Empire BlueCross BlueShield

Dental Benefit Policy

Empire Dental Prime for Individuals & Families

Plan C

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

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

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

RIGHT TO CANCEL: You have 10 days from the date of delivery to examine this *policy*. If you are not satisfied, for any reason, with the terms of this *policy*, you may return it to us within those 10 days. Return to Empire Blue Cross and Blue Shield, P.O. Box 1115, Minneapolis, MN 55440-1115 by midnight on the tenth day. We will then issue a full refund of any premiums and fees paid, less any payments made for benefits on behalf of you or your dependents.

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

INTRODUCTION

This *policy* is a legal contract between you, the *policyholder* ("*policyholder*", "you", and "your") and Empire Blue Cross and Blue Shield ("Empire", "we", "us", and "our"). This *policy* is governed by the laws of the State of New York. By paying the first *premium* and accepting this *policy*, you agree to be bound by the terms of this *policy*. We agree to provide coverage for benefits as set out in this *policy*.

Renewability: This *policy* will continue as long as your premiums are paid, subject to the 31 day grace period. We reserve the right to terminate this *policy*, in whole or in part, at any *policy* renewal date by giving you written notice at least 31 days prior to the renewal date. See the Renewability provision in the "Termination" section for more information.

We may arrange for others to provide certain administrative services on our behalf, including eligibility determination and *premium* billing. To ensure efficient administration of your benefits, you must cooperate with them in the performance of their duties.

READ YOUR POLICY CAREFULLY. The entire *policy* sets forth, in detail, the rights and obligations of both you and us. It is therefore important that you read your entire *policy* carefully.

Thank you for choosing Empire Blue Cross and Blue Shield!

Mark Wagar

SVP President and GM New York
Empire Blue Cross and Blue Shield

Administered by:
EMPIRE BLUE CROSS AND BLUE SHIELD
Administrative Offices
P.O. Box 856
Minneapolis, Minnesota 55440-0856
(877) 606-3338

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SUMMARY OF DENTAL BENEFITS

The Summary of Dental Benefits is a summary of the *deductibles*, *waiting periods*, *coverage percentages* and *benefit maximums* that apply when you receive *covered services* from a *dentist*. Please refer to the "Description of Covered Services" section of this *policy* for a more complete explanation of the specific services covered. All *covered services* are subject to the conditions, exclusions, limitations, terms and provisions of this *policy*, including any attachments or riders.

Coverage Year

A *coverage year* is a 12-month period in which *deductibles* and *benefit maximums* apply. Your *coverage year* is January 1st through December 31st.

Deductible

The *deductible* is the amount you must pay before we begin to pay for *covered services*. You have to meet your *deductible* every *coverage year* before we will pay for *covered services*.

Deductible Amount.....$50.00 per member

Waiting Periods

A *waiting period* is the length of time you must be covered under this *policy* before we pay benefits. Certain types of services may have *waiting periods* under your *policy*. You are eligible for benefits once you meet any applicable *waiting periods*.

Type of Service	**Waiting Period**
Diagnostic and Preventive Services	None
Basic Restorative Services	6 months
Endodontic Services	12 months
Periodontal Services	12 months
Oral Surgery Services	12 months
Major Restorative Services	12 months
Prosthodontic Services	12 months

Coverage Percentages

After you have met any *deductibles*, we pay the following percentages of the *maximum allowed amount* for *covered services*. The *maximum allowed amount* is different for *participating and non-participating dentists*. If you see a *non-participating dentist*, you may have more out-of-pocket expenses. To learn more about how the *maximum allowed amount* is determined, see the section called Dental Providers and Claims Payments.

Type of Service	**Participating Dentists**	**Non-Participating Dentists**
Diagnostic & Preventive Services	100%	100%
Basic Restorative Services	80%	80%
Endodontic Services	50%	50%
Periodontal Services	50%	50%
Oral Surgery Services	50%	50%

Major Restorative Services	50%	50%
Prosthodontic Services	50%	50%

Benefit Maximum

The *benefit maximum* is the dollar amount we will pay for *covered services* for each *member* per *coverage year*, subject to the *coverage percentages* identified above. If you do not reach your *benefit maximum*, any unused amount is not carried over to the next *coverage year*.

Benefit Maximum ..... $1,250.00 per *member*

DEFINITIONS

This section defines terms that have special meanings within this booklet. Terms that are defined in this section will be italicized throughout the booklet. When you see an italicized word, you should refer to this section.

