This booklet explains the benefits available to you under the self-funded dental benefits program maintained by the University of Rochester (the “Benefit Plan”). The Benefit Plan is funded by the University of Rochester (the “Group”). Excellus Health Plan, Inc. is the Claims Administrator for the Benefit Plan. Excellus Health Plan, Inc. is not acting as the insurer of your benefits. You should keep this booklet with your other important papers so it is available for your future reference.

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

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

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

**READ THIS ENTIRE BOOKLET CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE BENEFIT PLAN. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS OF THIS BOOKLET.**
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SECTION ONE - INTRODUCTION AND DEFINITIONS

1. **Your Coverage Under This Benefit Plan.** The Group has created this self-funded Benefit Plan effective as of January 1, 2015. Under this Benefit Plan, the benefits described in this booklet will be provided to employees or members of the Group and their covered family members, subject to the eligibility requirements. You should keep this booklet with your other important papers so that it is available for your future reference.

2. **Definitions.**

   A. **Allowable Expense.** “Allowable Expense” means the maximum amount the Benefit Plan will pay to a Dentist for the services or supplies covered under the Benefit Plan, before any applicable Deductible and Coinsurance amounts are subtracted. In the Claim Administrator’s Service Area and outside of the Claim Administrator’s Service Area, the Allowable Expense for services of Participating and Non-Participating Providers is based on the Claim Administrator’s Fee Schedule.

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

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

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

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

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

   G. **In-Network Benefits.** In-Network Benefits are the highest level of coverage available. In-Network Benefits apply when your care is provided by Participating Providers.
H. **Member.** Any employee of the Group or eligible dependent who meets all applicable eligibility requirements, for whom the required payment has actually been received by the Claims Administrator or the Group, and who is covered under this Benefit Plan.

I. **Non-Participating Provider.** A Dentist who does not have an agreement with the Claims Administrator or the Claims Administrator’s agent to provide dental services to Members.

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

K. **Participating Provider.** A Dentist who has an agreement with the Claims Administrator or the Claims Administrator’s agent to provide dental services to Members.

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

M. **“You”, “Your” and “Yours”.** Throughout this booklet, the word “you”, “your” or “yours” refers to you, the employee or member of the Group to whom this booklet was issued. If other than individual coverage applies, then in most cases the word “you”, “your” and “yours” also includes any family members who are covered under this Benefit Plan.

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

4. **Predetermination Of Benefits.** A predetermination of benefits is recommended for any dental work that is expected to cost $300 or more. A description of planned treatment and expected charges should be sent to the Claims
Administrator before treatment is started. If there is a major change in the treatment, a revised predetermination of benefits is required. The expenses that will be covered will be determined by the Claims Administrator and are subject to the Alternative Benefits provision in Paragraph 3 above. When there has not been a predetermination of benefits, the Claims Administrator will determine what services will be covered at the time the claim is received. Predetermination of benefits does not guarantee payment and expires one year after the date of issue. The estimate of benefits payable may change based on the benefits, if any, for which a Member qualifies at the time services are completed.

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

1. **Who Is Covered Under This Benefit Plan.** Subject to the permissible eligibility rules of the Group, you, the employee or member of the Group to whom this booklet is issued, are covered under this Benefit Plan. If you selected other than individual coverage, the following members of your family may also be covered, subject to the permissible eligibility rules of the Group:

   A. Your spouse, unless you are divorced or your marriage has been annulled. The term “spouse” means a person of the same or opposite gender that is legally married to you, the employee, and who is recognized as a spouse in accordance with the laws of the State of New York.

   B. Your eligible domestic partner. For a person to be your eligible domestic partner, you and he or she must satisfy the requirements as described in the “application for Domestic Partnership” and “Health Care and Dental Benefits for Domestic Partners Questions and Answers.”

   The value of the Plan coverage for an employee’s domestic partner is treated as taxable income to the employee if the domestic partner does not qualify as a dependent under tax law. The employer will comply with all federal and state tax withholding and reporting requirements for domestic partner coverage.

   C. Your children who are under 26 years of age regardless of marital status or student status.

   D. Any unmarried child, regardless of age, who is incapable of self-sustaining employment because of mental retardation, mental illness, or developmental disability as defined in the New York Mental Hygiene Law, or because of physical handicap. The condition must have occurred prior to the child’s attainment of age 26. The child’s disability must be certified by a physician. You must file an application in the form the Claims Administrator approves to request that the child be included in your family coverage. The Group and the Claims Administrator have the right to check whether a child is and continues to qualify under this Paragraph.

The term “child or children” include your natural children; legally adopted children; step children; children who are placed with you by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction; and children for which you are the proposed adoptive parent and for whom you have a legal obligation for total or partial support during the waiting period prior to the adoption period.
The Claims Administrator and the Group have the right to request and be furnished with such proof as may be needed to determine the eligibility status of a prospective Member and all prospective dependents for coverage under this Benefit Plan.

