DENTCARE
DELIVERY SYSTEMS, INC.

CERTIFICATE OF INSURANCE

Dentcare Delivery Systems, Inc.
333 Earle Ovington Boulevard, Suite 300
Uniondale, NY 11553-3608

General Administration	516 542 2200
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www.dentcaredeliverysystems.org

Plan Administered by Healthplex, Inc.
www.healthplex.com

CERTIFICATE OF INSURANCE

This form is a summary of the Group Policy features that affect your insurance. It is evidence of the coverage provided by such policy. The Group Policy is a contract between Dentcare Delivery Systems Inc. (Dentcare) and the Policyholder. It may be changed or ended without notice to, or consent of, any insured person.

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DEFINITIONS

Benefit Period: the extent of time for which benefits are payable. Unless otherwise defined in the Schedule of Benefits, the Benefit Period is the period stated in the Policy Section: Acceptance.

Benefit Program: the program of Dental Care benefits noted and described on the cover page of the Policy.

Calendar Year: A single year beginning on January 1 and ending on December 31. The first Calendar Year will begin on the Policy Effective Date and end that year on December 31.

Coinsurance: The fixed percentage of the Maximum Allowable Amount for Covered Services that the Member is required to pay. It is shown in the Schedule of Benefits.

Copayment: The amount that the Member is required to pay to the Dentist for Covered Services. It is shown in the Schedule of Benefits.

Cost Share (Cost Sharing): The amount that the Member is required to pay for Covered Services. Cost-Shares can be in the form of Coinsurance, Copayments, Deductibles and amounts over the plan MAA.

Covered Person: An Eligible Person as defined in the Eligibility Section, who has been accepted for membership under this Policy and in whose name an ID card is issued.

Covered Service: Diagnosis, care, treatment or supplies that are:

1. described in the Policy under the Covered Services Sections;
2. performed by a Dentist (Reimbursement Plan) or a participating dentist (Managed Care Plan); and
3. not described as exclusions or limitations in the Policy.

Deductible: The fixed amount that the Member must pay for Covered Services in a Calendar Year before Coinsurance is applied.

1. The individual and family Deductible amounts are shown in the Schedule of Benefits
2. The family amount (2 Members) is met when each Member meets the individual amount.
3. The family amount (3 or more Members) is met when family Members collectively meet the difference between the individual and family amounts.

Dental Emergency: Acute pain or a condition that needs immediate treatment but does not produce a definite cure. Includes, but is not limited to procedures to:

1. stop bleeding;
2. open and clean an infection; and/or
3. relieve pain.

Dentist: Any licensed Dentist (D.D.S., D.M.D.) who practices Dentistry, including:

1. Endodontist: a Dentist who treats disease of and injuries to the pulp.
2. Periodontist: a Dentist who treats diseases of the supporting tissues of the teeth.
3. Prosthodontist: a Dentist who restores and/or replaces missing teeth with artificial teeth.
4. Oral Surgeon: a Dentist who surgically treats diseases, injuries, deformities and defects of the teeth.
5. Orthodontist: a Dentist who treats teeth that are out of position or rotated.

Dependent: An Eligible Dependent as defined in the Policy Section: Eligibility.

Dependent Child: An eligible dependent as defined in the Policy Section: Eligibility. This could be a natural child, stepchild, adopted child or proposed adoptive child awaiting adoption.

Effective Date: The date on which the Member is eligible to receive benefits under the Policy.

Maximum Allowable Amount (MAA): A reasonable amount as determined by Dentcare and accepted by plan Dentists for Covered Services. The amount Dentcare will pay for Covered Services will be the lesser of the MAA or the billed fees. Dentcare has the right to create, as it deems fair, the MAA under the Policy. It is the Member's obligation to pay Cost-Shares towards the MAA and amounts in excess of the MAA.

Member: The Covered Person or an Eligible Dependent.

Participating Dentist: A Dentist who has signed an agreement with Dentcare to provide services to members on a per person basis or other fee basis.

Prior Authorization (Pre-Authorization): A case where prior approval has been obtained from Dentcare for a Member to receive benefits for Covered Services. Such approval is only valid if treatment is done during a period of Eligibility.

Treatment Plan: A written report showing the diagnosis and proposed treatment of any dental disease, defect or injury, prepared by a Dentist. A Treatment Plan for pre-determination of benefits may be sent to Dentcare if the planned Covered Services are at least $250.

