

This is Your

**PREFERRED PROVIDER ORGANIZATION
CONTRACT**

Issued by

MVP Health Services Corp.

This is Your individual Contract for preferred provider organization coverage issued by MVP Health Services Corp. This Contract, together with the attached Schedule of Benefits, applications, and any amendment or rider amending the terms of this Contract, constitute the entire agreement between You and Us.

You have the right to return this Contract. Examine it carefully. If You are not satisfied, You may return this Contract to Us and ask Us to cancel it. Your request must be made in writing within ten (10) days from the date You receive this Contract. We will refund any Premium paid including any Contract fees or other charges.

Renewability. The renewal date for this Contract is January 1 of each year. This Contract will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Contract or by the Subscriber upon 30 days' prior written notice to Us. Coverage under this Contract lasts until the end of the month in which You turn 19 years of age.

- 1. 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 or Our affiliate's network who are located within Our Service Area. You should always consider receiving dental care services first through the in-network benefits portion of this Contract. In-network care covered under this Contract must be provided, arranged or authorized in advance by Your Primary Care Dentist and, when required, approved by Us. In order to receive in-network benefits, You must contact Your Primary Care Dentist before You obtain the services except for Emergency Dental Care described in the Pediatric Dental Care section(s) of this Contract.
- 2. Out-of-Network Benefits.** The out-of-network benefits portion of this Contract provides coverage when You receive Covered Services from Non-Participating Providers or when You received Covered Services from Participating Providers without care being provided, arranged or authorized in advance by Your Primary Care Dentist and, when required, approved by Us. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider's charge.

READ THIS ENTIRE CONTRACT CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CONTRACT.

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

The insurance evidenced by this Contract provides DENTAL insurance ONLY.

This Contract is a New York State of Health, The Official Health Plan Marketplace, certified stand-alone dental plan offered outside the New York State of Health.

MVP Health Services Corp.
Schenectady, NY



By: _____
President

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SECTION I

Definitions

Defined terms will appear capitalized throughout the Contract.

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

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Contract for a description of how the Allowed Amount is calculated. If your Non-Participating Provider charges more than the Allowed Amount, You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements.

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

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

Contract: This Contract issued by MVP Health Services Corp., including the Schedule of Benefits and any attached riders.

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

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

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

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

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

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

a specific Covered Service that You owe before We begin to pay for a particular Covered Service.

Dependents: The Subscriber's Spouse and Children.

Emergency Dental Care: Emergency dental treatment required to alleviate pain and suffering caused by dental disease or trauma. Refer to the Pediatric Dental Care section(s) of this Contract for details.

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

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

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

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

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

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

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

In-Network Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the Covered Service that You are required to pay to a Participating Provider. The amount can vary by the type of Covered Service.

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

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

In-Network Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Participating Providers. This limit never includes Your Premium or services We do not Cover. The In-Network Out-of-Pocket Limit only applies to benefits that are part of the pediatric dental essential health benefit.

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

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

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

New York State of Health (“NYSOH”): The New York State of Health, the Official Health Plan Marketplace. The NYSOH is a resource where individuals, families and small businesses can learn about their health insurance options; compare plans based on cost, benefits and other important features; choose a plan; and enroll in coverage. The NYSOH also provides information on programs that help people with low to moderate income and resources to pay for coverage, including Medicaid, Child Health Plus, Premium Tax Credits, and cost-sharing reductions.

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

Out-of-Network Coinsurance: Your share of the costs of a Covered Service calculated as a percent of the Allowed Amount for the service that You are required to pay to a Non-Participating Provider. The amount can vary by the type of Covered Service.

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

Out-of-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Non-Participating Providers. The Out-of-Network Deductible applies before any Coinsurance or Copayments are applied. The Out-of-

Network Deductible may not apply to all Covered Services. You may also have an Out-of-Network Deductible that applies to a specific Covered Service that You owe before We begin to pay for a particular Covered Service.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of dental care services We do not Cover. The Out-of-Pocket Limit only applies to benefits that are part of the pediatric dental essential health benefit.

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

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

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

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, or device that the Covered Service, procedure, treatment plan, or device is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this Contract.

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

Premium Tax Credit: Financial help that lowers Your taxes to help You and Your family pay for private dental insurance. You can get this help if You get health insurance through the NYSOH and Your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly Premium.