Benefit maximum - the maximum amount we will pay for *covered services* for each *member* during the *coverage year*. See the "Summary of Dental Benefits" for your *benefit maximums*.

Coverage percentages - the percentage of the *maximum allowed amount* that you are responsible to pay for *covered services*. Your *coverage percentages* will not be reduced by refunds, rebates, or any other form of negotiated post-payment adjustments. *Coverage percentages* are listed in the "Summary of Dental Benefits".

Coverage year - a 12 month period in which *deductibles* and *benefit maximums* apply. Your coverage year is January 1st through December 31st.

Covered services - services or treatments that are performed, prescribed, directed or authorized by a *dentist*. *Covered services* are listed in the section "Description of Covered Services". To be considered *covered services*, services must be:

- within the scope of the license of the *dentist* performing the service;
- given while you are covered under this *policy*;
- a service that is not excluded or limited under this *policy*; and
- listed as a benefit within this booklet.

Deductible - the dollar amount you are responsible to pay each *coverage year* before we will pay for *covered services*. Your deductible amount is listed in the "Summary of Dental Benefits".

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

Dependent - a person in your family that is eligible for coverage under this *policy*. See the section "Eligibility and Termination" for more information.

Effective date - the date your coverage begins under this *policy*.

Identification card / ID card - a card we issue to you that shows your name, your member ID number, and important phone numbers to contact us.

Maximum allowed amount - the maximum amount we will pay for *covered services*. See the section "Dental Providers and Claims Payments" for more information on how we determine the *maximum allowed amounts.*

Member - any person that is covered under this *policy*.

Non-participating dentist - a *dentist* who has NOT signed a written agreement with us to service the program identified in this booklet.

Participating dentist - a *dentist* who has signed a written agreement with us to service the program identified in this booklet. Participating dentists have agreed to our *maximum allowed amount* as payment in full for *covered services*.

Policy - is the entire set of benefits, conditions, exclusions and limitations that make up your coverage. It consists of this booklet, your application, and any endorsements.

Policyholder - is the person who has applied and been accepted by us for coverage under this *policy*.

Premium - the periodic charges you must pay for coverage under this *policy*.

Waiting period - the length of time you must be covered under this *policy* before we pay benefits. See the “Summary of Dental Benefits” for your *waiting periods*.

DENTAL PROVIDERS AND CLAIMS PAYMENTS

You do not have to select a particular *dentist* to receive dental benefits. You have the freedom to choose the *dentist* you want for your dental care. However, your *dentist* choice can make a difference in the benefits you receive and the amount you pay. You may have additional out-of-pocket costs if your *dentist* is a *non-participating dentist*. There may be differences in the payment amount compared with a *participating dentist* if your *dentist* is *a non-participating dentist*.

We make payments only when the *covered service* has been completed. We may require additional information from you or your *dentist* before a claim can be considered complete and ready for processing. In order to properly process a claim, we may be required to add an administrative policy line to the claim. Duplicate claims previously processed will be denied.

This section describes how we determine the amount of reimbursement for *covered services*. Reimbursement for dental services rendered by *participating* and *non-participating dentists* is based on the *maximum allowed amount* for the type of service performed. There may be different levels of reimbursement for the *maximum allowed amount* depending upon whether you elect to receive services from a *participating* or a *non-participating dentist*.

The *maximum allowed amount* is the maximum amount of reimbursement we will pay for *covered services* provided by a *dentist* to a *member*. For *participating dentists*, the *maximum allowed amount* will be reimbursed according to the Schedule of Maximum Allowable Charges. For *non-participating dentists*, the *maximum allowed amount* will be reimbursed according to the Table of Allowances.

You will be required to pay a portion of *the maximum allowed amount* if you have not met your *deductible* or have a *coverage percentage* due. In addition, when you receive *covered services* from a *non-participating dentist*, you may be responsible for paying any difference between the *maximum allowed amount* and the *dentist's* actual charges. This amount may be significant.

When you receive dental care from a *dentist*, we will apply processing rules to the claim submitted for that dental care. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the dental procedure. Applying these rules may affect our determination of the *maximum allowed amount*. For example, your *dentist* may have submitted the claim using several procedure codes when there is a single procedure code that includes all or a combination of the procedures that were performed. When this occurs, our payment will be based on the single *maximum allowed amount* for the single procedure code rather than a separate *maximum allowed amount* for each billed procedure code.