ELIGIBILITY

An Eligible Person is:

1. a current employee or group member actively at work at least 20 hours a week. (This may be changed if Dentcare and the Policyholder agree): or
2. a current employee not actively at work due to a work related injury and receiving Worker's Compensation benefits under the former employer's policy: or
3. a former employee who elects to continue enrollment under COBRA, as amended, or N.Y. Ins. Law 3221 (m): or
4. a retiree of the Policyholder who meets the Policyholder's Eligibility rules.

If dependent coverage is selected, an Eligible Dependent is:

1. the lawful spouse of the Covered Person under a legal, existing marriage: or
2. the under 19, unmarried, dependent child of the Covered Person or lawful spouse: or
3. the under 19, unmarried, dependent child for whom the Covered Person or lawful spouse has been named as legal guardian: or
4. the under 23, dependent child of a Covered Person or lawful spouse who is a full-time student at a recognized college, university or trade school. (Dentcare may require yearly proof of student status): or
5. the unmarried, disabled dependent child of the Covered Person or lawful spouse.

EFFECTIVE DATE

The effective date of this plan is shown on the enclosed Group Benefit Page. Covered persons and their dependents are first eligible on the date shown. Applications received more than 31 days from the initial date of Eligibility shall be called Late Enrollees. Late Enrollees have no coverage and must wait to enroll in the Plan at the next Open Enrollment or Plan anniversary date. New hires and their dependents are covered when they have satisfied the eligibility requirements of their Group.

DENTAL BENEFITS

Deductibles, family deductibles, coinsurance, copayments and maximums are shown on the Group Benefit Pages. Some of these plan features apply to the Reimbursement Plan. Some apply to the Managed Care Plan. Check the Group Benefit Pages to determine the features that apply to your coverage. All covered services are subject to the exclusions, conditions, limitations and eligibility rules in this document. In the Reimbursement Plan, benefits for covered services of $250 or more should be predetermined prior to treatment.

To predetermine a Treatment Plan or claim, the Member must give Dentcare all material that it may require. This includes x-rays, models, charts and written reports. Dentcare has the right to require an oral exam of the Member in order to determine benefits.

Unless amended on the Group Benefit Page, the following is a summary of the key frequency limitations in the Policy:

Initial oral exams	-	one in 24 months
Periodic oral exams	-	one in 6 months
Complete series x-rays	-	one in 36 months
Bitewing x-rays	-	one in 6 months
Fillings	-	one in 12 months
Stainless Steel Crown up to age 19	-	one in 60 months
Root Canal Therapy	-	one per permanent tooth
Relining of Dentures	-	one in 24 months
Crowns Inlays and Onlays (per tooth)	-	one in 60 months
Bridge Abutments and Pontics (per bridge)	-	one in 60 months
Dentures: Full and Partial (per arch)	-	one in 60 months
Periodontal Surgery (quadrants)	-	one in 60 months
Periodontal Scaling and Root Planing (per quadrant)	-	one in 12 months
Orthodontic Services	-	one 24 month case (lifetime) For members to age 19

Unless amended on the Group Benefit Page, the following are key coverage limitations in the Policy:

1. Benefits for both cleanings and periodontal maintenance procedures will not be allowed on the same day.
2. Benefits for sedative fillings will not be allowed on the same day as root canal treatment.
3. Benefits for re-cementing a crown will not be allowed the year after the crown is first placed.

4. Dentcare will allow benefits for pulpotomies and pulp caps. If a root canal or extraction is done on the same tooth within three months, benefits will be reduced.
5. Dentcare will cover crowns, inlays and onlays only when fillings may not hold, as determined by Dentcare. On a Molar, full metal crown benefits will be allowed when Dentcare allows a crown.
6. For prosthetic services, Dentcare will allow for standard procedures, as determined by Dentcare. For fixed bridges, Dentcare will cover the replacement of missing teeth and one tooth on either side or two teeth on one side of the missing tooth.
7. Dentcare will not cover crowns to alter vertical spacing or when fused together for any reason. This precludes for periodontal stabilization.
8. Dentcare will allow benefits for partial dentures or the least costly option when teeth are missing on both sides of the mouth.
9. General anesthesia and IV sedation are Covered Services only when given for covered oral surgery in a dental office.