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

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

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCD to a Specialist) in order to arrange for additional care for a Member. A Referral can be transmitted electronically or by Your Provider completing a

paper Referral form. Except as provided in the Access to Care and Transitional Care section of this Contract or as otherwise authorized by Us, a Referral will not be made to a Non-Participating Provider. A Referral is not required but needed in order for You to pay the lower Cost-Sharing for certain services listed in the Schedule of Benefits section of this Contract.

Responsible Adult: The person who enters into this Contract with Us on behalf of his or her Child or Children.

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

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of: Albany, Broome, Cayuga, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Schuylar, Seneca, Steuben, St. Lawrence, Sullivan, Tioga, Tompkins, Ulster Warren, Washington, Wayne, Westchester, Wyoming and Yates Counties.

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

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

Subscriber: The person to whom this Contract is issued. In the case of a Contract that provides coverage for Pediatric Dental Care only, the Subscriber refers to the Responsible Adult if the Member is under 18 years of age.

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

Us, We, Our: MVP Health Services Corp. and anyone to whom We legally delegate performance, on Our behalf, under this Contract.

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

You, Your: The Member.

SECTION II

How Your Coverage Works

A. Your Coverage under this Contract.

You have purchased a dental insurance Contract from Us. We will provide the benefits described in this Contract to You and/or Your covered Dependents. You should keep this Contract with Your other important papers so that it is available for Your future reference.

B. Covered Services.

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

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

C. Participating Providers.

To find out if a Provider is a Participating Provider:

- Check Your Provider directory, available at Your request;
- Call the number on Your ID card; or
- Visit our website at www.healthplex.com.

D. The Role of Primary Care Dentists.

This Certificate has a gatekeeper, usually known as a Primary Care Dentist (“PCD”). This Certificate requires that you select a PCD. Although You are encouraged to receive care from your PCD, You do not need a written Referral from a PCD before receiving Specialist care from a Participating Provider. However, if You do obtain a written Referral, Your Cost-Sharing may be lower. See the Schedule of Benefits section of this Certificate for Your Cost-Sharing. You may select any participating PCD who is available from the list of PCDs in the Healthplex Exchange Network. Each Member may select a different PCD. Children covered under this Certificate may designate a participating PCD who specializes in pediatric care.

For purposes of Cost-Sharing, if You seek services from a PCD (or a dentist covering for a PCD) who has a primary or secondary specialty other than general dentistry, You must pay the specialty office visit Cost-Sharing in the Schedule of Benefits section of this Certificate when the services provided are related to specialty care.

- 1. Services Not Requiring Referral from Your PCD.** Your PCD is responsible for determining the most appropriate treatment for Your dental care needs. You do not need a Referral from Your PCD to a Participating Provider for the following services:

- Preventive services: cleanings and exams.

However, the Participating Provider must discuss the services and treatment plan with Your PCD; agree to follow Our policies and procedures including any procedures regarding Referrals or Preauthorization for services rendered by such Participating Provider; and agree to provide services pursuant to a treatment plan (if any) approved by Us. See the Schedule of Benefits section of this Contract for the services that require a Referral.

You may need to request Preauthorization before You receive certain services. See the Schedule of Benefits section of this Contract for the services that require Preauthorization.

2. Access to Providers and Changing Providers. Sometimes Providers in Our Provider directory are not available. Prior to notifying Us of the PCD You selected, You should call the PCD to make sure he or she is accepting new patients.

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

You may change Your PCD by calling the number on the back of your ID card. This can be done anytime.

E. Out-of-Network Services.

We Cover the services of Non-Participating Providers. See the Schedule of Benefits section of this Contract for the Non-Participating Provider services that are Covered. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to in-network and out-of-network services.

F. Services Subject To Preauthorization.

Our Preauthorization is required before You receive certain Covered Services. You are responsible for requesting Preauthorization for the in-network and out-of-network services listed in the Schedule of Benefits section of this Contract..

