Cigna Health and Life Insurance Company ("Cigna")

Individual Services

Cigna Dental Security 1500 Plan

POLICY FORM NUMBER: INDDENPOLNYv2

LIMITED BENEFITS HEALTH INSURANCE
REQUIRED DISCLOSURE STATEMENT

This policy provides limited benefits health insurance ONLY. This policy does NOT provide basic hospital, basic medical or major medical insurance, as defined by the New York State Department of Financial Services.

This disclosure statement is a very brief summary of Your Policy.

The Policy itself sets forth the rights and obligations of both You and Cigna. It is therefore imperative that you READ YOUR POLICY carefully.

A. **Coverage is provided by Cigna Health and Life Insurance Company (referred to herein as "Cigna"),** an insurance company that provides Participating Dental Provider benefits.

B. To **obtain additional information**, including Provider information, write to the following address or call the toll-free number:

Cigna
Individual Services
P. O. Box 30365
Tampa, FL 33630
1-877-484-5967

C. A **Participating Dental Provider Plan** enables the Member to incur lower dental costs by using Providers in the Cigna network.

- A **Participating Dental Provider** is a Provider who has a contract with Us to provide health care services to You. A list of Participating Dental Providers and their locations is available on Our website at myCigna.com or upon Your request to Us. The list will be revised from time to time by Us.
- A **Non-Participating Dental Provider** means a Provider who doesn't have a contract with Us to provide health care services to You.

D. Covered Services and Benefits

Benefits covered by Your dental plan include Preventive & Diagnostic Care such as oral exams, cleanings and x-rays. Your plan also includes Basic Restorative Care such as fillings and simple extractions. Major Restorative Care is covered under Your plan and includes crowns, dentures and bridges. Coverage for Orthodontia is also included under your plan. For a complete listing of Covered Services, please read Your plan documents.

The frequency of certain Covered Services, like cleanings, are limited. Refer to Your Policy for specific limitations on frequency under Your plan.

CIGNA DENTAL INSURANCE
Schedule of Benefits

For You and Your Dependent(s)

Benefit Schedule
If You select a Participating Dental Provider, Your cost will be less than if You select a Non-Participating Dental Provider.

Emergency Dental Care
The Coinsurance payable for Emergency Dental Care charges made by a Non-Participating Dental Provider is the same Coinsurance payable as for Participating Dental Provider. Emergency Dental Care services are services required to alleviate pain and suffering caused by dental disease or trauma. Refer to the Dental Care section of the Policy for details.

Deductibles
Deductibles are the amount You owe before We begin to pay for Covered Services. The Deductible applies before any Coinsurance is 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.

Simultaneous Accumulation of Amounts
Expenses incurred will be used to satisfy both the Participating and Non-Participating Dental Provider Deductibles shown in the Schedule of Benefits.

Benefits paid will be applied toward both the Participating and Non-Participating Dental Provider maximum shown in the Schedule of Benefits.

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Classes I, II, and III Plan Year Maximum	$1500 per person	$1500 per person
Class IV Lifetime Maximum	$2,000 per person	
Plan Year Deductible Individual	$50 per person Not Applicable to Class I	
Family Deductible	$150 per family Not Applicable to Class I	
Lifetime Class IV Deductible	$200 per person	
Class I	**The Percentage of Covered Expenses the Member Pay**	**The Percentage of Covered Expenses the Member Pay**
Preventive Care Oral Exams Routine Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers (non-orthodontic)	0%	0%

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Class II	**The Percentage of Covered Expenses the Member Pays**	**The Percentage of Covered Expenses the Member Pays**
Basic Restorative Fillings Emergency Care to Relieve Pain Non-Routine X-rays Oral Surgery, Simple Extractions	20% after plan deductible	20% after plan deductible
Class III	**The Percentage of Covered Expenses the Member Pays**	**The Percentage of Covered Expenses the Member Pays**
Major Restorative Crowns / Inlays / Onlays Dentures Bridges Root Canal Therapy / Endodontics Minor Periodontics Major Periodontics Oral Surgery, All Except Simple Extractions Surgical Extraction of Impacted Teeth Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs – Dentures Anesthetics	50% after plan deductible	50% after plan deductible
Class IV	**The Percentage of Covered Expenses the Member Pays**	**The Percentage of Covered Expenses the Member Pays**
Orthodontia	50% after separate Class IV deductible	50% after separate Class IV deductible

E. Waiting Periods

A Member may access their dental Covered Services once the following waiting periods are satisfied.