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

3. **Adopted Newborns.** If you have a type of coverage that will cover a newborn, or switch to a type of coverage that will cover a newborn, in accordance with Paragraph 2 above, the Benefit Plan will cover a proposed adoptive newborn from the moment of birth if you (the proposed adoptive parent) take physical custody of the infant as soon as the infant is released from the hospital after birth and you file a petition within 30 days of the infant’s birth pursuant to §115-C of the New York State Domestic Relations Law or a comparable provision when the child is adopted in another state. However, the Benefit Plan will not provide coverage for the newborn if a notice of revocation of the adoption has been filed or one of the natural parents revokes consent to the adoption. If the Benefit Plan provides coverage of an adopted newborn and notice of the revocation of the adoption is filed or one of the natural parents revokes their consent, the Benefit Plan will be entitled to recover any sums paid by the Benefit Plan for care of the adopted newborn.

4. **Types of Coverage other than Individual Coverage.** In addition to individual coverage, family coverage is also offered under this Benefit Plan.

If family coverage applies, then you, the employee or member of the Group, your spouse or domestic partner, and your child or children as described in Subparagraph 1.C and D. above are covered.

The names of all persons covered under this Benefit Plan must have been specified on the enrollment form for this Benefit Plan or provided to the Group as described in paragraph 7 below. No one else can be substituted for those persons. The Group and the Claims Administrator have administrative rules to determine which types of coverage are available to employees and members of the Group. You are only entitled to the types of coverage for which the Group
(or the Claims Administrator on behalf of the Group) receives your contribution and that the Group’s and the Claims Administrator’s records indicate is applicable. You may call the Group or the Claims Administrator if you have any questions about which type of coverage applies to you.

5. **When Coverage Begins.** Coverage under this Benefit Plan will begin as follows:

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

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

   C. If you, the employee, marry or enter into a domestic partnership while covered, and the Claims Administrator receives notice of such marriage or domestic partnership within 30 days thereafter, coverage for your spouse or domestic partner starts at 12:01 a.m. on the date of your marriage or the date of your domestic partnership. If the Claims Administrator does not receive notice of the marriage or domestic partnership within the 30-day period, your spouse or domestic partner must wait until the next open enrollment period for coverage. When your spouse or domestic partner is enrolled during the next open enrollment period, coverage for your spouse or domestic partner will start at 12:01 a.m. on the date to which the open enrollment period applies.

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

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

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

      (1) Termination of employment;
(2) Termination of the other plan or contract;

(3) Death of the spouse or domestic partner;

(4) Legal separation, divorce or annulment, or termination of a domestic partnership;

(5) Reduction in the number of hours worked;

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

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

(8) Cessation of dependent child status;

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

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

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

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

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

7. Notification of Change in Your Coverage.

A. To Add a Spouse, Domestic Partner or Child. If you need to add a spouse, domestic partner, or child to your coverage (other than a newborn
child added under Paragraph 2 or 3 above), you must complete and return to the Group an enrollment form for this purpose together with any requested documentation. The addition of a child will be effective as of the date of birth or adoption making the child eligible for coverage under Paragraph 1, if you return to your employer a completed enrollment form and requested documents within 30 days of the birth or adoption. The addition of a spouse, domestic partner or other dependent will be effective as of the date of the marriage or commencement of a domestic partnership, or other qualifying event making such individual eligible for coverage under this section or the date the election form is completed, whichever is later, if you return to your employer a completed enrollment form and requested documents within 30 days of the applicable event. If you do not return a completed election form and the requested documentation within 30 days, you will not be able to add the dependent until you reach the annual open enrollment period or experience another qualifying event. Any changes requested during the annual open enrollment period, including the addition of a dependent, will be effective the following January 1.

B. **When Coverage of a Spouse, Domestic Partner, or Child Terminates.**

If you have other than individual coverage, you should notify your employer of any event that affects your coverage, such as, your divorce termination of a domestic partnership; the death of your spouse or domestic partner; a Member becoming Medicare eligible, or a child reaching the age at which coverage terminates or otherwise experiencing an event which would normally result in termination of the child’s coverage. Upon your request, the Group will provide you with an enrollment form for that purpose. If such change results in you seeking a different type of coverage at a lower contribution level (such as a switch to individual coverage), the form and requested documentation must be returned within 30 days of the event. The change in contribution level will occur during the pay period in which the change in coverage becomes effective. Nothing in this Subparagraph B is designed to affect the provisions of Section Eight governing terminations of coverage. This Subparagraph B only involves the effective date of changes in required contribution levels due to terminations of coverage under Section Eight.