G. Medical Management.

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

H. Medical Necessity.

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

We may base Our decision on a review of:

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

Services will be deemed Medically Necessary only if:

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

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

I. Important Telephone Numbers and Addresses.

- **CLAIMS**
Healthplex, Inc.
Attn: CLAIMS DEPT.
P.O. Box 9255
Uniondale, NY 11553-9255

or

Claims-Referrals@healthplex.com
- **COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS**
Call the number on Your ID card or write to

Healthplex, Inc.
333 Earle Ovington BLVD Suite 300
Uniondale, NY 11553-3608
Attn: Quality Management
- **MEMBER SERVICES**
Call the number on Your ID card
(Member Services Representatives are available Monday – Friday 8:00 a.m. – 5:00 p.m.)
- **PREAUTHORIZATION**
Call the number on Your ID card
- **OUR WEBSITE**
www.mvphealthcare.com

SECTION III

Access to Care and Transitional Care

A. Referral to a Non-Participating Provider.

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

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

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

C. Standing Referral to a Participating Specialist.

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

Provider in Our network. If We approve a standing Referral to a non-participating Specialist, Covered Services rendered by the non-participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

D. When Your Provider Leaves the Network.

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

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

E. New Members In a Course of Treatment.

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

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

SECTION IV

Cost-Sharing Expenses and Allowed Amount

A. Deductible.

Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Certificate for Covered in-network and out-of-network Services during each Plan Year before We provide coverage. If You have other than individual coverage, the individual Deductible applies to each person covered under this Certificate. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year. However, after Deductible payments for persons covered under this Certificate collectively total the family Deductible amount in the Schedule of Benefits section of this Certificate in a Plan Year, no further Deductible will be required for any person covered under this Certificate for that Plan Year.

You have a separate In-Network and Out-of-Network Deductible. Cost-Sharing for out-of-network services does not apply towards Your In-Network Deductible. Cost-Sharing for in-network services does not apply toward Your Out-of-Network Deductible. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible.**

The Deductible runs from January 1 to December 31 of each calendar year.

B. Copayments.

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

C. Coinsurance.

Except where stated otherwise, after You have satisfied the Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your in-network or out-of-network benefit as shown in the Schedule of Benefits section of this Certificate. **You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.**

D. In-Network Out-of-Pocket Limit for the Pediatric Dental Essential Health Benefit. When You have met Your In-Network Out-of-Pocket Limit in payment of In-Network Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Contract for the pediatric dental essential health benefit, We will provide coverage for 100% of the Allowed Amount for Covered in-network Services for

the remainder of that Plan Year for the pediatric dental essential health benefit. Once a Member under age 19 meets the In-Network Out-of-Pocket Limit for one (1) Member under age 19, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person for the pediatric dental essential health benefit. If this Contract covers more than one Member under age 19, when two (2) or more Members under age 19 covered under this Contract have collectively met the In-Network Out-of-Pocket Limit for two (2) or more Members under age 19 in payment of In-Network Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Contract We will provide coverage for 100% of the Allowed Amount for the pediatric dental essential health benefit for the rest of that Plan Year.

Cost-Sharing for out-of-network services does not apply toward Your Out-of-Pocket Limit.

E. Out-of-Network Out-of-Pocket Limit for the Pediatric Dental Essential Health Benefit.

This Contract does not have an Out-of-Network Out-of-Pocket Limit on the pediatric dental essential health benefit.

F. Your Additional Payments for Out-of-Network Benefits.

When You receive Covered Services from a Non-Participating Provider, in addition to the applicable Copayments, Deductible and Coinsurance described in the Schedule of Benefits section of this Certificate, You must also pay the amount, if any, by which the Non-Participating Provider's actual charge exceeds Our Allowed Amount. This means that the total of Our coverage and any amounts You pay under Your applicable Copayment, Deductible and Coinsurance may be less than the Non-Participating Provider's actual charge.

When You receive Covered Services from a Participating or Non-Participating Provider, We will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services You received. Sometimes, applying these rules will change the way that We pay for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. For example, Your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. We will make one inclusive payment in that case, rather than a separate payment for each billed code.

G. Allowed Amount.

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

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

The Allowed Amount for Non-Participating Providers will be determined as follows:

1. For Providers in Our Service Area.

For Providers in Our Service Area, the Allowed Amount will be an amount based on Our Participating Provider fee schedule or rate.

Our Allowed Amount is not based on UCR. The Non-Participating Provider's actual charge may exceed Our Allowed Amount. You must pay the difference between Our Allowed Amount and the Non-Participating Provider's charge. Contact Us at the number on Your ID card or visit Our website www.mvphealthcare.com for information on Your financial responsibility when You receive services from a Non-Participating Provider.