Likewise, when multiple procedures are performed on the same day by the same *dentist* or another *dentist*, we may reduce the *maximum allowed amount* for those additional procedures, because reimbursement at 100% of the *maximum allowed amount* for those procedures would represent a duplicate payment for a dental procedure that may be considered incidental or inclusive.

Participating Dentists

A *participating dentist* is a *dentist* who has signed a written provider service agreement agreeing to service the program identified in this *policy*. For *covered services* performed by a *participating dentist*, the *maximum allowed amount* is based upon the lesser of the *dentist's* actual charges or the Schedule of Maximum Allowable Charges. Because *participating dentists* have agreed to accept the *maximum allowed amount* as payment in full for services, they should not send you a bill or collect for amounts above the agreed upon *maximum allowed amount*. However, you may receive a bill or be asked to pay a portion of the *maximum allowed amount* if you have exhausted your coverage for the service, have not met your *deductible*, have a *coverage percentage* due, have received non-covered services, or have

exceeded the *benefit maximum* as outlined in the "Summary of Dental Benefits". Please call our Customer Service Department at (877) 604-2142 for help in finding a *participating dentist* or visit our website at www.empireblue.com.

Non-Participating Dentists

Dentists who have NOT signed a written provider service agreement agreeing to service the program identified in this *policy* are considered *non-participating dentists*. For *covered services* you receive from a *non-participating dentist*, the *maximum allowed amount* will be the lesser of the *dentist's* actual charges or an amount based on our *non-participating dentist* fee schedule, referred to as the Table of Allowances, which we reserve the right to modify from time to time after considering one or more of the following: reimbursement amounts accepted by similar providers contracted with us, and other industry cost, reimbursement and utilization data. The Table of Allowances may be different from the *maximum allowed amount* reimbursed to *participating dentists*.

Unlike *participating dentists*, *non-participating dentists* may send you a bill and collect for the amount of the *dentist's* charge that exceeds the *maximum allowed amount*. You are responsible for paying the difference between the *maximum allowed amount* and the amount the *non-participating dentist* charges. This amount may be significant. Choosing a *participating dentist* will likely result in lower out of pocket costs to you. Please call our Customer Service Department at (877) 604-2142 for help in finding a *participating dentist* or visit our website at www.empireblue.com.

Customer Service is also available to assist you in determining the *maximum allowed amount* for a particular service from *a non-participating dentist*. In order for us to assist you, you will need to obtain the specific procedure code(s) from your *dentist* for the services the *dentist* will render. You will also need to know the *dentist's* charges to calculate your out of pocket responsibility. Although Customer Service can assist you with this pre-service information, the *maximum allowed amount* for your claim will be based on the actual claim submitted.

Your Cost Share

For certain *covered services* and depending on your dental program, you may be required to pay a part of the *maximum allowed amount* (for example, *deductible* and/or *coverage percentage*). Your *deductible*, *coverage percentage* and out-of-pocket costs may vary depending on whether you received services from a *participating* or *non-participating dentist*. Specifically, you may pay higher out-of-pocket costs when using *non-participating dentists*. Please see the "Summary of Dental Benefits" in this *policy* for your cost share responsibilities and limitations, or call Customer Service to learn how this *policy's* benefits or cost share amounts may vary by the type of *dentist* you use.

Pretreatment Estimates

It is recommended, but not required, that a pretreatment estimate be submitted to us prior to treatment for major restorative, periodontal, or prosthodontic services. See the section "Description of Covered Services" for more information on these services.

The pretreatment estimate is a valuable tool for both you and your *dentist*. Submitting a pretreatment estimate allows you and the *dentist* to know what benefits are available to you before receiving dental care. This process does not pre-authorize the treatment nor determine its dental necessity.

The pretreatment estimate is only an estimate. It does not guarantee we will pay for your dental care. Our final payment will be based on the claim that is submitted for your dental care.

If you would like a pretreatment estimate, tell your *dentist*. Your *dentist* will determine the dental care to be performed. You or your *dentist* should submit a claim form to us outlining the proposed care. We will determine if the proposed care is covered and estimate the *maximum allowed amount*. We will also estimate your cost share amount, such as any *coverage percentages* and *deductibles*. You are responsible to pay any *deductibles*, *coverage percentages*, or for any services not covered under this *policy*.

