had a tooth (or teeth) extracted after the existing denture, bridge or other prosthetic item was installed.
  - As a result, you need to replace or add teeth to your denture, bridge or other prosthetic item and:
    - The tooth that was removed was not an abutment to a removable or fixed partial denture, bridge or other prosthetic item installed during the prior 12 months.
    - Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.
- The present item cannot be made serviceable, and is:
  - A crown installed at least 5 years before its replacement.
  - An inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic item installed at least 5 years before its replacement.

Tooth missing but not replaced rule
The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges or other prosthetic items are needed to replace one or more natural teeth that were removed while you were covered by the plan. (The extraction of a third molar tooth does not qualify.)
- The tooth that was removed was not an abutment to a removable or fixed partial denture, bridge or other prosthetic item installed during the prior 5 years.

Any such appliance, prosthetic item or fixed bridge must include the replacement of an extracted tooth or teeth.

Additional Covered Services

We will provide additional **covered services** if you have at least one of the following conditions:

- Pregnancy
- Coronary artery disease/cardiovascular disease
- Cerebrovascular disease
- Diabetes

The additional **covered services** are:

- Prophylaxis (cleaning) (one additional per Calendar Year)
- Scaling and root planing, (4 or more teeth), per quadrant
- Scaling and root planing (limited to 1 to 3 teeth), per quadrant
- Full mouth debridement
- Periodontal maintenance

SECTION VII

Exclusions and Limitations

No coverage is available under this Certificate for the following:

A. Aviation.
We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care.
We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

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

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

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

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

G. Foot Care.
We do not Cover foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.

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

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

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

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

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

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

N. Pre-Existing Conditions.
For a period of 12 months from the enrollment date, We do not Cover any conditions for which medical advice was given, treatment was recommended by or received from a physician within six (6) months before the effective date of Your coverage.

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

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

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

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

S. Vision Services.
We do not Cover the examination or fitting of eyeglasses or contact lenses.

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

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

SECTION VIII

Claim Determinations

A. Claims.

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

B. Notice of Claim.

Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling 1-877-238-6200 or visiting Our website at www.aetna.com. Completed claim forms should be sent to the address in the How Your Coverage Works section of this Certificate. You may also submit a claim to Us electronically by visiting Our website at www.aetna.com.

C. Timeframe for Filing Claims.

Claims for services must be submitted to Us for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120-day period, You must submit it as soon as reasonably possible.

D. Claims for Prohibited Referrals.

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

E. Claim Determinations.

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

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

F. Pre-Service Claim Determinations.

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

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

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

G. Post-Service Claim Determinations.

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

H. Payment of Claims.

Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

SECTION IX

Grievance Procedures

A. Grievances.

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

B. Filing a Grievance.

You can contact Us by phone at 1-877-238-6200 or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

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

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

You may ask that We send You electronic notification of a Grievance or Grievance Appeal determination instead of notice in writing or by telephone. You must tell Us in advance if You want to receive electronic notifications. To opt into electronic notifications, call 1-877-238-6200 or visit Our website at www.aetna.com . You can opt out of electronic notifications at any time.

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

Expedited/Urgent Grievances:	By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of Your Grievance.

D. Grievance Appeals.
If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at 1-877-238-6200 or in writing. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

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

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

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

All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	30 business days of receipt of all necessary information to make a determination.

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

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

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

SECTION X

Utilization Review

A. Utilization Review.

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

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

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

B. Preauthorization Reviews.

1. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

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

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

C. Concurrent Reviews.

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) or Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) or Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within the earlier of 15 calendar days of receipt of part of the requested information or 15 calendar days of the end of the 45-day period.

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

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

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

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

E. Retrospective Review of Preauthorized Services.
We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

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

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

G. Utilization Review Internal Appeals.
You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone , 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. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is (1) a Physician or (2) a health care professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, You, or Your designee, must submit:
    - A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
    - Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Referral Denial.** You also have the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network Referral denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:
    - That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
    - Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

H. Standard Appeal.

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

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

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

   If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal appeal or an external appeal.

   Our failure to render a determination of Your Appeal within 30 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

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

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

SECTION XI

External Appeal

A. Your Right to an External Appeal.

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

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

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

B. Your Right to Appeal a Determination that a Service is Not Medically Necessary.

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

C. Your Right to Appeal a Determination that A Service is Experimental or Investigational.

If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph “A” above and Your attending Physician must certify that Your condition or disease is one for which:

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

In addition, Your attending Physician must have recommended one (1) of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

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

D. Your Right to Appeal a Determination that a Service is Out-of-Network.
If We have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph “A” above, and You have requested Preauthorization for the out-of-network treatment.

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

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

E. Your Right to Appeal an Out-of-Network Referral Denial to a Non-Participating Provider.

If We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above.