SECTION V

Who Is Covered

A. Who is Covered Under this Contract.

This Contract is issued to cover Members (known as You) who are under 19 years of age. Coverage lasts until the end of the month in which You turn 19 years of age.

B. Children Covered Under This Contract.

Children covered under this Contract include the Subscriber's natural Children, legally adopted Children, step Children, and Children for whom the Subscriber is the proposed adoptive parent without regard to financial dependence, residency with the Subscriber, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage also includes Children for whom the Subscriber is a legal guardian if the Children are chiefly dependent upon the Subscriber for support and the Subscriber has been appointed the legal guardian by a court order. Foster Children and grandchildren of the Subscriber are covered.

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

C. Open Enrollment.

You can enroll under this Contract during an open enrollment period that runs from November 1 of the prior calendar year through January 31 of the following calendar year. If We receive Your selection on or before December 15 of the prior calendar year, Your coverage will begin on January 1 as long as the applicable Premium payment is received by then. If We receive Your selection between December 16 of the prior calendar year through January 15 of the following calendar year, Your coverage will begin on February 1, as long as the applicable premium payment is received by then. If We receive Your selection between January 16 through January 31, Your coverage will begin on March 1 as long as the applicable premium payment is received by then.

If You do not enroll during open enrollment, or during a special enrollment period as described below, You must wait until the next annual open enrollment period to enroll.

D. Special Enrollment Periods.

Outside of the annual open enrollment period, You can enroll for coverage within 30 days of the date the Subscriber gains a Dependent through marriage, birth, adoption or placement for adoption.

We must receive notice and any Premium payment within 30 days of one (1) of these events.

If the Subscriber has a newborn or adopted newborn Child and We receive notice of such birth within 30 days thereafter, coverage for the newborn starts at the moment of birth; otherwise coverage begins on the date on which We receive notice. The adopted newborn Child will be covered from the moment of birth if the Subscriber takes physical custody of the infant as soon as the infant is released from the Hospital after birth and the Subscriber files a petition pursuant to Section 115-c of the New York Domestic Relations Law within 30 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. The Subscriber must also pay any applicable additional Premium within 30 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise coverage begins on the date on which We receive notice, provided that the Subscriber pays any additional Premium when due.

In all other cases, the effective date of Your coverage will depend on when We receive Your selection. If Your selection is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month, as long as Your applicable Premium payment is received by then. If Your selection is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month, as long as Your applicable Premium payment is received by then.

E. Coverage of Children of Domestic Partners.

Children covered under this Contract also include the Children of the Subscriber's domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists, or
2. For partners residing where registration does not exist, by an alternate affidavit of domestic partnership.
 - a. The affidavit must be notarized and must contain the following:
 - The partners are both 18 years of age or older and are mentally competent to consent to contract;
 - The partners are not related by blood in a manner that would bar marriage under the laws of the State of New York;
 - The partners have been living together on a continuous basis prior to the date of the application;
 - Neither individual has been registered as a member of another domestic partnership within the last six (6) months; and
 - b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and

- c. Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
- A joint bank account;
 - A joint credit card or charge card;
 - Joint obligation on a loan;
 - Status as an authorized signatory on the partner's bank account, credit card or charge card;
 - Joint ownership of holdings or investments;
 - Joint ownership of residence;
 - Joint ownership of real estate other than residence;
 - Listing of both partners as tenants on the lease of the shared residence;
 - Shared rental payments of residence (need not be shared 50/50);
 - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
 - A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
 - Shared household budget for purposes of receiving government benefits;
 - Status of one (1) as representative payee for the other's government benefits;
 - Joint ownership of major items of personal property (e.g., appliances, furniture);
 - Joint ownership of a motor vehicle;
 - Joint responsibility for child care (e.g., school documents, guardianship);
 - Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
 - Execution of wills naming each other as executor and/or beneficiary;
 - Designation as beneficiary under the other's life insurance policy;
 - Designation as beneficiary under the other's retirement benefits account;
 - Mutual grant of durable power of attorney;
 - Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
 - Affidavit by creditor or other individual able to testify to partner's financial interdependence; or
 - Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