Unless amended in the Group Benefit Page, the following are key exclusions in the Policy:

1. Any services for or treatment of TMJ dysfunction, when it has developed as a result of non-dental pathology.
2. Use of any experimental diagnosis, treatment, devices or supplies unless approved by an External Appeal Agent. Any service associated with or as follow-up to any of the above is not a Covered Service.
3. Any hospital or facility or treatment fee charged for services performed in a hospital or inpatient facility.
4. Cosmetic services done solely to improve appearance and not to address function or deformity from trauma or the treatment of cancer. This does not exclude coverage for treatment due to accidental injury or birth defects.
5. Any services for an injury or condition for which benefits exist under Worker's Compensation or occupational disease.
6. Any service or supply done without functional or pathological need.
7. Removal of third molars where there is no evidence of disease.
8. Any supplies meant for home use (e.g. toothbrush, floss, mouthwash, etc).
9. Any services from a dental department of an employer, a benefit association, labor union, trustee or other similar person or group.
10. Any services for which the Member incurs no charge, services usually done by an M.D., or charges which would not have been made if there was no insurance.
11. Temporary appliances or services, such as tooth preps and temporary fillings, bridges, or dentures. Temporary crowns, except as noted in the Dental Benefits Section of the Policy.
12. Any services done contrary to accepted dental practice, as determined solely by Dentcare.
13. Any services done due to occlusal wear, erosion, abrasion, attrition and/or surface defects of the teeth or to amend vertical spacing.
14. Implants and/or crowns and fixed bridgework placed on implants.
15. Any services done by a Dentist to himself or herself. Services done by a dentist to his or her immediate family including parents, spouse and children.
16. Services or procedures which are not completed prior to submission of the claim.
17. Periodontal splinting.
18. Charges incurred for the failure to keep an appointment with the Dentist.
19. Charges by a Dentist for completing dental forms or for complying with OSHA guidelines.
20. Crowns fused together, except when two crowns on non-adjacent teeth are fused together to fill a space.

21. Any items or procedures not specifically listed in this Policy. Any exclusion above will not apply to the extent that:
    - Coverage is specifically provided by name in this Plan; or
    - Coverage of the charges is required under any law that applies to the coverage.
22. Any dental services which were not rendered, prescribed, arranged by a participating dentist or approved by Dentcare. This does not apply in cases of Dental Emergency (Managed Care Plan Only.)
23. Treatment of unmanageable children or otherwise unruly patients. An attempt will be made by network dentists to treat all patients. However, if a patient is untreatable by virtue of apprehension or any other reason and/or declines treatment in-network, the insured is responsible for the costs of treatment outside the network (Managed Care Plan only).

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies to this Benefit Program when a Member has health care coverage under more than one Plan as follows:

DEFINITIONS

The following definitions apply to this COB Section:

Allowable Expense: A Medically Necessary Allowable Expense, for health care, when the item of expense is covered at least in part by one or more Plans covering the member. When this Benefit Program provides coverage, the reasonable cash value of each Covered Service is the Allowable Expense and is a benefit paid.

Plan:
a. Group health insurance, group coverage, insured or self-insured, or any other arrangement where a health benefit is provided; or
b. Coverage under a governmental plan or required or provided by law; or
c. Medical benefits coverage of group/or and individual no-fault and traditional automobile fault contracts.

Primary Plan: A Plan whose benefits for coverage must be determined without taking any other plan into account.

When this Program is Primary, Covered Services are provided without considering another Plan's benefits.

Secondary Plan: A Plan that is not Primary. The benefits of the Secondary Plan may take into account the benefits of the Primary Plan.

When this Benefit Program is Secondary, benefits for Covered Services under the Program may be reduced. If so, Dentcare may recover from the Primary Plan, the Provider, or the Member, the reasonable cash value of the benefit provided when Dentcare paid as if it were the Primary Plan.

Dentcare determines its order of benefits using the following rules:

1. The Plan that covers the member as a Covered Person (other than as a Dependent) is primary to the Plan that covers the member as a Dependent.
2. When this Program and another Plan cover the same child as a Dependent, the Plan of the parent whose birthday falls earlier in a year is primary.