In addition, Your attending Physician must: 1) certify that the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and 2) recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

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

F. The External Appeal Process.

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

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

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

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

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

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

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

G. Your Responsibilities.

It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

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

SECTION XII

Coordination of Benefits

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

A. Definitions.

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

2. **"Plan"** is other group dental coverage with which We will coordinate benefits. The term "plan" includes:
   - Group dental benefits and blanket or group remittance dental benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
   - Dental benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
   - Dental benefits coverage of a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

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

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

B. Rules to Determine Order of Payment.
The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION XIII

Termination of Coverage

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

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

2. The end of the month in which the Subscriber ceases to meet the eligibility requirements as defined by the Group.

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

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

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

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

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

8. If the Subscriber has performed an act that constitutes fraud or made a misrepresentation of material fact in writing on his/her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber. However, if the Subscriber makes a misrepresentation of material fact in writing on his or her enrollment application We will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Certificate. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

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

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

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

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

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

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

See the Continuation of Coverage section of this Certificate for Your right to continuation of this coverage under COBRA or USERRA.

SECTION XIV

Extension of Benefits

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

SECTION XV

Continuation of Coverage

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

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

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

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

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

If You want to continue coverage You must request continuation from the Group in writing and make the first Premium payment within the 60-day period following the later of:
1. The date coverage would otherwise terminate; or
2. The date You are sent notice by first class mail of the right of continuation by the Group.

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

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

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

Continuation Rights During Active Duty

Under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end due to service in the uniformed services or upon becoming eligible for medical and dental care under federal health insurance by reason of their service. Call or write Your Group to find out if You are entitled to temporary continuation of coverage under USERRA.

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

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

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

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

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

SECTION XVI

General Provisions

1. Agreements between Us and Participating Providers.

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

2. Assignment.

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

3. Changes in This Certificate.

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

4. Choice of Law.

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

5. Clerical Error.

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

6. Conformity with Law.

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

7. Continuation of Benefit Limitations.

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

8. Enrollment ERISA.

The Group 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 will provide Us with this information upon request. The Group may also have additional responsibilities as the "plan administrator" as defined by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The "plan administrator" is the Group, or a third party appointed by the Group. We are not the ERISA plan administrator.

The Group will provide Us with the enrollment form including Your name, address, age, and social security number and 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 of the Group's Policy with Us. If the Group fails to so advise Us, the Group 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 thirty (30) days.

9. Entire Agreement.

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

10. Fraud and Abusive Billing.

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

11. Furnishing Information and Audit.

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

12. Identification Cards.

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

13. Incontestability.

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

14. Independent Contractors.

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

15. Input in Developing Our Policies.

Subscribers may participate in the development of Our policies by:

- Having your health care professionals help you to make decisions about the need for services and with the complaint process.
- Suggesting changes in the plan's policies and services. To submit suggestions on the plan's policies, please write to us at the below address:

  Aetna Life Insurance Company
  980 Jolly Road
  U12N, Blue Bell, PA 19422

16. Material Accessibility.

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

17. More Information about Your Dental Plan.

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

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

18. Notice.

Any notice that We give You under this Certificate will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery or to the address of the Group. If notice is delivered to You electronically, You may also request a copy of the notice from Us. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to: **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156

19. Premium Refund.

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

20. Recovery of Overpayments.

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

21. Renewal Date.

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

22. Right to Develop Guidelines and Administrative Rules.

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

We review and evaluate new technology according to technology evaluation criteria developed by Our medical directors and reviewed by a designated committee, which consists of health care professionals from various medical specialties. Conclusions of the committee are incorporated into Our medical policies to establish decision protocols for determining whether a service is Medically Necessary, experimental or investigational, or included as a Covered benefit.

23. Right to Offset.

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

24. Severability.

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

25. Significant Change in Circumstances.

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

26. Third Party Beneficiaries.

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

27. Time to Sue.

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

28. Translation Services.

Translation services are available free of charge under this Certificate for non-English speaking Members. Please contact Us at 1-877-238-6200; the number on Your ID card to access these services.

29. Waiver.

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

30. Who May Change this Certificate.

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

31. Who Receives Payment under this Certificate.

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

32. Workers' Compensation Not Affected.

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

33. Your Dental Records and Reports.

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

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

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

SECTION XVII

MANAGED DENTAL SCHEDULE OF BENEFITS

Outten & Golden, LLP

Office visit copayment -Your office visit **copayment** is the amount you pay each time you visit the dentist. You pay the office visit copayment in addition to other cost sharing as outlined in the schedule

	Copayment
Office visit	$5 per visit

Orthodontic treatment copayment

Comprehensive **orthodontic treatment** of adolescent and adult dentition	$2,800

Dental emergency services maximum
The most the plan will pay for **covered services** incurred by any one covered person for any one **dental emergency** is called the **dental emergency services maximum**.