SECTION VI

Pediatric Dental Care

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

We Cover the following dental care services for Members through the end of the month in which the Members turn 19 years of age:

- A. Emergency Dental Care.** We Cover Emergency Dental Care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma. Emergency Dental Care is not subject to Our Preauthorization.
- B. Preventive Dental Care.** We Cover preventive dental care that includes procedures which help to prevent oral disease from occurring, including:
- Prophylaxis (scaling and polishing the teeth) at six (6) month intervals; two (2) times per Plan Year;
 - Topical fluoride application at six (6) month intervals; two (2) times per Plan Year where the local water supply is not fluoridated;
 - Sealants on unrestored permanent molar teeth; and
 - Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.
- C. Routine Dental Care.** We Cover routine dental care provided in the office of a dentist, including:
- Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt); two (2) times per Plan Year;
 - X-rays, full mouth x-rays or panoramic x-rays at 36-month intervals, bitewing x-rays at six (6) to 12-month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
 - Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
 - In-office conscious sedation;
 - Amalgam, composite restorations and stainless steel crowns; and
 - Other restorative materials appropriate for children.
- D. Endodontics.** We Cover endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.
- E. Periodontics.** We Cover periodontic services, including periodontic services in anticipation of, or leading to orthodontics Covered under this Contract.
- F. Prosthodontics.** We Cover prosthodontic services as follows:

- Removable complete or partial dentures, including six (6) months follow-up care; and
- Additional services including insertion of identification slips, repairs, relines and rebases and treatment of cleft palate.

Fixed bridges are not Covered unless they are required:

- For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full compliment of natural, functional and/or restored teeth;
- For cleft palate stabilization; or
- Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

G. Orthodontics. We Cover orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

Procedures include but are not limited to:

- Rapid Palatal Expansion (RPE);
- Placement of component parts (e.g. brackets, bands);
- Interceptive orthodontic treatment;
- Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted);
- Removable appliance therapy; and
- Orthodontic retention (removal of appliances, construction and placement of retainers).

SECTION VIII

Exclusions and Limitations

No coverage is available under this Contract for the following:

A. Convalescent and Custodial Care.

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

B. Cosmetic Services.

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

C. Coverage Outside of the United States, Canada or Mexico.

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

D. Experimental or Investigational Treatment.

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

E. Felony Participation.

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

F. Foot Care.

We do not Cover foot care, in connection with corns, calluses, flat feet, fallen arches,

weak feet, chronic foot strain or symptomatic complaints of the feet.

G. Government Facility.

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

H. Medical Services.

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

I. Medically Necessary.

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

J. Medicare or Other Governmental Program.

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

K. Military Service.

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

L. No-Fault Automobile Insurance.

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

M. Pre-Existing Conditions.

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

N. Services Not Listed.

We do not Cover services that are not listed in this Contract as being Covered.

O. Services Provided by a Family Member.

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

P. Services Separately Billed by Hospital Employees.

We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

Q. Services with No Charge.

We do not Cover services for which no charge is normally made.

R. Vision Services.

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

S. War.

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

T. Workers' Compensation.

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

SECTION IX

Claim Determinations

A. Claims.

A claim is a request that benefits or services be provided or paid according to the terms of this Contract. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us.

B. Notice of Claim.

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

C. Timeframe for Filing Claims.

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

D. Claims for Prohibited Referrals.

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

E. Claim Determinations.

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

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

F. Pre-service Claim Determinations.

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

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

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

G. Post-service Claim Determinations.

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

SECTION X

Grievance Procedures

A. Grievances.

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

B. Filing a Grievance.

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

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

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

C. Grievance Determination.

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

Expedited/Urgent Grievances:

By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.

Pre-Service Grievances:

(A request for a service or treatment that has not yet been provided.)

In writing, within 15 calendar days of receipt of Your Grievance.

Post-Service Grievances:

(A claim for a service or treatment that has already been provided.)

In writing, within 30 calendar days of receipt of Your Grievance.

All Other Grievances:
(That are not in relation to a claim or request for a service or treatment.)

In writing, within 45 calendar days of receipt of all necessary information.

D. Grievance Appeals.

If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at the number on Your ID card or in writing. However, Urgent Appeals may be filed by phone. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

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

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

Expedited/Urgent Grievances:

The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.