A statement will be sent to you and your *dentist* estimating the *maximum allowed amount* and your cost share amount. These estimates are based on your current coverage. Any change in your coverage or your eligibility will affect the final payment. If claims for any other dental care are submitted before the date you receive the proposed care, this may reduce our final payment, which will increase your cost share amount.

Before you receive dental care, be sure to ask your *dentist* if they have agreed to service this dental *policy*. This will help avoid any misunderstanding over the *maximum allowed amount* or your cost share amount.

DESCRIPTION OF COVERED SERVICES

The following services are covered when given by a licensed *dentist* and within the generally accepted standards of dental practice. Only services listed in this section are covered under this *policy*.

Diagnostic and Preventive Services

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

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

Radiographs (X-rays)

- **Bitewings** - Covered at 1 series of bitewings per 12-month period for *members* through the age of 17; 1 series of bitewings per 24-month period for *members* age eighteen 18 and over.
- **Full Mouth (Complete Series) or Panoramic** - Covered 1 time per 60-month period.
- **Periapical(s)** - 4 single x-rays are covered per 12-month period.
- **Occlusal** - Covered at 2 series per 24-month period.

Dental Cleaning

- **Prophylaxis** - Any combination of this procedure and Periodontal Maintenance (See Periodontal Services) are covered 2 times per calendar year.

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

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

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

Fluoride Varnish - Covered 1 time per 12-month period for dependent children through the age of 18.

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

Enhanced benefit for members who are pregnant or who have diabetes

Enhanced dental benefits are available for *members* who are pregnant or diagnosed with Type 1 or Type 2 diabetes. *Members* diagnosed with gestational diabetes are eligible for benefits due to pregnancy or diabetes, but not both.

A *member* who is pregnant or diagnosed with gestational diabetes is eligible for one additional benefit for a maximum of two *coverage years*. A *member* diagnosed with Type 1 or Type 2 diabetes is eligible for

one additional benefit per *coverage year* until their coverage ends. The enhanced benefits include a maximum of one of the following procedures:

- Prophylaxis-adult.
- Periodontal maintenance. Covered only when following active periodontal therapy.

To obtain the additional benefit(s), the *member* must complete the enhanced benefit application enrollment form and submit it to us at:

Empire Dental Claims
Attention: Clinical Integration Coordinator
P.O. Box 1115
Minneapolis, MN 55440-1115

The enhanced benefit will be available on the first of the month following the date we receive the enhanced benefit enrollment form.

Basic Restorative Services

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

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth.

Composite (white) Resin Restorations

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

  NOTE: Coverage for amalgam or composite restorations shall be limited to only 1 service per tooth surface per 24-month period.

Space Maintainers - Covered 1 time per lifetime on eligible dependent children through the age of 16 for extracted primary posterior (back) teeth. Repair or replacement of lost/broken appliances is not a covered benefit.

Basic Extractions

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

Brush Biopsy - Covered 1 time every 36 months for *members* age 20 to 39. Covered 1 time per 12 months for *members* age 40 and above.

Endodontic Services

Endodontic Therapy on Primary Teeth

- **Pulpal Therapy**
- **Therapeutic Pulpotomy**

Endodontic Therapy on Permanent Teeth

- **Root Canal Therapy**
- **Root Canal Retreatment**

All of the above procedures are covered 1 time per tooth per lifetime.

Periodontal Services

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

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

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

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

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

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

Only 1 complex surgical periodontal service is covered per 36-month period per single tooth or multiple teeth in the same quadrant and only if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Complex Surgical Extractions

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

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

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

Adjunctive General Services

Intravenous Conscious Sedation, IV Sedation and General Anesthesia - Covered when performed in conjunction with complex surgical services. Intravenous conscious sedation, IV sedation and general anesthesia will not be covered when performed with non-surgical dental care.] Analgesia, analgesic agents, nitrous oxide, prescription drug charges, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care are not covered.

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

Major Restorative Services

Services performed to restore lost tooth structure as a result of decay or fracture. Dental services performed for cosmetic purposes, including cosmetic surgery and services or supplies that have the primary purpose of improving the appearance of your teeth are not covered. This includes but is not limited to tooth whitening agents, tooth bonding and veneer covering of the teeth.

Gold foil restorations - Covered 1 time per 24-month period. Benefits are available at the same level that applies to an amalgam (silver filling) and are subject to the same number of surface limitations and allowances. The patient must pay the difference in cost between the *maximum allowed amount* for the *covered services* and optional treatment, plus any *deductible* and/or *coverage percentage* for the *covered service*.