   If the other Plan has a rule based on the gender of the parent, as stated below, and the Plans do not agree on the order, the rule in the other Plan shall determine the order of benefits.
3. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits are in this order:
   i. First, the plan of the parent with custody of the child shall be used;

ii. then, the plan of the spouse of the parent with custody of the child shall be used;

iii. Finally, the benefits of the Plan of the parent without custody shall be used.

If the terms of a court order state that one of the parents is responsible for the health expenses of the child, and the entity covering that parent is aware of those terms, the benefits of that plan are determined first.

4. A Plan which covers a person as an employee who is neither laid off nor retired is primary to a Plan which covers that person as a laid-off or retired employee.

5. If none of the above rules determines the order of benefits, the Plan which covered a Covered Person longer is primary to the Plan which covered that person for the shorter time.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Dentcare has the right to decide what information it needs. By enrolling in the Program, the Member consents to the release of information necessary to apply the COB rules. Any Member claiming benefits must give information to Dentcare that Dentcare feels is necessary for COB.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under this Program. If it does, Dentcare may pay that amount to the organization which made that payment. Such amount shall be considered as though it were a benefit paid under this Program.

RIGHT OF RECOVERY

If the amount of the Dentcare payment is more than it should have been under the COB rules, Dentcare may recover the excess from the person(s) it has paid or for whom, insurance companies, or other organizations.

TERMINATION

TERMINATION OF THE MEMBER

The Member's enrollment in the Program shall end if any of the following apply to the Covered Person:

i. Death (termination will be on the day following the Covered Person's death); or

ii. Loss of employment with the Employer Group or a decrease in work hours; or

iii. He or she no longer meets the eligibility terms of the Benefit Program.

When termination occurs for the reasons stated in (ii) or (iii) above, it shall be on the first of the month following the loss of eligibility. When a Covered Person dies, Dependents shall be terminated the first of the month following the person's death.

The Benefit Program shall end immediately if:

i. The Member has let any other person to use his or her ID Card to obtain services; or

ii. The Member has given Dentcare false or misleading data concerning eligibility.

The Member's enrollment in the Program shall end on the first of the month following 30 days written notice when the Member fails to pay the agreed upon share of the Program.
Coverage of a Dependent will end on the first day of the month after a Divorce or legal separation of the spouse or if other Dependent's criteria are no longer met by the spouse or enrolled Dependents.

Benefits After Termination

1. Expenses for covered Category I, II and III services begun while coverage was in effect will be covered.
2. Expenses for crowns, dentures and fixed bridgework incurred after the members' coverage ceases will be deemed to be incurred when ordered.
3. "Ordered" means that:
    i. Impressions have been taken from which the dentures, crowns, or fixed bridgework will be made; and
    ii. For fixed bridgework and crowns, the teeth must have been fully prepared if they are part of bridges or if they are being restored.

TERMINATION OF THE EMPLOYER GROUP

The Group or Dentcare may terminate the Program at the end of any 12-month period that begins on the policy effective date. To do so, either party must give at least thirty (30) days prior written notice to the other party. It may also be terminated by Dentcare for various reasons including:

1. If the Employer fails to pay premiums on time, or fails to pay all or any portion of the Premium due.
2. If the Employer fails to meet any criteria in the Benefit Program, or any underwriting term adopted by Dentcare.
3. If the Employer ceases to meet the requirements for a group; or a participating employer, union, association or other entity ceases membership or participation in the group to which the plan is issued.
4. Dentcare may also end the Program if it determines there was material misrepresentation on behalf of the Employer during the initial application and enrollment process that affects coverage.
5. At Dentcare's discretion, with thirty (30) days prior written notice if cancellations by plan dentists make it unable to provide benefits (Managed Care Plan Only).

CONTINUATION AND CONVERSION

As provided by New York law, an Employer shall allow a Covered Person and his or her Dependents who lose coverage to continue participation in this Program. Such persons who are not enrolled in a Group subject to the COBRA Act of 1985, P.L. 99-272, may elect to continue coverage as follows:

1. When a Covered Person's employment ends, the Person and his or her Dependents may choose to continue coverage. Such coverage will continue for 18 months after coverage ceased under this Program.
2. If the Covered Person dies, his or her Dependents may choose to continue coverage. Such coverage will continue for 36 months after coverage ceased under this Program.
3. If the Covered Person's marriage dissolves, his or her Dependents may choose to continue coverage. Such coverage will continue for 36 months after coverage ceased under this Program.