Pre-Service Grievances:

(A request for a service or treatment that has not yet been provided.)

15 calendar days of receipt of Your Appeal.

Post-Service Grievances:

(A claim for a service or treatment that has already been provided.)

30 calendar days of receipt of Your Appeal.

All Other Grievances:

(That are not in relation to a claim or request for a service or treatment.)

30 business days of receipt of all necessary information to make a determination.

E. Assistance.

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

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit

One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov

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

SECTION XI

Utilization Review

A. Utilization Review.

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

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

B. Preauthorization Reviews.

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

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

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice

will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period.

C. Concurrent Reviews.

- 1. Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) , by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee), by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within 15 calendar days of the end of the 45-day period.
- 2. Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

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

D. Retrospective Reviews.

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

Once We have all the information to make a decision, Our failure to make a Utilization

Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. Retrospective Review of Preauthorized Services.

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

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

F. Reconsideration.

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

G. Utilization Review Internal Appeals.

You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will, if necessary, inform You of any additional information needed before a decision can be made. A clinical peer reviewer who is a Physician or a health care professional 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.

1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service

is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. You are not eligible for a Utilization Review Appeal if the service You request is available from a Participating Provider, even if the Non-Participating Provider has more experience in diagnosing or treating Your condition. (Such an Appeal will be treated as a Grievance.) For a Utilization Review Appeal of denial of an out-of-network health service, You, or Your designee, must submit:

- A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
- Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Referral Denial.** You also have the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network Referral denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:

- That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and

Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

H. Standard Appeal.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.
2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 60 calendar days of receipt of the Appeal

request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

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

Our failure to render a determination of Your Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

I. Appeal Assistance.

If you need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:

Community Health Advocates

633 Third Avenue, 10th Floor

New York, NY 10017

Or call toll free: 1-888-614-5400, or email cha@cssny.org

[Website: www.communityhealthadvocates.org](http://www.communityhealthadvocates.org)

SECTION XII

External Appeal

A. Your Right to an External Appeal.

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

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

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

B. Your Right to Appeal A Determination that A Service Is Not Medically Necessary.

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

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

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

1. Standard health services are ineffective or medically inappropriate; or

2. There does not exist a more beneficial standard service or procedure covered by Us; or
3. There exists a clinical trial or rare disease treatment (as defined by law).

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

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

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

D. Your Right to Appeal A Determination that a Service is Out-of-Network.

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

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

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

E. Your Right to Appeal an Out-of-Network Referral Denial.

If We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training

and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph “A” above.

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

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

F. The External Appeal Process.

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

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

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

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

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending

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

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

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

G. Your Responsibilities.

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

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

SECTION XIII

Termination of Coverage

This Contract may be terminated as follows:

A. Automatic Termination of this Contract.

This Contract shall automatically terminate upon the death of the Subscriber, unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, this Contract will terminate as of the last day of the month for which the Premium has been paid.

B. Automatic Termination of Your Coverage.

Coverage under this Contract shall automatically terminate:

1. For Spouses in cases of divorce, the date of the divorce.
2. For Children, the end of the month in which the Child turns 19 years of age. For a Child who is a student at an accredited institution of learning, until the end of the month in which the Child turns 26 years of age.
3. For all other Dependents, the end of the month in which the Dependent ceases to be eligible.

C. Termination by You.

The Subscriber may terminate this Contract at any time by giving Us at least 30 days prior written notice.

D. Termination by Us.

We may terminate coverage Contract with 30 days written notice as follows:

1. For Non-payment of Premiums.
Premiums are to be paid by the Subscriber to Us on each Premium due date. While each Premium is due by the due date, there is a grace period for each Premium payment. If the Premium payment is not received by the end of the grace period, coverage will terminate as follows:
 - If the Subscriber fails to pay the required Premium within a 30-day grace period, this Contract will terminate retroactively back to the last day Premiums were paid. The Subscriber will be responsible for paying any claims submitted during the grace period if this Contract terminates.
2. Fraud or Misrepresentation of Material Fact.
If the Subscriber has performed an act that constitutes fraud or made a misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, this Contract will terminate immediately upon a written notice to the Subscriber from Us. However, if the Subscriber makes a misrepresentation of material fact in writing on his or her enrollment application We will rescind coverage if the facts misrepresented would have led Us to refuse to issue this Contract and the application is attached to this Contract. Rescission means that the termination of Your coverage will have a

retroactive effect of up to one (1) year; the issuance of this Contract. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

3. If the Subscriber no longer lives, or resides in Our Service Area.
4. The date the Contract is terminated because We stop offering the class of contracts to which this Contract belongs, without regard to claims experience or health related status of this Contract. We will provide the Subscriber with at least five months prior written notice.