Inlays - Benefits are available at the same level that applies to an amalgam (silver) restoration and are subject to the same surface limitations and allowance. If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the *maximum allowed amount* for the *covered service* and optional treatment, plus any *deductible* and/or *coverage percentage* for the *covered service*.

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

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

> NOTE: Porcelain/ceramic substrate onlays/crowns – Benefits will be limited to the *maximum allowed amount* for a porcelain to noble metal crown. The patient must pay the difference in cost between the allowed fee for the *covered service* and optional treatment, plus any *deductible* and/or *coverage percentage* for the *covered service*.

Implant Crowns - See Prosthodontic Services.

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

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

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

Prosthodontic Services

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

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

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

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

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

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

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

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

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

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

- For *members* age 16 or older;
- For the replacement of extracted (removed) permanent teeth;
- If 7 years have elapsed since the last benefited removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

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

- For *members* age 16 or older;
- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been benefited previously as a crown or cast restoration in the last 7 years;

- If 7 years have elapsed since the last benefited removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, a removable partial denture may be the benefit since it would be the least costly, commonly performed course of treatment. The optional benefit is subject to all contract limitations on the *covered service*.

Recement Fixed Prosthetic - Covered 1 time per 12 months.

Other Complex Surgical Procedures - Covered when necessary to prepare for dentures.
- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis - per site
- Surgical reduction of osseous tuberosity

Completed Single Tooth Implant Body, Abutment and Crown - Covered 1 time per 7-year period for Members age 16 and over. Coverage includes the single surgical placement of the implant body, implant abutment and implant/abutment supported crown. It is recommended that a Pretreatment Estimate be requested prior to beginning treatment.

Coverage for congenitally missing teeth is available once the Member has been continuously covered under this Plan for 24 months or more.

Coverage will be limited to the least expensive professionally acceptable treatment.

Optional Treatment Plans
In all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the *member* and the *dentist*; however, the benefits payable hereunder will be made for the applicable percentage of the least costly course of treatment, with the balance of the treatment cost remaining the payment responsibility of the *member*.

EXCLUSIONS

We will not pay for services incurred for, or in connection with, any of the items below.

- Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any State or Federal workers' compensation, employers' liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family; and services for which no charge is normally made.Dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly;
- Experimental and/or investigational services recommended by an external appeal agent pursuant to an external appeal must be covered as per New York Insurance Law.
- Cosmetic surge*ry, ex*cept that cosmetic surgery shall not include reconstructive surgery when *such s*ervice is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. However, if the policy provides hospital, surgical or medical expense coverage, including a policy issued by a health maintenance organization, then coverage and determinations with respect to cosmetic surgery must be provided.

ELIGIBILITY AND TERMINATION

This section will tell you who is eligible for coverage under this *policy* and how to add or remove *dependents* from your *policy*. It will also give you information about how your coverage ends under this *policy*.

Who is Eligible

Policyholder

1. To be a *policyholder*, you must meet the following requirements:
    a. be a New York resident;
    b. be at least 18 years of age;
    c. have applied and been accepted for coverage; and
    d. are not enrolled in any other Empire group or individual dental coverage.

Dependents

The following *dependents* of a *policyholder* may be covered under this *policy*:

1. Spouse, meaning:
    a. Married
    b. Legally separated
    c. Qualified domestic partner, if all of the following criteria are met:
        i. are not related by blood closer than permitted under applicable state marriage laws;
        ii. are not married and do not have any other domestic partners;
        iii. are at least 18 years of age and have the capacity to enter in a contract;
        iv. share a residence;
        v. are jointly responsible to each other for the necessities of life and could produce documentation of at least three of the following items as evidence:
            - joint mortgage or joint tenancy on a residential lease;
            - joint bank account
            - join liabilities (e.g., credit cards or car loans);
            - joint ownership of significant property (e.g., cars, land, etc.);
            - naming of each other a beneficiary in wills or life insurance policies;
            - written notarized agreements or contracts regarding the relationship, showing mutual support obligations, or joint ownership of assets acquired during the relationship;
            - commitment to a long-term relationship with the intention of remaining together indefinitely.

        All references to spouses in this *policy* will include domestic partners.
2. Dependent children up to the age of 26, including:
    a. You and your spouse's natural-born and legally adopted children.

b. Children for whom you or your spouse are the legal guardian.

c. Stepchildren.

d. Grandchildren who are financially dependent on you and reside with you or your spouse continuously from birth.