Dental emergency services maximum $100

Covered dental services for Fixed Copayment Plans

In-network coverage

This listing of Covered Services applies to **covered services** provided by **primary care dentists** (**PCDs**) and other **in-network providers** upon **referral** from your **PCD**. The plan covers only the **covered services** listed below.

Primary Care Services	Limitations	Copayment Amounts
Periodic oral evaluation - established patient	4 visits per year for all oral evaluations combined	$0
Limited oral evaluation - problem focused		$0
Oral evaluation for a patient under 3 years of age and counseling with primary caregiver		$0
Comprehensive oral evaluation – new or established patient		$0
Detailed and extensive oral evaluation – problem focused, by report		$0
Re-evaluation - limited, problem focused		$0
Comprehensive periodontal evaluation - new or established patient		$0
Intraoral - complete series of radiographic images	1 set every 3 years	$0
Intraoral - periapical image- first radiographic image		$0
Intraoral- periapical each additional radiographic image		$0
Intraoral - occlusal radiographic image		$0
Extra-oral image- first radiographic image		$0
Extra-oral posterior dental radiographic image		$0
Bitewing - single radiographic image	1 set every year	$0
Bitewings - 2 radiographic images		$0
Bitewings - 3 radiographic images		$0
Bitewings - 4 radiographic images		$0
Vertical bitewings - 7 to 8 radiographic images	1 set every 3 years	$0
Panoramic radiographic image	Frequency combined with Intraoral	$0

Interpretation of diagnostic image by practitioner not associated with capture of the image, including report		$0
Diagnostic casts		$0
Accession of tissue, gross examination, preparation and transmission of written report		$0
Accession of tissue, gross and microscopic examination, preparation and transmission of written report		$0
Accession of tissue, gross and microscopic exam, including assessment of surgical margins for presence of disease, preparation & transmission of written report		$0
Panoramic radiographic image - image capture only		$0
Extra-oral posterior dental radiographic image - image capture only		$0
Intraoral - occlusal radiographic image - image capture only		$0
Intraoral - periapical radio graphic image - image capture only		$0
Intraoral - bitewing radiographic image - image capture only		$0
Intraoral - complete series of radiographic images - image capture only		$0
Prophylaxis – adult	2 visits per year	$0
Prophylaxis – child	2 visits per year	$0
Topical application of fluoride varnish if you are under age 16	1 treatment per year	$0
Topical application of fluoride-excluding varnish if you are under age 16		$0
Oral hygiene instruction		$0
Sealant - per tooth, if you are under age 16	1 application every 3 years for permanent molars	$0
Preventive resin restoration in a moderate to high risk caries patient – permanent tooth if you are under age 16	1 application every 3 years for permanent molars	$0
Sealant repair - per tooth, if you are under age 16	For permanent bicuspids and molars combined frequency for all sealants	$0

Caries arresting medicament application if you are under age 16 – per tooth	1 application every 3 years for permanent molars	$0
Caries preventive medicament application - per tooth		$0
Space maintainer - fixed - unilateral - per quadrant	Only when needed to preserve space resulting from premature loss of deciduous teeth; includes all adjustments within 6 months after installation	$92
Space maintainer - fixed - bilateral - per quadrant	Only when needed to preserve space resulting from premature loss of deciduous teeth; includes all adjustments within 6 months after installation	
Mandibular		$92
Maxillary		$92
Space maintainer - removable - unilateral - per quadrant	Only when needed to preserve space resulting from premature loss of deciduous teeth; includes all adjustments within 6 months after installation	$92
Space maintainer - removable - bilateral - per quadrant	Only when needed to preserve space resulting from premature loss of deciduous teeth; includes all adjustments within 6 months after installation	
Mandibular		$92
Maxillary		$92
Re-cement or re-bond space maintainer - maxillary		$92
Re-cement or re-bond space maintainer - mandibular		$92
Removal of fixed unilateral space maintainer - per quadrant		$8
Removal of fixed bilateral space maintainer - maxillary		$15
Removal of fixed bilateral space maintainer - mandibular		$15
Distal shoe space maintainer– fixed – unilateral, per quadrant		$101
Amalgam – 1 surface, primary or permanent		$19