To continue coverage, the Covered Person and/or his/her enrolled Dependents shall:

a. Make a written request to the Employer within 60 days of the later of the date of the terminating event or the date notice of the right to continue is given by the Employer.
b. Make the required Premium payment.

Continuation under this section shall end:

a. the date Dependents become eligible again for benefits under this Program;

b. the date the Member becomes eligible for benefits under another group plan, unless the new plan does not cover preexisting conditions.

c. the end of the 18 or 36 month period.

d. the last day of the period for which the premium has been paid.

11 more months are available to a Covered Person and Dependent who is disabled when he or she becomes eligible for continued coverage. The 11 months are also given if the person or dependent becomes disabled during the first 60 days of continuation.

When the Employer or Dentcare ends the Program, benefits for a Member who was totally disabled on the date of termination will continue. This extension of benefits will end on the first of the following dates:

a. 12 months from the date coverage first terminated.

b. the date the Member is no longer disabled.

c. the day before the Member becomes insured for that condition under any other group health care plan.

A Member who continues coverage is required to pay the applicable Premium payment to the Employer. Failure of the Member to pay such Premium may result in termination.

As per New York law, coverage may be continued for a covered dependent student who takes a leave of absence from school. The leave must be due to illness and coverage will be for up to 12 months from the last day of school. This continued coverage shall end after 12 months, or when the dependent attains the age of 23, whichever occurs first. To qualify for this coverage, a written statement must be sent to Dentcare. The rate for this extended coverage shall be the same as that charged for full-time students.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA) PL 99-272

Members in groups subject to COBRA may continue coverage in the Program to the extent allowed by law.

Continuation for up to 36 months shall be available for an enrolled Dependent following:

a. the death of the Covered Person.

b. the legal separation or divorce from the Covered Person.

c. the Covered Person's entitlement for Medicare.

d. the attainment of the limiting age for a Dependent child or student.

Continued coverage for up to 18 months is available to a Covered Person and his or her enrolled Dependents following:

a. the Covered Person's reduction in work hours.

b. the Covered Person's voluntary resignation.

c. lay-off or termination of the Covered Person for any reason (other than gross misconduct).

11 more months are available to a Covered Person and an enrolled Dependent who is disabled when he or she becomes eligible for continued coverage. The 11 months are also given if the person or dependent becomes disabled during the first 60 days of COBRA coverage. When the Member is no longer disabled, the extended coverage can be ended. This will occur on the first of the month following 30 days from the final determination notice.

A Member eligible for continued coverage must be given at least 60 days to choose such coverage. A Member's eligibility for this coverage ends before the period required by law if:

a. the Member becomes covered under another group health plan; or

b. the Premium for continued coverage is not paid on time; or

c. the Member becomes covered by Medicare; or

d. the Employer no longer provides group health coverage for its employees.

CLAIMS PROVISIONS

PAYMENT FOR COVERED SERVICES (Reimbursement Plan Only)

1. Dentcare will make payments to the Member or Covered Person for Covered Services. The Member or Covered Person may assign benefits to a dentist subject to Dentcare's approval. Benefits will be auto-assigned if the dentist is belongs to a Dentcare PPO.
2. Dentcare can make payments directly to dentists. However, Dentcare has the right to pay either the Member or Covered Person, in Dentcare's discretion.
3. Dentcare will accept all standard dental claim forms. If a claim is not suitable for processing, Dentcare will furnish a standard claim form to the member within 15 days of claim receipt. Our failure to provide the proper form within 15 days will not affect the members compliance with the 90 day requirement for filing claim forms.
4. In order to be paid, claims submitted by a Member for payment must be received by Dentcare less than 90 days after the date(s) of services. Failure to submit claims on time shall not deny or reduce any claim if it was not reasonably possible to submit a claim on time. In such case, the claim must be submitted as soon as reasonably possible.

Claims for Covered Services must be sent to:

Dentcare Delivery Systems, Inc.
333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553-3608

5. The time period when any benefit determination must be made begins when a claim is filed, whether or not all information needed to process the claim is with the filing. If more time is needed to make a determination due to missing information, the time for making the determination can be extended. The time between the date the member is asked for more information and the receipt of that information is not counted in the time period to make a determination.
6. An explanation of benefits form will be available to the Member. A phone number for questions shall also be included.
7. The Member must pay Cost-Shares specified in the Schedule of Benefits and all amounts over the MAA.
8. If Dentcare pays for Covered Services in error or over the maximum amount due, it has the right to recover the excess payments. Dentcare's right to recover may result in deductions from future benefits payments.