3. Disabled children who have reached age 26 if:

   a. they are primarily dependent upon you or your spouse;

   b. they are incapable of self sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability; and

   c. were disabled before they reached age 26.

Newborn and Adopted Children
Children may be added to the *policy* at the time the *policyholder* originally purchases the *policy* or may be added anytime up to 31 days following the child's 3rd birthday. If a child is born or adopted after the *policyholder's* original policy *effective date*, the child may be added anytime between birth (or date of adoption) and 31 days following the child's 3rd birthday. If the child is added within 31 days following the child's birth/adoption, coverage for the child will be effective on the date of the child's birth/adoption. If the child is not added within 31 days following their 3rd birthday, that child may be added only if there is a family status change, or at the next policy renewal date.

Family Status Change
Your benefit and enrollment elections are intended to remain the same until your next renewal date. Changes to your *policy* can only be made at your renewal date, unless you have a family status change. Events that qualify as a family status change are:

- Change in legal marital status such as marriage, divorce or dissolution of a domestic partnership.
- Change in number of *dependents* in the event of birth, adoption, a court order to provide coverage, or death.
- Change in your spouse's employment, such as starting or losing a job.
- Change in your spouse's work schedule, such as going from full-time to part-time or part-time to full-time, or beginning or ending an unpaid leave of absence.
- Covered child reaches age 26.

Due to federal regulations, the changes you make to your benefits must be consistent with the family status change event that you experience. For example, if you have a baby, it is consistent to add your newborn to your current dental coverage but it is not consistent to drop your dental coverage altogether.

If you experience one of the above eligible family status changes during the year, you have 31 days from the event to change your elections. If you need to make changes to your *policy* due to a family status change, you should contact Customer Service at the number listed on your *ID card* to obtain an Enrollment Change Form.

Policy Effective Date
Your *policy* begins on the *effective date* stated on the Policy Confirmation that you received following your enrollment.

Termination

When Your Coverage Ends
Your coverage and that of your *dependents* will end on the earliest of the following dates:

1. The end of the month in which you are no longer eligible;
2. The end of the month in which your *dependent* is no longer a *dependent* as defined in this *policy*;
3. The last day of the month for which a *premium* has not been paid, subject to the 31 day grace period; or
4. The date the *policy* ends.

Cancelling Your Policy
After your initial 12 month policy period, you may terminate this *policy* by giving written notice to us 31 days prior to any premium due date. If you elect coverage and subsequently cancel your *policy*, you and your *dependents* will not be allowed to re-enroll in the *policy* for a period of 24 months from the date your *policy* was cancelled.

Renewability
This *policy* will continue as long as your *premiums* are paid, subject to the 31 day grace period. We reserve the right to terminate the *policy*, in whole or in part, at any *policy* renewal date by giving you written notice at least 31 days prior to the renewal date. Please see the section above entitled "When Your Coverage Ends" for reasons that your coverage may not be renewed. Termination of the *policy* will result in loss of coverage for all *members* under your *policy*. If the *policy* is terminated, the rights of the *members* are limited to *covered services* incurred before termination. Termination is without prejudice to any claim originating while the *policy* was in force.

Reinstatement
If your *policy* is terminated because you do not pay your *premium* within the grace period you may have it reinstated. Your *policy* will be reinstated if we, or an agent authorized by us, accept your *premium* payment after we have terminated your *policy*. If we accept your *premium*, we will not require an application to reinstate your *policy*.

However, we may ask for a new application to accept your *premium* and reinstate your *policy*. If we ask for a new application we will only re-instate your *policy* after we approve your application. We will notify you if we do not approve of your application within 45 days. If we do not notify you within 45 days after we received your application, it will be deemed approved.

If your *policy* is reinstated, only dental care received after the reinstated date will be covered. Your rights will be the same and will not change due to the reinstatement. We will apply the reinstated *premium* to the period for which the *premium* was not paid. However, we will not apply *premium* to any period over 60 days prior to reinstatement.

Reinstatement for Members of the Military
If you are a reservist of the armed forces of the United States, including the National Guard, you may contact us to suspend your coverage as a result of being ordered to active duty. Any unearned premiums during your suspension will be refunded to you.

Upon completion of active duty, your coverage will be reinstated with no limitations or conditions imposed as a result of your suspension. Any *waiting period* not completed prior to your suspension will still need to be met after your coverage is reinstated.