- there is no waiting period for Class I Covered Services.
- after 6 consecutive months of coverage, Covered Services will increase to include the list of Class II dental procedures.
- after 12 consecutive months of coverage, Covered Services will increase to include the list of Class III dental procedures.
- after 12 consecutive months of coverage, Covered Services will increase to include the list of Class IV dental procedures.

F. Subscriber's Financial Responsibility

The Subscriber is responsible for paying the monthly or quarterly premium on a timely basis. The Subscriber is also responsible to pay Providers for charges that are applied to the Deductibles, Coinsurance and any amounts charged by Non-Participating Dental Providers in excess of the Allowed Amount. In addition, any charges for Medically Necessary items that are excluded under the Policy are the responsibility of the Subscriber.

G. Exclusions and Limitations

No coverage is available under this Policy for the following:

- **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.
- **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 except for emergency services to treat Your Emergency Dental Care Condition.
- **Services Not Listed.** We do not Cover services that are not listed in this Policy as being Covered.
- **Medically Necessary.** In general, We will not Cover any dental care 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 Policy.
- **Services with No Charge.** We do not Cover services for which no charge is normally made.
- **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.
- **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.
- **Military Service.** We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.
- **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).
- **Experimental or Investigational Treatment.** We do not Cover any dental care service, procedure, treatment, or device that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be covered under this Policy for non-investigational treatments. See the Utilization Review and External Appeal sections of this Policy for a further explanation of Your Appeal rights.
- **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.
- **Medical Services.** We do not Cover medical services or dental services that are medical in nature, including any Hospital charges or prescription drug charges.
- We do not Cover procedures, appliances or restorations whose main purpose is to diagnose or treat jaw joint problems, including dysfunction of the temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex muscles, nerves and other tissues related to that joint.
- **Missing Teeth Limitation.** There is no payment for replacement of teeth that are missing when a person first becomes insured. This payment limitation no longer applies after 12 months of continuous coverage.
- There is no payment for the replacement of a bridge, crown or denture within 7 years after the date it was originally installed unless: (a) the replacement is made Necessary by the placement of an original opposing full denture or the Necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a Covered Person is insured for these benefits.

- There is no payment for the replacement of a bridge, crown or denture which is or can be made useable according to common dental standards.
- There is no payment for precious or semi-precious metals for crowns, bridges and abutments.

H. Pre-Determination/Pre-Treatment Estimates

We allow You to request and obtain an estimate of coverage. You or Your Provider may contact Us and request a pre-determination of benefits, also known as a pre-treatment estimate. If We determine that an alternative procedure or treatment is more appropriate than the requested service, You may appeal Our decision through an internal Appeal or external appeal. See the Utilization Review and External Appeal sections of the Policy for Your right to an internal Appeal and external appeal.

I. General Provisions

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 1-877-484-5967. 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 1-877-484-5967 or visit Our website at myCigna.com. You may ask that We send You electronic notification of a Utilization Review determination instead of notice in writing or by telephone. You must tell Us in advance if You want to receive electronic notifications. To opt into electronic notifications, call 1-877-484-5967 or visit Our website at myCigna.com. You can opt out of electronic notifications at any time.

Preauthorization Reviews.

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

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. Written notification will be provided within the earlier of three (3) business days of Our receipt of the information or three (3) calendar days after the verbal notification.

Concurrent Reviews.

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) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within the earlier of 15 calendar days of receipt of part of the requested information or 15 calendar days of the end of the 45-day period.