Amalgam – 2 surfaces, primary or permanent		$30
Amalgam – 3 surfaces, primary or permanent		$41
Amalgam – 4+ surfaces, primary or permanent		$50
Resin-based composite – 1 surface, anterior		$26
Resin-based composite – 2 surfaces, anterior		$37
Resin-based composite – 3 surfaces, anterior		$37
Resin-based composite – 4+ surfaces or involving incisal angle, anterior		$72
Resin-based composite crown, anterior		$72
Resin-based composite – 1 surface, posterior		$63
Resin-based composite – 2 surfaces, posterior		$84
Resin-based composite – 3 surfaces, posterior		$119
Resin-based composite – 4+ surfaces, posterior		$126
Inlay – metallic - 1 surface		$236
Inlay – metallic - 2 surfaces		$236
Inlay – metallic - 3 or more surfaces		$236
Onlay – metallic - 2 surfaces		$252
Onlay – metallic - 3 surfaces		$252
Onlay - metallic – 4 or more surfaces		$252
Inlay, porcelain/ceramic – 1 surface		$236
Inlay, porcelain/ceramic – 2 surfaces		$236
Inlay, porcelain/ceramic – 3 or more surfaces		$236
Onlay, porcelain/ceramic – 2 surfaces		$252
Onlay, porcelain/ceramic – 3 surfaces		$252
Onlay, porcelain/ceramic – 4 or more surfaces		$252
Inlay, resin based composite – 1 surface		$236
Inlay, resin based composite – 2 surfaces		$236
Inlay, resin based composite – 3 or more surfaces		$236

Onlay, resin based composite – 2 surfaces		$252
Onlay, resin based composite – 3 surfaces		$252
Onlay, resin based composite – 4 or more surfaces		$252
Crown – resin-based composite, indirect		$362
Crown – 3/4 resin-based composite, indirect		$265
Crown – resin with predominantly base metal		$362
Crown – resin with noble metal		$362
Crown – porcelain/ ceramic		$362
Crown – porcelain fused to predominantly base metal		$362
Crown – porcelain fused to noble metal		$362
Crown – porcelain fused to titanium and titanium alloys		$362
Crown – 3/4 cast predominantly base metal		$362
Crown – 3/4 cast noble metal		$362
Crown – 3/4 cast porcelain/ceramic		$362
Crown – full cast predominantly base metal		$362
Crown – full cast noble metal		$362
Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration		$15
Re-cement or re-bond indirectly fabricated or prefabricated post and core		$8
Re-cement or re-bond crown		$15
Reattachment of tooth fragment, incisal edge or cusp		$7
Prefabricated porcelain/ceramic crown – primary tooth		$76
Prefabricated stainless steel crown – primary tooth		$54
Prefabricated stainless steel crown - permanent tooth		$65
Protective restoration		$8
Interim therapeutic restoration – primary dentition		$4
Core buildup, including any pins		$158
Pin retention – per tooth		$14

Post & core in addition to crown, indirectly fabricated		$179
Each additional indirectly fabricated post		$179 4 $140 5
Prefabricated post & core in addition to crown		$95
Each additional prefabricated post		$95
Additional procedures to customize a crown to fit under an existing partial denture framework		$49
Resin infiltration of incipient smooth surface lesions if you are under age 16	1 application every 3 years	$8
Pulp cap – direct-excluding final restoration		$6
Pulp cap – indirect -excluding final restoration		$6
Therapeutic pulpotomy -excluding final restoration		$77
Pulpal debridement, primary and permanent teeth		$14
Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development		$70
Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)		$77
Pulpal therapy (resorbable filling) – posterior, primary tooth -(excluding final restoration)		$77
Endodontic therapy, anterior tooth -(excluding final restoration)		$135
Endodontic therapy, premolar tooth-(excluding final restoration)		$216
Treatment of root canal obstruction; non-surgical access		$135
Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth		$99
Internal root repair of perforation defects		$99
Surgical repair of root resorption - anterior		$67
Surgical repair of root resorption - premolar		$89
Surgical repair of root resorption - molar		$111

Periodontal scaling and root planing, 4 or more teeth per quadrant	4 separate quadrants every 2 years	$59
Periodontal scaling and root planing – 1-3 teeth per quadrant	4 per site every 2 years	$36
Scaling in presence of generalized moderate or severe gingival inflammation– full mouth, after oral evaluation	2 treatments per year combined with prophylaxis	$35
Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per lifetime	$70
Periodontal maintenance- following surgical therapy	2 per year	$65
Unscheduled dressing change (by someone other than treating dentist or their staff)		$11
Complete denture – maxillary	Relines/Rebases/Adjustments are not separately eligible within 6 months of placement of the denture	$347
Complete denture – mandibular	Relines/Rebases/Adjustments are not separately eligible within 6 months of placement of the denture	$347
Immediate denture – maxillary	Relines/rebases/adjustments are separately eligible within 6 months of placement of the immediate denture	$347
Immediate denture – mandibular	Relines/rebases/adjustments are separately eligible within 6 months of placement of the immediate denture	$347
Maxillary partial denture – resin base -(including any conventional clasps, rests and teeth)	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the denture	$347
Mandibular partial denture – resin base-(including any conventional clasps, rests and teeth)	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the denture	$347
Maxillary partial denture – cast metal framework with resin denture bases-(including any conventional clasps, retentive/clasping materials, rests and teeth)	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the denture	$420