If you think there are reasons coverage of the person experiencing the change should continue, you must notify your employer of the reasons for the continuation of the coverage on an enrollment form provided by the Group to you for that purpose, and provide any documentation that is requested by the Group, no later than 60 days after the date on which dependent coverage would usually terminate.

Removing a dependent due to a qualifying event will be effective as of the date of the event or the date the enrollment form is completed, whichever
is later. However, any claims incurred after a dependent becomes ineligible will not be paid by the Benefit Plan.
SECTION THREE - COST SHARING EXPENSES

1. **Deductible.** Except where stated otherwise, each person covered under this Benefit Plan must pay the first $50 of Allowable Expenses incurred for the following benefits under this Benefit Plan during each Calendar Year: Class II; Class IIA; and Class III. If you have other than individual coverage, the Deductible applies to each person covered under this Benefit Plan. However, after Deductible payments for any and all persons covered under this Benefit Plan total $150 in a Calendar Year, no further Deductible will be required for any person covered under this Benefit Plan for that Calendar Year. No more than $50 of any person’s Allowable Expenses can be applied to the maximum limit of $150.

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

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

4. **Annual Maximum.** The annual maximum aggregate amount the Benefit Plan will pay under this booklet for any individual is $2,000 for all of the following covered services: Class II; Class IIA; and Class III. The annual maximum aggregate amount the Benefit Plan will pay under this booklet for all Class IV covered services is $750.

5. **Lifetime Maximum.** The lifetime maximum aggregate amount the Benefit Plan will pay under this booklet for all Class IV covered services for any individual is $1,500.

6. **Alternative Benefits.** As set forth in Section One, paragraph 3, if you or your Dentist choose a procedure that is not medically necessary and carries a higher Allowable Expense than another appropriate procedure, you will be liable for the difference between the Benefit Plan’s payment and the amount billed by the Participating Provider or Non-Participating Provider.
SECTION FOUR - BENEFITS FOR DENTAL SERVICES

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

1. Preventive and Diagnostic Services (Class I).

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

   B. **Radiographs.**

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

      (2) **Bitewings.** The Benefit Plan will provide coverage for up to two bitewing films in a Calendar Year. The Benefit Plan will not provide coverage for bitewings provided in conjunction with a full mouth series.

      (3) **Diagnostic Radiographs and Photographs.** The Benefit Plan will provide coverage for diagnostic x-rays and photographs. Coverage will only be provided for photographs once in a Calendar Year.

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

   C. **Dental Prophylaxis, Including Cleaning, Scaling and Polishing.** The Benefit Plan will provide coverage for prophylaxis twice in a Calendar Year. Coverage will also be provided for cleaning or scaling of teeth performed by a licensed dental hygienist if such treatment is rendered under the supervision and direction of a Dentist.
D. **Topical Fluoride Treatments (Office Procedure).** The Benefit Plan will provide coverage for topical fluoride treatments twice in a Calendar Year for Members less than 16 years of age.

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

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

G. **Space Maintainers.** The Benefit Plan will provide coverage for space maintainers for Members less than 16 years of age once every five years from the date of the last major restorative service (please refer to Class III services below for a list of major restorative services). This includes coverage for adjustment and re-cementation within six months after placement.

H. **Payments for Class I Benefits.**

   **In-Network Benefits.** In-Network Benefits are covered at 100% of the Allowable Expense.

   **Out-of-Network Benefits.** Out-of-Network Benefits are covered at 100% of the Allowable Expense. Out-of-Network Benefits are also subject to balance billing.

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

   A. **Amalgam and Composite Restorations.** The Benefit Plan will provide coverage for amalgam and composite restorations for treatment of cavities. Restorations including multiple surfaces will, for the purpose of providing benefits, be combined; and benefits will be provided according to the number of surfaces treated. Benefits for each surface are allowed once in 12 consecutive months. Bonding is not a covered benefit.

   B. **Oral Surgery.** The Benefit Plan will provide coverage for simple extractions. Coverage for local anesthesia, routine pre and post operative procedures, sutures and suture removal are included in our Allowable Expense for the surgery; and coverage for additional benefits for such services will not be provided.
C. Payments For Class II Benefits.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 80% of the Allowable Expense, after Deductible. Out-of-Network Benefits are also subject to balance billing.

3. Basic Restorative Services (Class IIA).

A. Oral Surgery. The Benefit Plan will provide coverage for oral surgery, consisting of: surgical extractions, including removal of impacted teeth; odontogenic cysts, lesions and biopsies; tooth re-implantation; tooth transplantation and alveoplasty. Coverage for local anesthesia, routine pre and post operative procedures, sutures and suture removal are included in the Allowable Expense for the surgery; and coverage for additional benefits for such services will not be provided. Benefits for extraction of impacted wisdom teeth include coverage for IV sedation. Coverage will be provided for replacing an existing inlay/onlay or crown only if the initial placement of the restoration is over five years old. Benefits for upgrading existing filings to an inlay/onlay or crown are limited to the allowance for a filling.