Please contact Customer Service to request a suspension or reinstatement of your coverage.

HOW TO FILE CLAIMS

A claim must be filed in order for us to pay for *covered services*. Most *dentists* will file your claim for you. If your *dentist* does not file the claim, you must file your claim with us. This section will tell you how to file a claim.

Notice of Claim

We must receive written notice of claim within 20 days from the date you received dental care. If it was not reasonably possible to send the notice within that time, send it to us as soon as is reasonably possible. Notice given to us, or an agent authorized by us, with information sufficient to identify you will meet the notice of claim requirements. If the notice does not include sufficient data we need to process the claim, the necessary data must be submitted to us within the time frames specified below or no benefits will be payable except as required by law.

Claim Forms

When you send us your written notice of claim, we will send you the necessary claim form. The form will be sent to you within 15 days after we receive your notice of claim. If you do not receive the claim forms, you can send us other documents as your proof of claim. You may also contact Customer Service and request a claim form be sent to you. Your proof of claim must have the following:

- Name of patient
- Patient's relationship to you
- Identification number
- Date, type and place of service
- Your signature and the *dentist's* signature

We also accept the standard American Dental Association (ADA) claim form used by most *dentists*.

Please submit your notice of claim, completed claim forms, or proof of claim to:

Empire Blue Cross and Blue Shield
PO Box 1115
Minneapolis, MN 55440-1115
(877) 604-2158

Proof of Claim

We must receive your written proofs of claim within 120 days after the date you received dental care. If proof of claim is not sent within that time, your claim will not be reduced or denied, as long as it was not possible to send your proof. However, you must send it as soon as reasonably possible. In any case, the proof of claim must be sent to us no later than 15 months after the date of service, unless you were legally incapacitated.

Time of Payment of Claim

Any payments for *covered services* under this *policy* will be made immediately upon receipt of written proof of claim and any additional information reasonably necessary to determine our obligation.

If more information is needed to process your claim, we will send you written notice within 30 days after we receive your claim. The notice will tell you what additional information is needed before we can process your claim. You will have 45 days from receipt of the notice to provide us with the information. Without complete information, your claim will be denied.

HOW TO FILE AN APPEAL

This section explains and offers instructions on what to do if you disagree with a denial or modification of benefits for a dental claim, or are dissatisfied with the dental treatment or a service rendered by either a *dentist* or by us, and wishes to file an appeal.

Appeals

In the event that we deny your claim in whole or in part, you have a right to a full and fair review. Your request to review a claim must be in writing and submitted within 180 days from the claim denial. We will make a decision within 60 days following the receipt of your appeal. If special circumstances require an extension of time, the extension will not exceed 120 days after that appeal is received.

Your appeal must include your name, your ID number, the claim number, and the *dentist's* name as shown on your Explanation of Benefits. Send your appeal to:

Empire Blue Cross and Blue Shield
Attention: Appeals Unit
PO Box 551
Minneapolis, MN 55440-0551
(877) 606-3338

You may submit written comments, documents, or other information in support of your appeal. You will also be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The appeal will be reviewed and a final decision made within 60 days after we receive the information necessary to make a decision. The review will take into account all information regarding the denied or reduced claim (whether or not the information was presented or available at the initial decision) and our initial decision will not be given any weight.

The review will be conducted by someone different from the original decision-makers and without deference to any prior decision. In all cases where professional judgment is required to determine if a procedure is covered under your *policy*, we will consult with a dental professional who has appropriate training and experience. In such a case, this professional will not be the same individual whose advice was obtained in connection with the initial decision (nor a subordinate of any such individual). In addition, we will identify any dental professional whose advice was obtained on our behalf, without regard to whether the advice was relied upon in making the decision. If, after review, we continue to deny the claim, you will be notified in writing and our decision will contain specific reasons for the decision. Where review involves an adverse determination, the review will be conducted by a clinical per reviewer. A clinical peer reviewer is a licensed *dentist* or other licensed, certified or appropriately credentialed professional, who is in the same profession and same or similar specialty as a health care provider who typically manages the condition or disease or provides the dental care service or treatment under review.

Authorized Representative
You may authorize another person to represent you and who you want us to communicate with regarding your claim or an appeal. To authorize a representative, you must complete a form. The form is available at our website or by calling customer service at (877) 606-3338. You can only authorize one person as your representative. Your may revoke the authorization at any time. **Note**: No authorization is required for your treating *dentist* to make a claim or appeal on your behalf.