Mandibular partial denture – cast metal framework with resin denture bases-(including any conventional clasps, retentive/clasping materials, rests and teeth)	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the denture	$420
Immediate maxillary partial denture – resin base-(including any conventional clasps, retentive/clasping materials, rests and teeth)	Relines/rebases/adjustments are separately eligible within 6 months of placement of the immediate denture	$399
Immediate mandibular partial denture – resin base-(including any conventional clasps, retentive/clasping materials, rests and teeth)	Relines/rebases/adjustments are separately eligible within 6 months of placement of the immediate denture	$399
Immediate maxillary partial denture – cast metal framework with resin denture bases-(including any conventional clasps, retentive/clasping materials, rests and teeth)	Relines/rebases/adjustments are separately eligible within 6 months of placement of the immediate denture	$483
Immediate mandibular partial denture – cast metal framework with resin denture bases-(including any conventional clasps, retentive/clasping materials, rests and teeth)	Relines/rebases/adjustments are separately eligible within 6 months of placement of the immediate denture	$483
Maxillary partial denture – flexible base -(including retentive/clasping materials, rests and teeth)	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the immediate denture	$396
Mandibular partial denture – flexible base-(including retentive/clasping materials, rests and teeth)	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the immediate denture	$396
Immediate maxillary partial denture – flexible base (including any clasps, rests and teeth)		$396
Immediate mandibular partial denture – flexible base (including any clasps, rests and teeth)		$396
Removable unilateral partial denture – one piece cast metal -(including retentive/clasping materials, rests and teeth)	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the denture	$396
Mandibular		$396
Maxillary		$396

Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests and teeth) – per quadrant		$198
Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests and teeth) – per quadrant		$174
Adjust complete denture – maxillary	Adjustment is not separately eligible within 6 months of placement of the denture	$11
Adjust complete denture – mandibular	Adjustment is not separately eligible within 6 months of placement of the denture	$11
Adjust partial denture – maxillary	Adjustment is not separately eligible within 6 months of placement of the denture	$11
Adjust partial denture – mandibular	Adjustment is not separately eligible within 6 months of placement of the denture	$11
Repair broken complete denture base, maxillary		$40
Repair broker complete denture base, mandibular		$40
Replace missing or broken teeth – complete denture (each tooth)		$30
Repair resin denture base, maxillary		$40
Repair resin denture base, mandibular		$40
Repair cast framework, maxillary		$40
Repair cast framework, mandibular		$40
Repair or replace broken clasp - per tooth		$40
Replace broken teeth – per tooth		$40
Add tooth to existing partial denture		$40
Add clasp to existing partial denture - per tooth		$50
Replace all teeth and acrylic on cast metal framework (mandibular)		$110
Replace all teeth and acrylic on cast metal framework (maxillary)		$110
Rebase complete maxillary denture	Rebase is not separately eligible within 6 months of placement of the denture	$110
Rebase complete mandibular denture	Rebase is not separately eligible within 6 months of placement of the denture	$110

Rebase maxillary partial denture	Rebase is not separately eligible within 6 months of placement of the denture	$110
Rebase mandibular partial denture	Rebase is not separately eligible within 6 months of placement of the denture	$110
Rebase hybrid prosthesis	Rebase is not separately eligible within 6 months of placement of the denture	$110
Reline complete maxillary denture (direct)	Reline is not separately eligible within 6 months of placement of the denture	$55
Reline complete mandibular denture (direct)	Reline is not separately eligible within 6 months of placement of the denture	$55
Reline maxillary partial denture (direct)	Reline is not separately eligible within 6 months of placement of the denture	$55
Reline mandibular partial denture (direct)	Reline is not separately eligible within 6 months of placement of the denture	$55
Reline complete maxillary denture (indirect)	Reline is not separately eligible within 6 months of placement of the denture	$125
Reline complete mandibular denture (indirect)	Reline is not separately eligible within 6 months of placement of the denture	$125
Reline maxillary partial denture (indirect)	Reline is not separately eligible within 6 months of placement of the denture	$125
Reline mandibular partial denture (indirect)	Reline is not separately eligible within 6 months of placement of the denture	$125
Soft liner for complete or partial removable denture - indirect	Reline is not separately eligible within 6 months of placement of the denture	$125
Interim partial denture (including retentive/clasping materials, rests, and teeth),-maxillary	Eligible when replacing anterior teeth	$157
Interim partial denture (including retentive/clasping materials, rests, and teeth),-mandibular	Eligible when replacing anterior teeth	$157
Tissue conditioning, maxillary	Tissue conditioning is not separately eligible within 6 months of placement of the denture	$55