MAKING INQUIRIES TO DENTCARE

Customer Services staff members are available to explain policies and procedures. They can also answer questions about benefits and claim determinations. For information or help, a Member may call or write Dentcare. The toll-free telephone number for the Customer Services Department is 1-800-468-0600. The address of Dentcare is:

Dentcare Delivery Systems, Inc.
333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553-3608

In the event a problem or complaint can't be resolved, a formal appeal and grievance procedure is described below.

MEMBER APPEAL/GRIEVANCE PROCESS

This Appeal/Grievance process applies to any determination under this Program. Determinations may apply to predeterminations, claims or care provided by plan dentists. The process is available to the Member, the dentist, or to an authorized agent of the Member.

DEFINITIONS

The following definitions apply to this Appeal/Grievance Section:

ADVERSE DETERMINATION: a determination by a Utilization Review (UR) agent that based on the information provided, the healthcare service is not Medically Necessary.

EXPEDITED APPEAL: the process for appeal of an adverse determination in which an immediate appeal is needed due to the urgency of the treatment.

EXTERNAL APPEAL: an appeal conducted by an External Appeal Agent.

EXTERNAL APPEAL AGENT: an entity certified by the State of New York to review Adverse Determinations and make decisions based upon information presented.

FINAL ADVERSE DETERMINATION: an Adverse Determination that has been upheld by a UR Agent.

UR AGENT: either Dentcare or an independent UR entity or individual under contract with Dentcare to perform reviews.

In the event of a denial or Adverse Determination, Dentcare will send written notice that states the reason(s) for the determination and instructions how to start the appeals process.

LEVEL I, THE APPEAL

An Appeal of a denial or an adverse determination may be requested in writing or by telephone within 180 days from the date of the notice of determination. The Appeal review request should be mailed to:

Dentcare Delivery Systems, Inc.
333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553-3608

For POST-SERVICE claims, Dentcare will provide written notice of receipt of the Appeal within 15 days of such filing and will make a decision within 30 days of receipt of the appeal request. For PRE-SERVICE reviews of adverse benefit determinations, claimants shall be notified not later than 15 days after receipt of the request for review. For URGENT CARE reviews of adverse determinations, claimants shall be notified within the lesser of 2 business days of receipt of the needed information or 72 hours of receipt of the request for review.

The period for calculating reviews of denials or adverse determinations shall begin at the time the appeal is filed, without regard to whether all the information necessary to make a decision is with the filing. In the event that the time is extended due to a claimant's failure to submit information, the period for making a decision on review shall be extended. The time from the date on which notice of the extension is sent until the date the claimant responds to the request for information is not counted.

Dentcare will send notice, in writing, of the appeal decision within two business days of the rendering of such decision. The notice will include:

1. The reason for the denial or adverse determination and the clinical basis for such determination. The clinical basis will be noted if the original decision is upheld on appeal or dealt with medical necessity, experimental treatment or a similar exclusion.
2. Reference to the specific plan provisions on which the decision was based and a free copy of the specific rule or guideline.
3. A statement that the claimant may receive access to and copies of all information relevant to their claim for benefits, free of charge.

4. A notice of the claimant's right to an external appeal with a description of the process and the time frames for such appeals.
5. Statements describing any voluntary appeal procedures offered by the plan; the claimant's right to obtain information about such procedures; and a statement of the claimant's right to bring an action under Section 512(a) of the Act.
6. If the adverse decision was based on MEDICAL NECESSITY or experimental treatment, an explanation of the clinical judgment applying the terms to the claimant's circumstances. Or a statement that such an explanation will be provided free of charge upon request.
7. The statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and the N.Y. State Insurance Department".

If the notice is a final adverse determination of an expedited or standard appeal involving medical necessity or experimental/investigational denials, it will also include the following:

1. A clear statement that the notice is the final adverse determination.
2. The name and telephone number of a Dentcare Delivery Systems, Inc. contact person.
3. The insured's coverage type.
4. The name and full address of Dentcare Delivery Systems' UR agent;
5. The UR agent's contact person and telephone number.
6. A description of the service that was denied. This will include the date of service and the name of the dentist who proposed to provide the treatment.
7. A clear, bold statement that the 45-day time frame for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal. This is regardless of whether or not a second level appeal is requested, and that by choosing to request a second level internal appeal, the time may expire for the insured to request an external appeal.