External Appeals

You have the right to an external appeal of a final adverse decision by us is based on a determination that the requested service is experimental or investigational or that it is not dentally necessary. You do not have the right to an external appeal of any other determination. You may request an external appeal only if the requested service is a *covered service* under this *policy*.

An external appeal is an independent review of an appeal decision by a third party known as an External Appeal Agent. External Appeal Agents are certified by the State, and may not have a prohibited affiliation with any health insurer, health maintenance organization (HMO), medical facility, or health care provider associated with the appeal.

You may request an external appeal by filing a standard external appeal request form with the New York State Insurance Department. If the requested service has already been provided to you, your *dentist* may file an appeal on your behalf. We will send a standard request form to you when we have made a final adverse decision. You or your *dentist* may obtain additional standard request forms at any time from the State Insurance Department, the Department of Health, or by contacting us.

You, or your authorized representative, must file your request for an external appeal with the State Insurance Department within four months of receiving a final adverse decision or receiving a letter from us waiving our internal review process. We do not have the authority to grant extensions of this deadline.

The External Appeal Agent is required to make a determination on the appeal within 30 days of receipt of the request for the appeal. The Agent may request additional information from you, your provider or us within that 30 day period, and will then have up to five additional business days to make a decision on the appeal. The External Appeal Agent is required to notify you and us in writing, of the decision within two business days of making the decision.

The decision of the External Appeal Agent is binding on both parties. If the External Appeal Agent decides in our favor, we will not cover the requested service. If the External Appeal Agent decides in your favor, we will cover the service as follows:

- for services denied as not dentally necessary, we will treat the service as dentally necessary and provide coverage subject to all other conditions of the *policy*;
- for services denied as experimental or investigational, other than services provided in a clinical trial, we will pay for the patient costs you incur for the services, subject to all other conditions of this *policy*;
- for services denied as experimental or investigational that are provided in a clinical trial, we will cover the costs of health services required to provide treatment according to the design of the trial, subject to all other conditions of the *policy*. We are not required to pay for and will not pay for, drugs or devices that are the subject of the clinical trial.

GENERAL POLICY PROVISIONS

Premium Calculations and Payment

The payment of any *premium* will keep the coverage in force until the next premium due date, subject to the grace period provision of the *policy*.

Your *premium* amount, the premium payment schedule and the payment method is stated on the Policy Confirmation that you received following your enrollment.

We may change the *premium* for this *policy* by giving you a written notice of at least 60 days prior to any change.

For *premium* and payment questions, call (877) 606-3338.

Grace Period

You have a grace period of 31 days to pay your *premium*. This *policy* will remain in effect during the grace period.

Entire Contract; Changes

This *policy*, including any endorsements or attached papers, is the entire contract of insurance. Its terms can be changed only by a written endorsement signed by one of our authorized officers. No agent or employee of ours is authorized to change the terms or waive any other the provisions of this *policy*.

Time Limit on Certain Defenses

After you have been insured under this *policy* for 2 consecutive years, we will not use any material misstatements you may have made in your application for this *policy*, except any fraudulent misstatements, to either void this *policy* or to deny a claim for any *covered services* incurred after the expiration of such 2 year period.

Legal Actions

No action at law or in equity will be brought to recover on this *policy* sooner than 60 days after written proof of claim has been furnished in accordance with the requirements of this *policy*. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Conformity to Law

The laws of the State of New York will be used to interpret any of this *policy*.

Dental Examination

We have the right to have a *dentist* examine you, at our own expense, as often as is reasonably required while processing a claim under this *policy*. We will notify you in advance.

Change in Beneficiary

You can change your beneficiary at any time by giving us written notice. The beneficiary's consent is not required for this or any other change in the *policy*, unless the designation of the beneficiary is irrevocable.

CONTACT US

CUSTOMER SERVICE DEPARTMENT
(877) 606-3338

Hours: 8 a.m. to 4:30 p.m. Central Time
Monday - Friday

For claims and eligibility:

Empire Blue Cross and Blue Shield
P.O. Box 1115
Minneapolis, MN 55440-11115

Send your appeal to:

Empire Blue Cross and Blue Shield
Attention: Appeals Unit
P.O. Box 1122
Minneapolis, MN 55440-1122

Our website:

www.empireblue.com