Tissue conditioning, mandibular	Tissue conditioning is not separately eligible within 6 months of placement of the denture	$55
Abutment supported porcelain/ceramic crown		$362
Abutment supported porcelain fused to metal crown (predominantly base metal)		$362
Abutment supported porcelain fused to metal crown (noble metal)		$362
Abutment supported cast metal crown (predominantly base metal)		$362
Abutment supported cast metal crown (noble metal)		$362
Implant supported porcelain/ceramic crown		$362
Abutment supported retainer for porcelain/ceramic fixed partial denture		$362
Abutment supported retainer for porcelain fused to metal fixed partial denture (predominantly base metal)		$362
Abutment supported retainer for porcelain fused to metal fixed partial denture (noble metal)		$362
Abutment supported retainer for cast metal fixed partial denture (predominantly base metal)		$362
Abutment supported retainer for cast metal fixed partial denture (noble metal)		$362
Implant supported retainer for ceramic fixed partial denture		$362
Re-cement or re-bond implant/abutment supported crown		$24
Re-cement or re-bond implant/abutment supported fixed partial denture		$26
Implant /abutment supported removable denture for edentulous arch – maxillary		$347
Implant /abutment supported removable denture for edentulous arch – mandibular		$347
Implant /abutment supported removable denture for partially edentulous arch – maxillary		$347

Implant /abutment supported removable denture for partially edentulous arch – mandibular		$347
Implant /abutment supported fixed denture for edentulous arch – maxillary		$347
Implant /abutment supported fixed denture for edentulous arch – mandibular		$347
Implant /abutment supported fixed denture for partially edentulous arch – maxillary		$347
Implant /abutment supported fixed denture for partially edentulous arch – mandibular		$347
Implant supported crown – porcelain fused to predominantly base alloys		$362
Implant supported crown – porcelain fused to noble alloys		$362
Implant supported crown – porcelain fused to titanium and titanium alloys		$362
Implant supported crown – predominantly base alloys		$362
Implant supported crown – noble alloys		$362
Implant supported crown – titanium and titanium alloys		$362
Abutment supported crown – porcelain fused to titanium and titanium alloys		$362
Implant supported retainer – porcelain fused to predominantly base alloys		$362
Implant supported retainer for fixed partial denture – porcelain fused to noble alloys		$362
Implant supported retainer – porcelain fused to titanium and titanium alloys		$362
Implant supported retainer for metal fixed partial denture – predominantly base alloys		$362
Implant supported retainer for metal fixed partial denture – noble alloys		$362
Implant supported retainer for metal fixed partial denture – titanium and titanium alloys		$362

Pontic – indirect resin based composite		$362
Pontic – cast predominantly Base metal		$362
Pontic – cast noble metal		$362
Pontic – porcelain fused to predominantly base metal		$362
Pontic – porcelain fused to noble metal		$362
Pontic – porcelain fused to titanium and titanium alloys		$362
Pontic – porcelain/ceramic		$362
Pontic – resin with predominantly base metal		$362
Pontic – resin with noble metal		$362
Retainer – cast metal for resin-bonded fixed prosthesis		$236
Retainer – porcelain/ceramic for resin-bonded fixed prosthesis		$236
Resin retainer – for resin bonded fixed prosthesis		$181
Retainer inlay – porcelain/ceramic, 2 surfaces		$236
Retainer inlay – porcelain/ceramic, 3 or more surfaces		$236
Retainer inlay – cast predominantly base metal, 2 surfaces		$236
Retainer inlay – cast predominantly base metal, 3 or more surfaces		$236
Retainer inlay – cast noble metal, 2 surfaces		$257
Retainer inlay – cast noble metal, 3 or more surfaces		$257
Retainer onlay – porcelain/ceramic, 2 surfaces		$252
Retainer onlay – porcelain/ceramic, 3 or more surfaces		$252
Retainer onlay – cast predominantly base metal, 2 surfaces		$252
Retainer onlay – cast predominantly base metal, 3 or more surfaces		$252
Retainer onlay – cast noble metal, 2 surfaces		$273
Retainer onlay – cast noble metal, 3 or more surfaces		$273
Retainer crown – indirect resin based composite		$362

Retainer crown – resin with predominantly base metal		$362
Retainer crown – resin with noble metal		$362
Retainer crown – porcelain/ceramic		$362
Retainer crown – porcelain fused to predominantly base metal		$362
Retainer crown – porcelain fused to noble metal		$362
Retainer crown – 3/4 cast predominantly base metal		$362
Retainer crown – 3/4 cast noble metal		$362
Retainer crown – 3/4 porcelain/ceramic		$362
Retainer crown – full cast predominantly base metal		$362
Retainer crown – full cast noble metal		$362
Re-cement or re-bond fixed partial denture		$25
Pediatric partial denture, fixed		$157
Extract, coronal remnants – deciduous tooth		$8
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)		$17
Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated		$41
Removal of impacted tooth – soft tissue		$65
Palliative (emergency) treatment of dental pain – minor procedure		$11
Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	For second opinions only	$0
Consultation with a medical health care professional		$0
Cleaning and inspection of removable complete denture, maxillary		$25
Cleaning and inspection of removable complete denture, mandibular		$25