LEVEL II, THE GRIEVANCE

If the Appeal determination is not satisfactory, a Grievance review may be requested. The Grievance review request must be sent in writing to the Grievance Committee. This should be within 60 days from the date of notice of the appeal determination. The written Grievance request should be mailed to the same address shown above.

An oral or written Grievance may be made directly to Dentcare. A notice will then be mailed to the member with a list of all materials and information that the member will need to provide Dentcare. A written Appeal review request or written Grievance review request should include copies of any additional forms supporting the Appeal or Grievance. Within 15 business days of Dentcare's receipt, Dentcare will provide the member with an acknowledgment of the Grievance.

An Appeal or Grievance determination will be issued in writing within 15 days of receipt of the Appeal or Grievance. If the case involves urgent care, a decision will be rendered within the lesser of 2 business days or 72 hours of receipt of the request. The decision will include the same information contained in the Level I Notice. In the event of an emergency or life-threatening situation, a decision will be issued within one day of receipt of the Appeal or Grievance. Emergency services rendered shall not be subject to prior authorization and payment shall not be denied, if services were medically necessary to treat a dental emergency.

EXTERNAL APPEAL PROCESS

A Member has the right to an External Appeal of certain coverage decisions made by Dentcare.

The Member may not request an External Appeal unless Dentcare has issued a Final Adverse Determination through the first level of the internal appeal process. To be eligible, the Final Adverse Determination must be based on a determination that the Requested Service is not Medically Necessary or is experimental or investigational.

The member may request an External Appeal by filing a standard request form with the New York State Insurance Department. The Member must file the request within 45 days of receiving a Final Adverse Determination. The Member may be charged a fee of up to $50 to request an External Appeal. The fee is returned if the External Appeal is successful.

The Member has the right to an expedited External Appeal if a delay in providing the Requested Service poses a threat to the Member's health or the case involves continued dental services for an insured in a course of continued treatment by a dentist. Expedited External Appeals are reviewed by a certified External Appeal Agent and will be decided within 3 days.

If the Member does not understand any part of the External Appeal process, or if the Member has any questions regarding the right to external appeal, the Member may contact the N.Y.S. Insurance Department at 800-400-8882.

INTERNAL APPEAL PROCESS

If an Expedited Internal Appeal is requested, Dentcare will provide access to its review agent within one day of receiving notice. The Agent will contact the claimant's dentist by telephone or facsimile to discuss coverage and treatment. The Expedited Appeal will be determined within two days of receipt of information needed for such appeal. Expedited Internal Appeals that are not decided in favor of the appealing party may be further appealed through the standard appeal process or through an external appeal.

PROVISIONS RELATING TO THE INTERNAL REVIEW PROCESS

If Dentcare has not notified the Member of an Adverse Determination within the specified time, the Member may request an internal review without waiting for Dentcare to make a decision. If the Member has requested an internal review of an Adverse Determination, and Dentcare has not made and notified the Member of its decision within the specified time, Dentcare is required to cover the service, subject to all other conditions of the Program.

CONFIDENTIALITY

Dentcare recognizes the need to protect the confidentiality of the Member's Protected Health information (PHI). By enrolling in this Program, Members agree to furnish information to Dentcare and consents to the release of it to other entities as deemed necessary by Dentcare for treatment, payment or healthcare operations (TPO). This usually relates to disclosures made in administering the provisions of this Program or for provider auditing. For a more complete description of how we use and disclose PHI and members' rights, please read our Notice of Privacy Practices or visit www.dentcaredeliverysystems.org. When requested, the Member shall give Dentcare any required authorization to allow Dentcare to administer the provisions of this Program.

TERM AND AMENDMENT

1. Dentcare may amend this Evidence of Coverage on the renewal date of the Group with approval from the State of New York Insurance Department. Dentcare will give notice to Policyholders at least 30 days before such change.
2. No agent of Dentcare, other than a Company officer, can change this Program or waive any of its provisions. Any such changes or waivers must be in writing.

