



The Ohio State University Faculty and Staff Dental Plan Specific Plan Details Document

2024 Plan Year (January 1 – December 31, 2024)



THE OHIO STATE UNIVERSITY
HUMAN RESOURCES



CONTACT INFORMATION

THE OHIO STATE UNIVERSITY Office of Human Resources

HR Connection | 614-247-myHR(6947)
1590 North High Street, Suite 300
Columbus, OH 43201-2190
800-678-6010
Fax: 614-292-6235
E-mail: HRConnection@osu.edu
hrconnection.osu.edu

Provides information regarding:

- Certification of state service requests
- Flexible Spending Accounts – Dependent Care and Health Care
- Health Insurance
 - Enrollment
 - Verification of coverage
- Life Insurance
 - Change of beneficiary
 - Enrollment
- Retirement Programs
 - ARP, OPERS, STRS
- Supplemental Retirement Accounts– 403(b) and 457(b) plans
- Tuition Assistance
 - For dependents
 - For faculty and staff
- Your Plan for Health, yp4h.osu.edu

Employee and Labor Relations

614-292-2800

Provides information regarding:

- Family/medical leave, sick leave, vacation leave, medical leave, personal leave, military leave, paid parental leave, organ donation leave, jury duty/court

Integrated Absence Management and Vocational Service

614-292-3439
800-678-6413
Fax: 614-688-8120
E-mail: id@hr.osu.edu

Available to provide consultation on:

- Department presentations
- Long-term and short-term disability
- OPERS/STRS disability retirement
- Unemployment compensation, 614-688-3578
- Transitional work
- Workers' compensation

YOUR PLAN FOR HEALTH

614-292-4700 or 800-678-6269 (OSU Health Plan)
E-mail: yp4h@osu.edu or visit yp4h.osu.edu

- Biometric Health Screenings
- Educational Programming
- Personal Health & Well-Being Assessment (PHA)
- Incentive Programs
- Personal Health Coaching Program
- Care Coordination Program

Ohio State Employee Assistance Program (EAP) . . . 800-678-6265

- 24/7/365 live connection osuhealthplan.com
Serves faculty, staff and their families

Other Important Contacts

Care Works of Ohio, Inc. 888-627-0058

- Workers' compensation claims assistance

Delta Dental Plan of Ohio 800-524-0149

- Customer and Claims Services
- View claims, find dentist, print ID cards toolkitsonline.com

Express Scripts 866-727-5867

- Prescription drugs–retail/home delivery/claims . . express-scripts.com
- Print prescription drug ID cards

Ohio State Travel Assistance

U.S. 866-807-6193

International 01-770-667-0247

Medical care coordination outside Ohio

Ohio State University Health Plan, Inc. 614-292-4700

. 800-678-6269

. osuhealthplans@osumc.edu

- Prior authorization of required services and admissions, provider network inquiries and other medical services
- General benefit information and questions . . . osuhealthplan.com

HealthEquity/WageWorks (Flexible Spending Account and HRA Administrator) Customer Support 877-924-3967

Trustmark Health Benefits. 800-678-6269

- View medical claims myTrustmarkBenefits.com
- Print medical ID cards
- COBRA administration

Unum 866-245-3013

- Disability claims assistance

Vision Service Plan (VSP) 800-877-7195

- Vision providers and claims assistance vsp.com

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INTRODUCTION

This Faculty and Staff Dental Plan Specific Plan Details Document describes and establishes the important provisions of The Ohio State University Faculty and Staff Dental Plan (the Dental Plan), which provides dental benefits to faculty and staff and their eligible dependents by The Ohio State University and its designated affiliates.

ABOUT THIS DOCUMENT

This SPD provides a summary of Ohio State's dental benefits and how you can obtain them.

- You are strongly urged to read this SPD in its entirety. The guidelines outlined will dictate how dental claims are processed or considered as Covered Services under the Dental Plan.
- This SPD is broken down into a number of related sections and is best used by familiarizing yourself with the following:
 - **The inside front cover** – contact information for the services discussed in this SPD, as well as other employee benefit programs maintained by Ohio State.
 - **The table of contents** – the easiest way to navigate this SPD.
 - The definitions section – contains a list of several important terms used throughout this SPD.
- This SPD also describes your rights and responsibilities as a Covered Person enrolled in the Dental Plan. It is very important that you have a good understanding of the Covered Services available to you and of the items that are excluded or limited by the Dental Plan.
- Every attempt has been made to ensure the accuracy of information in this SPD. However, if there is a discrepancy between this SPD and other legal documents, including, but not limited to, the Delta Dental Service Contract between Delta Dental and The Ohio State University (Service Contract), the other legal documents will govern.