B. Endodontics.

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

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

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

(a) Coverage for root canal therapy includes the following: any related diagnostic and/or palliative treatment provided during, or 30 days before or after, root canal therapy; and temporary re-cementation of crowns/bridges.
(b) Coverage will be provided for root canal treatment received up to 30 days after termination of your coverage under this Benefit Plan for a tooth opened while coverage was in effect.

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

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

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

C. **Periodontic Services.**

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

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

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

**In-Network Benefits.** In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

**Out-of-Network Benefits.** Out-of-Network Benefits are covered at 80% of the Allowable Expense, after Deductible. Out-of-Network Benefits are also subject to balance billing.

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

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

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

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

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

2. The Benefit Plan will not provide coverage for denture replacement made necessary by reason of loss or theft.

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

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

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

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

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

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

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

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

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

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

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

(3) The Benefit Plan will only provide coverage for plastic or stainless steel crowns for Members less than 16 years of age.

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

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

C. Payments For Class III Benefits.

In-Network Benefits. In-Network Benefits are covered at 50% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 50% of the Allowable Expense, after Deductible. Out-of-Network Benefits are also subject to balance billing.

5. Orthodontics (Class IV).

A. Orthodontic Services. Coverage will be provided for orthodontic services for handicapping malocclusion, consisting of: the initial and subsequent installations of orthodontic appliances; and all orthodontic treatments concerned with the reduction or elimination of an existing malocclusion and its attendant sequelae through the correction of malposed teeth. Coverage is subject to the following conditions, limitations and exclusions:

(1) The Benefit Plan will only provide coverage to Members under 19 years of age.

(2) The need for orthodontic services must be diagnosed by a Dentist and a treatment plan must be submitted to and approved by the Claims Administrator. The diagnosis must indicate that the orthodontic condition consists of handicapping malocclusion which is abnormal and is correctable.

(3) The Benefit Plan reserves the right to review your dental records, including necessary x-rays, photographs and models, to determine whether orthodontic needs and treatment are within the limitations and exclusions of this booklet.

(4) For purposes of determining benefits available for treatment in progress at the commencement or termination of a Member’s coverage, all orthodontic services shall be deemed to have been rendered on the date performed.
(5) Coverage will not be provided for: appliances or restorations specifically to increase vertical dimensions or restore the occlusion; or for the replacement and/or repair of any orthodontic appliance.

B. Payments For Class IV Benefits.

In-Network Benefits. In-Network Benefits are covered at 50% of the Allowable Expense.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 50% of the Allowable Expense. Out-of-Network Benefits are also subject to balance billing.
SECTION FIVE - EXCLUSIONS

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

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

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

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

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

5. **Court Ordered Services.** The Benefit Plan will not provide coverage for any dental service or care (including evaluation, testing, and/or treatment) that is ordered by a court, or that is required by a court as a condition of parole or probation, unless:
   
   A. The service or care would be covered under this Benefit Plan in the absence of a court order;
   
   B. The Claims Administrator’s procedures have been followed to authorize the service or care; and
   
   C. The Claims Administrator’s dental director determines, in advance, that the service or care is medically necessary and covered under the terms of this Benefit Plan.

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

6. **Criminal Behavior.** The Benefit Plan will not provide coverage for any dental service or care related to the treatment of an accident or condition arising out of your participation in a felony. The felony will be determined by the law of the state where the criminal behavior occurred.
7. **Free Care.** The Benefit Plan will not provide coverage for any service or care that is furnished to you without charge, or that would have been furnished to you without charge if you were not covered under this Benefit Plan. This exclusion applies even if a charge for the service or care is billed. When service or care is furnished to you by your spouse, brother, sister, mother, father, son or daughter; or the spouse of any of them; the Benefit Plan will presume that the service or care would have been furnished without charge. You must prove to the Claims Administrator that a service or care would not have been furnished without charge.

8. **Grafting Procedures.** The Benefit Plan will not provide coverage for grafting procedures.

9. **Implants.** The Benefit Plan will not provide coverage for implants or services related to implants.

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

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

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

13. **Oral Hygiene Programs.** The Benefit Plan will not provide coverage for training or supplies used for: dietary counseling; tobacco counseling; oral hygiene; or plaque control programs.
14. **Procedures to Increase Vertical Dimension.** The Benefit Plan will not provide coverage for procedures, restorations and appliances to increase vertical dimension or to restore occlusion.