Cleaning and inspection of removable partial denture, maxillary		$25
Cleaning and inspection of removable partial denture, mandibular		$25
Occlusal guard, by report	1 every 3 years	
Hard appliance, full arch		$224
Soft appliance, full arch		$195
Hard appliance, partial arch		$117
Repair and/or reline of occlusal guard		$22
Occlusal guard adjustment	Adjustments are not eligible within 6 months of the placement of the appliance	$24
Full mouth rehabilitation, per unit (6 or more covered units of crowns and/or pontics under one treatment plan)		$125

Specialty Care Services	Limitations	Copayment Amounts
Endodontic therapy, molar (excluding final restoration)		$333
Retreatment of previous root canal therapy – anterior		$242
Retreatment of previous root canal therapy – premolar		$308
Retreatment of previous root canal therapy – molar		$435
Apicoectomy – anterior		$148
Apicoectomy – bicuspid (first root)		$148
Apicoectomy – molar (first root)		$158
Apicoectomy – each additional root		$99
Surgical repair of root resorption - anterior		$67
Surgical repair of root resorption - premolar		$89
Surgical repair of root resorption - molar		$111
Retrograde filling – per root		$80
Root amputation – per root		$88
Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior		$88
Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar		$118
Surgical exposure of root surface without apicoectomy or repair of root resorption - molar		$147
Gingivectomy or gingivoplasty, 4 or more contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	$168
Gingivectomy or gingivoplasty, 1-3 contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	$78
Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth		$26

Gingival flap procedure, including root planing, 4 or more contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	$180
Gingival flap procedure, including root planing, 1-3 contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	$108
Apically positioned flap		$147
Clinical crown lengthening – hard tissue		$205
Osseous surgery (including elevation of a full thickness flap and closure),4 or more contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	$341
Osseous surgery (including elevation of a full thickness flap and closure), 1-3 contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	$205
Surgical revision procedure, per tooth		$137
Pedicle soft tissue graft procedure		$263
Autogenous connective tissue graft procedure (including donor and recipient surgical sites), first tooth, implant or edentulous tooth position		$158
Non-autogenous connective tissue graft (including recipient site and donor material), first tooth, implant, or edentulous tooth position in graft		$347
Combined connective tissue and pedicle graft, per tooth		$260
Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth, implant, or edentulous tooth position in graft		$111
Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant, or edentulous tooth position in same graft site		$56

Autogenous connective tissue graft procedure (including donor and recipient surgical sites), each additional contiguous tooth, implant or edentulous tooth position in same graft site		$87
Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material), each additional contiguous tooth, implant or edentulous tooth position in same graft site		$191
Add metal substructure to acrylic full denture (per arch)		$40
Removal of impacted tooth – partially bony		$85
Removal of impacted tooth – completely bony		$155
Removal of impacted tooth – completely bony, with unusual surgical complications		$155
Removal of residual tooth roots - cutting procedure		$37
Coronectomy - intentional partial tooth removal		$70
Exposure of an unerupted tooth		$63
Mobilization of erupted or malpositioned tooth to aid eruption		$77
Placement of device to facilitate eruption of impacted tooth		$15
Incisional biopsy of oral tissue – hard (bone, tooth)		$195
Incisional biopsy of oral tissue – soft		$195
Exfoliative cytological sample collection		$110
Alveoloplasty in conjunction with extractions, 4 or more teeth or tooth spaces, per quadrant		$39
Alveoloplasty in conjunction with extractions, 1 to 3 teeth or tooth spaces, per quadrant		$20
Alveoloplasty not in conjunction with extractions, 4 or more teeth or tooth spaces, per quadrant		$66
Alveoloplasty not in conjunction with extractions, 1 to 3 teeth or tooth spaces, per quadrant		$33

Incision and drainage of abscess – intraoral soft tissue		$33
Incision and drainage of abscess – intraoral soft tissue - complicated		$36
Buccal/ labial frenectomy (frenulectomy)		$99
Lingual frenectomy (frenulectomy)		$99
Frenuloplasty		$105
Evaluation for deep sedation or general anesthesia		$0
Deep sedation/general anesthesia, first 15 minutes		$109
Deep sedation/general anesthesia – each 15 minute increment		$87
Intravenous moderate (conscious) sedation/analgesia, first 15 minutes		$109
Intravenous moderate (conscious) sedation/analgesia, each 15 minute increment		$87
Infiltration of a sustained release therapeutic when provided as part of an eligible dental service		$0
Occlusal adjustment – limited		$53
Occlusal adjustment – complete		$120

Payment of benefits for Additional Covered Services

These additional benefits will not be subject to any frequency limits except as shown above, or to any **Calendar Year** and **lifetime maximum**.