Urgent Concurrent Reviews. For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request. If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of 72 hours or of one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if We do not receive the information, within 48 hours of the end of the 48-hour period.

Retrospective Reviews.

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

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

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.

Reconsideration.

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

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. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is (1) a Physician or (2) a health care professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

First Level 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 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

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

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

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

Full and Fair Review of an Appeal.

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

Second Level Appeal.

If You disagree with the first level Appeal determination, You or Your designee can file a second level Appeal. You or Your designee can also file an external Appeal. The four (4) month timeframe for filing an external appeal begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second level Appeal, the time may expire for You to file an external appeal.

A second level Appeal must be filed within 45 days of receipt of the final adverse determination on the first level Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt.

This acknowledgment will inform You, if necessary, of any additional information needed before a decision can be made.

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

3. **Expedited Appeal.** If Your Appeal related to an urgent matter, We will decide the Appeal and provide written notice to Your (or Your designee), and where appropriate, Your Provider, within 72 hours of receipt of the Appeal request.

Appeal Assistance.

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

J. Participating Dental Providers

To find out if a Provider is a Participating Dental Provider:

- Check Our Provider directory, available at Your request;
- Call 1-877-484-5967; or
- Visit Our website myCigna.com.

K. Renewability

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

We may terminate this Policy 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 Policy 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 Policy terminates.

   - If the Subscriber receives advanced payments of the Premium Tax Credit and has paid at least one (1) full month's Premium, this Policy will terminate one (1) month after the last day Premiums were paid. That is, retroactive termination will not exceed 61 days. We may pend claims incurred during the 61-day grace period. The Subscriber will be responsible for paying any claims incurred during the 61-day grace period if this Policy coverage terminates.

2. Fraud or Intentional Misrepresentation of Material Fact.

If the Subscriber has performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, this Policy will terminate immediately upon a written notice to the Subscriber from Us. However, if the Subscriber makes an intentional 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 Policy and the application is attached to this Policy. Rescission means that the termination of Your coverage will have a retroactive effect of up to one (1) year; the issuance of this Policy. 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 Policy is terminated because We stop offering the class of policies to which this Policy belongs, without regard to claims experience or health related status of this Policy. We will provide the Subscriber with at least 90 days' prior written notice.

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

L. Eligibility

Who is Covered Under this Policy.

You, the Subscriber to whom this Policy is issued, are covered under this Policy. You must live or reside in Our Service Area to be covered under this Policy. If You are enrolled in Medicare, You are not eligible to purchase this Policy. Members of Your family may also be covered depending on the type of coverage You selected.

Types of Coverage.

We offer the following types of coverage:

1. **Individual.** If You selected individual coverage, then You are covered.
2. **Individual and Spouse.** If You selected individual and Spouse coverage, then You and Your Spouse are covered.
3. **Parent and Child/Children.** If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.
4. **Family.** If You selected family coverage, then You, Your Spouse and Your Child or Children, as described below, are covered.

Children Covered Under this Policy.

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

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

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

Effective Dates of Coverage for Special Enrollment Periods.

You can enroll under this Policy at any time during the Plan Year.

You, Your Spouse or Child 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 You, Your Spouse or Child enroll because You got married, Your coverage will begin on the first day of the month following Your selection of coverage. If You, Your Spouse or Child enroll because You gain a Dependent through adoption or placement for adoption, Your coverage will begin on the date of the adoption or placement for adoption. If You, Your Spouse or Child enroll because of a court order, Your coverage will begin on the date the court order is effective.

If You have a newborn or adopted newborn Child and We receive notice of such birth within 30 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 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. If You have individual or individual and Spouse coverage, You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within 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 You pay 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.

Domestic Partner Coverage.

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

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

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

M. Premium

The first month's Premium is due and payable when You apply for coverage. Coverage will begin on the effective date of the Policy as defined therein. Subsequent Premiums are due and payable on the first of each month thereafter.