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

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

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

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

   B. That is continuing dental treatment (such as crowns, bridgework, dentures, or root canal therapy or orthodontic services) that began before the Effective Date of this booklet and continues after the Effective Date.

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

19. **Temporomandibular Joint.** The Benefit Plan will not provide coverage for appliances, therapy, surgery or any services rendered for what the Claims Administrator determines in its sole judgment is for the medical treatment of the temporomandibular joint.

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

21. **Workers' Compensation.** The Benefit Plan will not provide coverage for any service or care for which benefits are provided under a workers' compensation or similar law.
SECTION SIX - WAITING PERIODS

There are no waiting periods under this Benefit Plan.
SECTION SEVEN - COORDINATION OF BENEFITS
This section applies only if you also have other group dental benefits coverage with another plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

E. If none of the above rules determine which plan shall be primary, then the plan that has covered you for the longest time will be primary.
3. **Payment Of The Benefit When This Plan Is Secondary.** When this plan is secondary, the benefits of this plan will be reduced so that the total benefits payable under the other plan and this plan do not exceed your expenses for an item of service. However, the Benefit Plan will not pay more than it would have paid if the Benefit Plan was primary.

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

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

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

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

6. **The Benefit Plan’s Right To Recover Overpayment** In some cases the Benefit Plan may have made payment even though you had coverage under another plan. Under these circumstances, it will be necessary for you to refund to the Benefit Plan the amount by which it should have reduced the payment it made. The Benefit Plan also has the right to recover the overpayment from the other health benefits plan if the Benefit Plan has not already received payment from that other plan. You must sign any document that the Group and/or the Claims Administrator deems necessary to help the Benefit Plan recover any overpayment.
SECTION EIGHT - TERMINATION OF YOUR COVERAGE

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

All terminations are effective on the date specified.

1. **Termination of the Benefit Plan.** Your benefits under the Benefit Plan may be terminated at any time if the Group ends the Benefit Plan.

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

   A. You experience a qualifying event and as a result you choose to terminate your coverage. You must give the Group thirty (30) days’ written notice. Your coverage will terminate on the date to which your contributions are paid;

   B. You are no longer a Member of the Group. Your coverage will terminate on the last day of the month in which your employment terminates or you no longer satisfy the eligibility requirements for the Benefit Plan;

   C. You make an intentional misrepresentation of a material fact or commit fraud in applying for coverage or in filing a claim under this Benefit Plan. Your coverage will terminate 30 days from the date notice is provided to you;

   D. On your death or the death of the employee or member of the Group. Your coverage under this Benefit Plan will automatically terminate on the date after your death or the death of the employee or member of the Group;

   E. Termination of the employee or member of the Group's marriage. If the employee or member of the Group becomes divorced, or the employee or member of the Group's marriage is annulled, coverage of the employee or member of the Group's spouse under this Benefit Plan will automatically terminate on the date of the divorce or annulment; or

   F. Termination of coverage of a child. Coverage of an employee or member of the Group's child under this Benefit Plan will terminate on the date the child no longer qualifies under Section Two of this booklet or, if later, the
next contributions due date after the Group and/or the Claims Administrator receives notice of termination.

3. **Temporary Continuation Of Coverage.** Under the continuation of coverage provisions of the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), most employer sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. Call or write your Group to find out if you are entitled to temporary continuation of coverage under COBRA.
SECTION NINE - GENERAL PROVISIONS

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

2. **Notice.** Any notice that the Group or the Claims Administrator give to you under this Benefit Plan will be mailed to your address as it appears records or to the address of the Group. If you have to give the Benefit Plan or the Claims Administrator any notice, it should be mailed to: 165 Court Street, Rochester, NY 14647.

3. **Your Dental Records.** In order to provide your coverage under this Benefit Plan, it may be necessary for the Group and/or the Claims Administrator to obtain your medical records and information from Facilities, Professional Providers, Providers of Additional Health Services, and pharmacy who provided services to you. Actions to provide that coverage include processing your claims, reviewing grievances or complaints involving your care, and quality assurance reviews of your care, whether based on a specific complaint or a routine audit of randomly selected cases. When you become covered under this Benefit Plan, you automatically give the Group and/or the Claims Administrator permission to obtain and use those records for those purposes.

   The Group and the Claims Administrator agree to maintain that information in accordance with state and federal confidentiality requirements. However, you automatically give the Group and the Claims Administrator permission to share that information with the New York State Department of Health, quality oversight organizations and third parties with which the Group and the Claims Administrator contract to assist them in administering this Benefit Plan, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

4. **Who Receives Payment Under This Benefit Plan.** The Benefit Plan reserves the right to pay either you or the provider.