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

SECTION XIV

Extension of Benefits

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

SECTION XV

Temporary Suspension Rights for Armed Forces' Members

If You, the Subscriber, are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government, and
2. You serve no more than five (5) years of active duty.

You must make a written request to Us to have Your coverage suspended during a period of active duty. Your unearned Premium will be refunded during the period of such suspension.

Upon completion of active duty, Your coverage may be resumed as long as You:

1. Make written application to Us; and
2. Remit the Premium within 60 days of the termination of active duty.

The right of resumption extends to coverage for Your Dependents. For coverage that was suspended while on active duty, coverage will be retroactive to the date on which active duty terminated.

SECTION XVI

General Provisions

1. Agreements between Us and Participating Providers.

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

2. Assignment.

You cannot assign any benefits or monies due under this Contract 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 Contract or Your right to collect money from Us for those services. However, You may request Us to make payment for services directly to Your Provider instead of You.

3. Changes in This Contract.

We may unilaterally change this Contract upon renewal, if We give You 45 days' prior written notice.

4. Choice of Law.

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

5. Clerical Error.

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

6. Conformity with Law.

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

7. Continuation of Benefit Limitations.

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

all benefits previously utilized when you were a covered family member will be applied toward your new status as a Subscriber.

8. Entire Agreement.

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

9. Fraud and Abusive Billing.

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

10. Furnishing Information and Audit.

All persons covered under this Contract will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Contract. You must provide Us with certain information over the telephone for reasons such as the following: to determine the level of care You need; so that We may certify care authorized by Your Provider, or make decisions regarding the Medical Necessity of Your care.

11. Identification Cards.

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

12. Incontestability.

No statement made by the Subscriber in an application for coverage under this Contract shall avoid the Contract or be used in any legal proceeding unless the application or an exact copy is attached to this Contract.

13. Independent Contractors.

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

14. Input in Developing Our Policies.

Subscribers may participate in the development of Our policies by calling the number on

the back of your ID card.

15. Material Accessibility.

We will give You ID cards Contracts, riders and other necessary materials.

16. More Information about Your Dental Plan.

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

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

17. Notice.

Any notice that We give You under this Contract will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery. If notice is delivered to You electronically, You may also request a copy of the notice from Us. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to the address on Your ID card.

18. Premium Payment.

The initial Premium is payable (1) one month in advance by the Subscriber to Us at Our office. The first month's Premium is due and payable upon submission of the application. Coverage will begin on the effective date of the Contract as defined herein. Subsequent Premiums are due and payable on the first of each month thereafter.

19. Recovery of Overpayments.

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

made unless We have a reasonable belief of fraud or other intentional misconduct.

20. Renewal Date.

The renewal date for the Contract is January 1 Contract of each year. This Contract will automatically renew each year on the renewal date unless otherwise terminated by Us, as permitted by this Contract, or by the Subscriber upon 30 days' prior written notice to Us.

21. Reinstatement after Default.

If the Subscriber defaults in making any payment under this Contract, the subsequent acceptance of payment by Us or by one of Our authorized agents or brokers shall reinstate the Contract, but with respect to sickness and injury, only to Cover such sickness as may be first manifested more than 10 days after the date of such acceptance.

22. Right to Develop Guidelines and Administrative Rules.

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

23. Right to Offset.

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

24. Severability.

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

25. Third Party Beneficiaries.

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

26. Time to Sue.

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

27. Translation Services.

Translation services are available under this Contract for non-English speaking Members. Please contact Us at the number on your ID card to access these services.

28. Waiver.

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

29. Who May Change this Contract.

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

30. Who Receives Payment under this Contract.

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

31. Workers’ Compensation Not Affected.

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

32. Your Dental Records and Reports.

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

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

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

SECTION XIX

MVP Health Services Corp. SCHEDULE OF BENEFITS 01 Pediatric