MISCELLANEOUS PROVISIONS

1. To receive benefits under this Program, Members must follow all guidelines and procedures of Dentcare. It is the obligation of Members to be aware of the limitations and exclusions to Dentcare's Program as stated in all Sections of this Evidence of Coverage.
2. Members shall complete and give to Dentcare applications or other forms as Dentcare may reasonably request.
3. Dentcare's contracting with Providers is not a guarantee or warranty of the professional services of such dentists. Regardless of any managed care decisions Dentcare may make under

the terms of this Program, the decision to receive or decline dental services is ultimately and solely the responsibility of the Member.

4. Participating Dentists and other providers are NOT agents or employees of Dentcare or of any organization that provides non-dental services for Dentcare. Dentcare does not provide health care. All health care services covered are provided by independent dentists who are solely responsible for the services they provide. Dentcare shall not be responsible for any dentist's clinical acts or omissions, or conduct. Dentcare has no liability in connection with any dentist's services rendered other than to provide benefits as set forth under this Contract.
5. Dentcare shall have no obligation to cover any service when a Member refuses to accept the medical advice and treatment prescribed by a Provider. This applies when such refusal obstructs the recommended treatment and no professionally acceptable alternative to such recommended treatment exists. Members may seek other sources of care on a self-pay basis. Members who use non-Dentcare sources of care because of such refusal do so with the knowledge that Dentcare has no obligation for the cost or outcome of such care.
6. Members must comply with the missed appointment policies of a Provider. Dentcare will not cover any charges incurred for failure to comply with these policies.
7. Members agree that their Provides can furnish Dentcare with all information and records relating to diagnosis, treatment or services rendered, if permitted by law.
8. Members must agree to abide by any policies, procedures, rules, and interpretations established by Dentcare for the efficient administration of this Program.
9. No legal action shall be brought against Dentcare before the expiration of sixty days after proof of loss has been filed according to the policy requirements. No such action shall be brought after the expiration of two years following the time such proof of loss is required.
10. ID Cards and other identification as may be needed must be presented before receiving Covered Services. If Members do not properly identify themselves as Members when services are rendered, they shall be responsible for paying all related charges. Possession of a Dentcare ID card is not proof of eligibility, as cards cannot be withdrawn from terminated members. Proof of eligibility should be done with predeterminations or by contacting Dentcare.
11. Member's rights to Covered Services described in this Benefit Program depends upon their payment of all applicable Premiums and Cost-Shares. It also depends on their continued eligibility for coverage under this Program and adherence to the guidelines and procedures of this Program.
12. This Program is entered into and is subject to the laws of the State of New York to the extent such laws are not pre-empted by federal law.
13. Dentcare will not provide benefits for services if the services are not Medically Necessary.

DENTCARE DELIVERY SYSTEMS, INC.

RIDER TO

CERTIFICATE OF INSURANCE

Issued by

DENTCARE DELIVERY SYSTEMS, INC.

The Certificate of Insurance to which this Rider is attached is hereby amended to include the following provision under Definitions:

Deductible: The term Deductible means a fixed amount which the Member must pay for Covered Services in a Calendar Year before Coinsurance is applied.

1. The individual and family Deductible amounts are shown in the Schedule of Benefits
2. The family Deductible amount (2 Members) is met when each Member meets the individual Deductible amount as specified in the Schedule of Benefits.
3. The family Deductible amount (3 or more Members) is met when all family Members collectively meet the family Deductible amounts, as specified in the Schedule of Benefits.

DENTCARE DELIVERY SYSTEMS, INC.

RIDER TO

CERTIFICATE OF INSURANCE

Issued by

DENTCARE DELIVERY SYSTEMS, INC.

Paragraphs # 4 and #9 on page 4 of the Certificate of Insurance to which this Rider is attached are hereby deleted and are hereby amended to read as follows:

Subparagraph # 9 on page 4 pertaining to "key coverage limitations" under the Dental Benefits Section shall now read as follows:

9. General anesthesia and IV sedation are Covered Services only when given for covered oral surgery in a dental office and specified on the Group Benefit Page.

Subparagraph # 4 on page 4 pertaining to "key exclusions" under the Dental Benefits Section shall now read as follows:

4. Cosmetic services done solely to improve appearance (such as porcelain or facings on posterior teeth) and not to address function or deformity from trauma or the treatment of cancer. This does not exclude coverage for treatment due to accidental injury or birth defects.