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

6. **Time To Sue.** No action at law or in equity may be maintained against the Benefit Plan or the Claims Administrator to recover benefits under the Benefit Plan prior to the expiration of 60 days after written submission of a claim for such benefits has been furnished to the Benefit Plan as required in this booklet. In
addition, no legal action may be commenced or maintained to recover benefits under the Benefit Plan more than twenty four months after the date you received the service for which you want the Benefit Plan to pay.

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

8. **Choice Of Law.** All disputes relating to this Benefit Plan shall be governed by Federal law and, as applicable, the laws of the State of New York.

9. **Recovery Of Overpayments.** On occasion a payment will be made when you are not covered, for a service that is not covered, or which is more than is proper. When this happens the Group and/or the Claims Administrator will explain the problem to you and you must return the amount of the overpayment within 60 days after receiving notification.

10. **Right To Offset.** If the Benefit Plan makes a claim payment to you or on your behalf in error or you owe the Benefit Plan any money, you must repay the amount you owe. If the Benefit Plan owes you a payment for other claims received, the Benefit Plan has the right to subtract any amount you owe to the Benefit Plan from any payment the Benefit Plan owes you.

11. **Continuation Of Benefit Limitations.** Some of the benefits under this Benefit Plan are limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if your coverage status should change during the Calendar Year. For example, if your coverage status changes from covered family member to employee or member of the Group, all benefits previously utilized when you were a covered family member will be applied toward your new status as an employee or member of the Group.

12. **Subrogation.** If a Member becomes injured or ill because of the actions or inactions of a third party, the Benefit Plan shall have the right to pursue a claim against the third party for expenses paid by the Benefit Plan related to such injury or illness. If so requested by the Claims Administrator, the Member (or if a minor, his or her parent or legal guardian) shall:

   A. provide proof, satisfactory to the Claims Administrator, that no right, claim, interest or cause of action against a third party has been, or will be, discharged or released without the written consent of the Claims Administrator;
B. execute a written agreement assigning to the Benefit Plan all rights, claims, interests, and causes of action that the Member has against a third party in connection with the expenses paid by the Benefit Plan;

C. authorize the Benefit Plan, in writing, to sue, compromise or settle, in the Member’s name or otherwise, all rights, claims, interests, or causes of action to the extent of benefits paid by the Benefit Plan and shall do nothing to prejudice the rights given to the Benefit Plan under this section; and

D. agree, in writing, to assist the Benefit Plan in prosecuting any rights, interests, claims, or causes of action that have been assigned to the Benefit Plan against a third party, including, if requested by the Claims Administrator or the Group, the institution of a formal proceeding against a third party.

**Benefit Plan’s Right of Recovery.** If a Member becomes injured or ill because of the actions or inactions of a third party, the Benefit Plan shall have the right to recover related Benefit Plan expenses out of any payments made by (or on behalf of) the third party (whether by lawsuit, settlement, or otherwise) to a Member (or his or her assignee). The Benefit Plan’s right of recovery applies to the extent the Benefit Plan has paid expenses related to the injury or illness, regardless of whether any related settlement or other third-party payment states that the payment (all or part of it) is for health care expenses. By accepting benefits under the Benefit Plan to pay for treatments, devices or other products or services related to such injury or illness, Member agrees to place such third-party payments in Member’s separate identifiable account (in an amount equal to related expenses paid by the Benefit Plan or, if less, the full third-party payment amount) and that the Benefit Plan has an equitable lien on such funds, without regard to whether the Member has been made whole or fully compensated for the injury or illness. Member also agrees to serve as a constructive trustee over the funds until the time they are paid to the Benefit Plan. Member further agrees to cooperate with the Benefit Plan’s recovery efforts and do nothing to prejudice the Benefit Plan’s recovery rights. The Benefit Plan is not required to participate in or contribute to any expenses or fees (including attorney’s fees and costs) incurred in obtaining the funds.

**Enforcement of Benefit Plan’s Subrogation and Recovery Rights.** Should it be necessary for the Benefit Plan to institute proceedings against the Member for failure to reimburse the Benefit Plan or to otherwise honor the Benefit Plan’s equitable interest in obtaining amounts described in this section 9.12, the Member shall be liable for the costs of collection relating to such failure, including reasonable attorney’s fees.

The Benefit Plan shall have the right to offset future benefits to which a Member
may be entitled, until the amount otherwise due the Benefit Plan under this section 9.12, plus interest, has been received by the Benefit Plan.

The Benefit Plan’s rights under this section 9.12 shall be enforceable regardless of whether the third party admits liability for the injury or illness to a Member, and shall remain enforceable against the heirs and estate of any Member.

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

14. **Changes in This Benefit Plan.** The Group may unilaterally change this Benefit Plan at any time in accordance with Section Seventeen, Paragraph 13.