Aetna Life Insurance Company

Rider

Policyholder: Outten & Golden, LLP

Group policy number: 0149284-A

Rider effective date: January 1, 2022

This rider adds the following to the **group policy** issued to Outten & Golden, LLP and is effective on its issue date.

Section XVIII. Discount programs 4

Discount arrangements

We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called “third party service providers”. These third party service providers may pay us so that they can offer you their services.

Third party service providers are independent contractors. The third party service provider is responsible for the goods or services they deliver. We have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don’t pay the third party service providers for the services they offer. You are responsible for paying for the discounted goods or services.

Wellness and other incentives

Purpose

The purpose of this wellness program is to encourage you to take a more active role in managing your oral health and well-being.

Description

We provide benefits in connection with the use of or participation in any of the following wellness and health promotion actions and activities:

- A health risk assessment tool, which may include completing an online health risk assessment
- Designated online wellness activities, which may include completing an educational course or quiz on dental health or watching videos on dental health topics
- Designated healthy activities, which may include visiting a dentist 1-2 times a year for cleanings and brushing and flossing your teeth
- Programs that promote preventive dental care, such as using an electronic toothbrush for 1-2 minutes a day, visiting a mobile dental clinic, or receiving care for routine dental check-ups

Eligibility
You, the subscriber, and the subscriber's covered spouse; each covered dependent can participate in the wellness program.

Participation
The preferred method for accessing the wellness program is through our website at www.aetna.com. You need to have access to a computer with internet access in order to participate in the website program. However, if you do not have access to a computer, please call us at 1-877-238-6200 and we will provide you with information regarding how to participate without internet access.

Rewards
Rewards for participation in a wellness program include:

- The waiver or reduction of copayments, deductibles or coinsurance.
- Contributions to a health reimbursement account ("HRA") or health savings account ("HSA").
- Monetary rewards in the form of cash, gift cards or gift certificates, so long as the recipient is encouraged to use the reward for a product or service that promotes good oral health, such as specialty toothbrushes, oral health supplies, or sugar-free gum.
- Merchandise, so long as the item is geared at promoting good oral health, such as specialty toothbrushes, oral health supplies, or sugar-free gum.

Aetna Life Insurance Company

Rider

Policyholder: Outten & Golden, LLP

Group policy number: 0149284-A

Rider effective date: January 1, 2022

This rider adds the following to the **group policy** issued to Outten & Golden, LLP and is effective on its issue date.

Who is eligible
The policyholder decides and tells us who is eligible for dental care coverage.

When you can join the plan
As an employee you can enroll yourself and your dependents:

- At the end of any waiting period the policyholder requires
- At any time
- Once each **Calendar Year** during the annual enrollment period
- As determined by the policyholder

If you don't enroll yourself and your dependents when you first qualify for dental benefits, you may have to wait until the next annual enrollment period to join.

When will your coverage end?
Coverage under this plan will end if:

- This plan is no longer available
- You voluntarily stop your coverage
- The **group policy** ends
- You are no longer eligible for coverage
- Your employment ends
- You do not pay any required **premium** payment
- We end your coverage.
- You become covered under another dental plan offered by your policyholder

Your coverage will end on either the date your employment ends or the day before the first **premium** contribution due date that occurs after you stop active work.

When coverage may continue under the plan

Your coverage under this plan will continue if:

Your employment ends because of **illness, injury**, sabbatical or other authorized leave as agreed to by the policyholder and us.	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue, until stopped by the policyholder, but not beyond 30 months from the start of your absence.
Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by the policyholder and us.	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage will stop on the date that your employment ends.
Your employment ends because either: • Your job has been eliminated • You have been placed on severance • This plan allows former employees to continue their coverage	You may be able to continue coverage. See the *Special coverage options after your plan coverage end*s section.
Your employment ends because of a paid or unpaid medical leave of absence	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 30 months from the start of the absence.

Your employment ends because of a leave of absence that is not a medical leave of absence	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 1 month from the start of the absence.
Your employment ends because of a military leave of absence	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 24 months from the start of the absence.

Notification of when your employment ends

It is the policyholder's responsibility to let us know when your employment ends. The limits above may be extended only if we and the policyholder agree in writing to extend them.

Additional Information Provided by

Outten & Golden, LLP

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:
Outten & Golden LLP Health and Welfare Plan

Employer Identification Number:
13-4014306

Plan Number:
501

Type of Plan:
Welfare

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
Outten & Golden, LLP
685 Third Avenue 25th Floor
New York, NY 10017
Telephone Number: (917) 282-5176

Agent For Service of Legal Process:
Outten & Golden, LLP
685 Third Avenue 25th Floor
New York, NY 10017

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:
December 31

Source of Contributions:
Employer and Employee

Procedure for Amending the Plan:
The Employer may amend the Plan from time to time by a written instrument signed by the Chief Operating Officer.

ERISA Rights
As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage
Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.