ALTERATION OF DOCUMENT

Only the university has the authority to change the coverage and/or terms under the Dental Plan.

TERMS USED IN THIS DOCUMENT

The following terms are used interchangeably throughout this booklet:

- The Ohio State University Faculty and Staff Dental Plan Specific Plan Details Document also called Faculty and Staff Dental Plan Specific Plan Details Document, the SPD, or the document.
- The Ohio State University Faculty and Staff Dental Plan also called the Dental Plan.
- Faculty and staff also called you, employee or subscriber.
- The Ohio State University also called OSU, Ohio State, the university, the employer and the Plan Sponsor.
- Office of Human Resources also called OHR.
- The Internal Revenue Code of 1986, as amended, also called the Code.
- Other important terms are defined in the "Definitions" section at the end of this SPD.

OPERATION AND ADMINISTRATION OF THE DENTAL PLAN

- The Ohio State University is the Plan Sponsor.
- Benefits under the Dental Plan are paid for directly by Ohio State, which means the Dental Plan is considered to be self-funded. Eligible employees pay all or part of the cost of providing benefits under the Dental Plan through payroll deductions (i.e., employee contributions) and, if applicable, the employing departments provide the balance.
- Delta Dental is the university's third party administrator and provides certain administrative services under the Dental Plan.
- Trustmark provides COBRA administration services under the Dental Plan.
- The Plan Administrator (defined in the "Definitions" section) has the discretionary authority to interpret the Dental Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Dental Plan. Benefits under the Dental Plan shall be paid only if the Plan Administrator decides in its sole discretion that a Covered Person is entitled to them. If any of the authority of the Plan Administrator has been delegated by the Plan Administrator to a delegate, a reference in this Faculty and Staff Dental Plan Specific Plan Details Document to the Plan Administrator shall be deemed to include a reference to such delegate.

FOR MORE INFORMATION (SEE PAGE 2 FOR CONTACT INFORMATION)

If you have questions when using your dental benefits, refer to the following for assistance:

- **Delta Dental**, deltadentaloh.com – Dental benefits, claims processing, ID cards, provider directory assistance
- **Office of Human Resources (OHR) HR Connection**, hrconnection@osu.edu – General benefits information, enrollment, eligibility, publications
- **OHR website**, hr.osu.edu – Link to provider network listings for the Dental Plan, general benefits information
- **OSU Health Plan**, osuhealthplan.com – Assistance with coordination of dental benefits with medical plan, precertification
- **Trustmark**, myTrustmarkBenefits.com – Coverage continuation administration

DISCRIMINATION IS AGAINST THE LAW

The Ohio State University complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Ohio State University does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Ohio State University:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact The Ohio State University's affirmative action and EEO coordinator.

If you believe that The Ohio State University has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Affirmative Action and EEO Coordinator
1590 N. High St., Suite 300
Columbus, OH 43201-2190
Phone: 614-292-2800
Fax: 614-292-6199
Email: aa-eeo@osu.edu

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the affirmative action and EEO Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HMI Building
Washington, D.C. 20201
1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html.

Continued on the following page.

DISCRIMINATION IS AGAINST THE LAW

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-800-264-1552, Access Code# 80014189.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-264-1552, Código de acceso # 80014189.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-264-1552，访问代码 # 80014189

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-264-1552, Zugangscode # 80014189.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 2551 462 008 1 رمز الدخول 98141008

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-264-1552, Toegangscodes # 80014189.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-264-1552, Код доступа # 80014189.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-264-1552, Code d'accès # 80014189.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-264-1552, mã số truy cập # 80014189.

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-264-1552, Access Code# 80014189.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-264-1552, 액세스 코드 # 80014189, 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-264-1552, Codice d'accesso # 80014189.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-264-1552，访问代码 # 80014189，まで、お電話にてご連絡ください。

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-264-1552, Toegangscodes # 80014189.