15. **Agreements between the Claims Administrator and In-Network Providers.** Any agreement between the Claims Administrator and In-Network Providers may only be terminated by the Claims Administrator or the providers. This Benefit Plan and the Claims Administrator do not require any provider to accept a Member as a patient. Neither the Benefit Plan, nor the Group nor the Claims Administrator guarantees a Member’s admission to any In-Network Provider or any health benefits program.

16. **Notice Of Claim.** Claims for services under this Benefit Plan must include all information designated by the Group and/or the Claims Administrator as necessary to process the claim, including, but not limited to, Member identification number, name, date of birth, social security number, and supporting medical records, when necessary. A claim that fails to contain all necessary information may be denied.

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

18. **Right To Develop Guidelines and Administrative Rules.** The Group and/or the Claims Administrator may develop or adopt standards that describe in more detail when payment will or will not be made under this Benefit Plan. Examples
of the use of the standards are: to determine whether Hospital inpatient care was Medically Necessary; whether emergency care in the outpatient department of a Facility was necessary; or whether certain services are Skilled Care. Those standards will not be contrary to the descriptions in this booklet. If you have a question about the standards that apply to a particular benefit, you may contact the Claims Administrator and it will explain the standards or send you a copy of the standards. The Group and/or the Claims Administrator may also develop administrative rules pertaining to enrollment and other administrative matters. The Group and/or the Claims Administrator shall have all the powers necessary or appropriate to enable them to carry out their duties in connection with the administration of their respective duties under this Benefit Plan.

19. **Furnishing Information and Audit.** All persons covered under this Benefit Plan will promptly furnish the Group and/or the Claims Administrator with all information and records that they may require from time to time to perform their obligations under this Benefit Plan. You must provide the Group and/or the Claims Administrator with information over the telephone for reasons such as the following: to allow the Group and/or the Claims Administrator to determine the level of care you need; so that the Group and/or the Claims Administrator may certify care authorized by your physician; or to make decisions regarding the Medical Necessity of your care.

20. **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 Benefit Plan, and any other information required to confirm their eligibility for coverage. The Group will provide the Claims Administrator with the enrollment form including your name, address, age and social security number and advise the Claims Administrator in writing when you are to be added to or subtracted from the list of covered persons, on a monthly basis. In no event will retroactive additions to or deletions from coverage be made for periods in excess of 30 days.

The Group may also have additional responsibilities as the “plan administrator” as defined by the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). The “plan administrator” is the Group, or a third party appointed by the Group. The Claims Administrator is not the ERISA plan administrator.

21. **Reports and Records.** The Group and the Claims Administrator are entitled to receive from any provider of services to Members, information reasonably necessary to administer this Benefit Plan subject to all applicable confidentiality requirements as defined in the General Provisions Section of this booklet. By accepting coverage under this Benefit Plan, the employee or member of the Group, for himself or herself, and for all family members covered hereunder,
authorizes each and every provider who renders services to a Member hereunder to:

A. Disclose all facts pertaining to the care, treatment and physical condition of the Member to the Group and/or the Claims Administrator, or a medical, dental, or mental health professional that the Group and/or the Claims Administrator may engage to assist the Group and the Claims Administrator in reviewing a treatment or claim, or in connection with a complaint or quality of care review;

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

C. Permit copying of the Member’s records by the Group and the Claims Administrator.

22. **Service Marks.** Excellus Health Plan, Inc. (“Excellus”) is an independent corporation organized under the Insurance Law of New York State. Excellus also operates under licenses with the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans, which licenses Excellus to use the Blue Cross and Blue Shield service marks in a portion of New York State. Excellus does not act as an agent of the Blue Cross and Blue Shield Association. Excellus is solely responsible for its obligations created under the Administrative Services Agreement between the Group and Excellus.

23. **Utilization Review.** The Claims Administrator reviews proposed and rendered health services to determine whether the services are or were Medically Necessary or experimental or investigational (for purposes of this Paragraph only, these will be collectively referred to as “Medically Necessary”). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being rendered (“prospective”); when the service is being rendered (concurrent); or after the service is rendered (retrospective).

The Claims Administrator has developed Utilization Review policies to assist it in administering the Utilization Review program. These policies describe the process and procedures of Utilization Review activities. Reviews are conducted by registered nurses and Claims Administrator’s Medical Directors. All determinations that services are not Medically Necessary will be made by licensed physicians. The Claims Administrator does not compensate or provide financial incentives to its employees or reviewers for determining that services are not or were not Medically Necessary. The Claims Administrator has
developed guidelines and protocols to assist it in this process. Specific guidelines and protocols are available for your review. For more information, you can contact the Claims Administrator.

A. **Prospective Reviews.** All requests for prior authorization of care are reviewed for Medical Necessity (including the appropriateness of the proposed level of care and/or provider). The initial review is performed by a nurse. If the nurse determines that the proposed care is Medically Necessary, the nurse will authorize the care. If the nurse determines that the proposed care is not Medically Necessary or that further evaluation is needed, the nurse will refer the case to a licensed physician.

If the Claims Administrator has all the information necessary to make a determination regarding a prospective review, it will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing within three business days of receipt of the request. If the Claims Administrator needs additional information, it will request it within three business days. You or your provider will then have 45 calendar days to submit the information. The Claims Administrator will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three business days of the earlier of its receipt of the information or the end of the 45-day time period.

With respect to urgent prospective claims, if the Claims Administrator has all information necessary to make a determination, it will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing within 72 hours of receipt of the request. If the Claims Administrator needs additional information, it will request it within 24 hours. You or your provider will then have 48 hours to submit the information. The Claims Administrator will make a determination and provide notice to you and your provider by telephone and in writing within 48 hours of the earlier of the Claims Administrator’s receipt of the information or the end of the 48-hour time period.

B. **Concurrent Reviews.** When you are receiving services that are subject to concurrent review, a nurse will periodically assess the Medical Necessity and appropriateness of care you receive throughout the course of treatment. Once a case is assigned for concurrent review, a nurse will determine whether the services are Medically Necessary. If so, the nurse will authorize the care. If the nurse determines that Medical Necessity is lacking or that further evaluation is needed, the nurse will refer the case to a licensed physician.

Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to your provider,
by telephone and in writing, within one business day of receipt of all information necessary to make a decision, but no later than 15 calendar days of receipt of the request.

For concurrent reviews that involve urgent matters, the Claims Administrator will make a determination and provide notice to you and your provider within 24 hours of receipt of the request.

If care is authorized, the notice will identify the number of approved services, the new total of approved services, the date of onset of services and the date of the next scheduled concurrent review of the case.

C. Retrospective Reviews. At the Claims Administrator's option, a nurse will review retrospectively the Medical Necessity of claims that are subject to Utilization Review. If the nurse determines that care you received was Medically Necessary, the nurse will authorize the benefits. If the nurse determines that Medical Necessity was lacking of that further evaluation is needed, the nurse will refer the case to a licensed physician.

If Excellus BlueCross BlueShield has all information necessary to make a determination regarding a retrospective claim, it will make a determination and provide notice to you and your provider within 30 calendar days of receipt of the claim. If the Claims Administrator needs additional information, it will request it within 30 calendar days. You or your provider will then have 45 calendar days to provide the information. The Claims Administrator will make a determination and provide notice to you and your provider within 15 calendar days of the earlier of its receipt of the information or the end of the 45-day time period.

D. Notice of Adverse Determination. A notice of adverse determination (notice that a service is not Medically Necessary) will include the reasons, including clinical rationale, for the Claims Administrator's determination. The notice will also advise you of your right to an internal appeal of the determination and specify that you may request a copy of the clinical review criteria used to make the determination. The notice will specify additional information, if any, needed for the Claims Administrator to review an appeal. The Claims Administrator will send notices of determination to your or your designee and to your health care provider.

If, prior to making an adverse determination, no attempt was made to consult with the provider who recommended the service at issue, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For prospective and concurrent reviews, the reconsideration will take place within one business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to the provider, by telephone.
and in writing.

E. **Internal Appeals of Adverse Determinations.** You, your designee and, in retrospective review cases, your health care provider, may request an internal appeal of an adverse determination, either by phone, in person or in writing.

You have up to 180 calendar days after you receive notice of the adverse determination to file an appeal. The Claims Administrator will acknowledge your request for an internal appeal within 15 calendar days of receipt. This acknowledgment will include the name, address and phone number of the person handling your appeal, and if necessary, inform you of any additional information needed before a decision can be made. A clinical peer reviewer who is in the same or similar specialty as the provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the appeal.

The Claims Administrator will decide internal appeals related to prospective reviews within 30 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you or your designee (and your health care provider if he or she requested the review) within two business days after the determination is made but no later than 30 calendar days after receipt of the appeal request.

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

Reviews of continued or extended health care services, additional services rendered in the course of continued treatment, services in which a provider requests an immediate review, or any other urgent matter, will be handled on an expedited basis. Expedited appeals are not available for retrospective reviews.

For expedited appeals, you provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the lesser of 72 hours or two business days of receipt of the appeal request. Written notice will follow within 24 hours of the determination but no later than 72 hours of receipt of the appeal request.
If you are not satisfied with the resolution of your expedited appeal, you may file a standard internal appeal.

F. **Notice of Determination of Internal Appeal.** The notice of determination of your internal appeal will indicate that it is a “final adverse determination” and will include the clinical rationale for the decision. The Claims Administrator will send notices of determination to you or your designee and to your health care provider.