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-264-1552, Код доступу# 80014189.

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-264-1552, Cod de acces # 80014189.

COVERED PERSON'S RIGHTS

The university is committed to offering quality dental coverage for its employees and their eligible dependents. As a person covered by the Dental Plan, you have certain rights that help ensure you and your enrolled dependents receive quality dental care. You are expected to be an active participant in your dental care.

AS A COVERED PERSON UNDER THE DENTAL PLAN, YOU HAVE THE RIGHT TO THE FOLLOWING:

- Receive and have access to information about the terms and conditions of the Dental Plan, network dental providers, and your rights and responsibilities.
- Fair and respectful consideration and treatment by staff at the OSU Health Plan, OHR, Trustmark, Delta Dental, Delta Dental network providers and customer service.
- Confidentiality and privacy regarding your dental care matters.
- Receive an explanation of all benefits to which you are entitled under the Dental Plan.
- Receive quality Dental Services through your Dental Plan network in a timely manner and in the most appropriate setting possible.
- Participate with your providers in decision-making about your dental needs and how best to meet those needs within the guidelines of the Dental Plan.
- Have access to complete and understandable information about your dental conditions and the treatments rendered by your dental providers.
- Refuse treatment and be informed by your network dental provider or the OSU Health Plan of the consequences of such action.
- Express concerns and complaints about provider services and administration.
- File a formal appeal, as outlined in the "Disputed Claims Procedures" section of this SPD.

COVERED PERSON'S RESPONSIBILITIES

For the Dental Plan to work effectively there are certain procedures, which you, as a Covered Person, must follow. As a person covered by the Dental Plan, you have certain responsibilities that will help ensure that you and your enrolled dependents receive quality care. You are expected to be an active participant in your dental care.

AS A COVERED PERSON UNDER THE DENTAL PLAN, YOU HAVE THE RESPONSIBILITY TO:

- Provide complete, honest and factual information about your dental status that is needed by providers in order to address your dental needs.
- Follow a consensual treatment plan as discussed with and recommended by your dental providers.
- Listen to and understand the potential consequences that may result should you refuse such treatment.
- Understand your dental benefits, as described in this SPD.
- Understand and meet your financial obligations for annual Deductibles, Coinsurance and non-covered dental-related services, as indicated in this booklet. Refer to the Schedule of Benefits for further details.
- Provide, when requested, complete and factual information related to dependent eligibility verification.
- Provide, when requested, complete and factual information to Delta Dental and/or Trustmark about any other dental, medical coverage or insurance benefits.
- Treat other Covered Persons, providers and administrative staff with respect and consideration.

UPDATING YOUR INFORMATION:

- Inform your departmental human resource contact of any address, name changes, or make the change online using Employee Self Service at workday.osu.edu.
- Inform HR Connection of any changes you may have in your family status (for example, marriage, divorce, birth or adoption of a child, dependent child reaching the limiting age, death of a spouse or dependent child) within 30 days of the status change by using Employee Self Service online at workday.osu.edu or by submitting a completed Health Election Form, available at hr.osu.edu/policies-forms, to OHR within 30 days of the status change.

WHEN RECEIVING COVERED DENTAL SERVICES:

- Inform the dentist that you are covered by Delta Dental.
- If you are receiving services from a Network Dentist:
 - No claim forms are necessary. Network Dentist will file your claim directly with Delta Dental.
 - You may be required to pay the portion of the expenses that are your responsibility (i.e. Deductible, Coinsurance) at the time of service.
- If you are receiving services from an Out-of-Network Dentist:
 - Out-of-Network Dentist may require that you file your claim directly with Delta Dental. (For instructions see the "Steps for Using the Dental Plan" section of this SPD).
 - You may be required to pay all expenses at the time of service.
 - Your claim must be submitted to Delta Dental **within 12 months** of receiving services.

GENERAL PLAN PROVISIONS

ELIGIBILITY

- An eligible employee is any faculty or staff member who holds a qualifying appointment, as determined by The Ohio State University. The Benefits Eligibility Chart is available at hr.osu.edu/benefits/eligibility.
- If you are an eligible employee, you may cover yourself and those persons who qualify as your Eligible Dependent(s). Dependents can only be enrolled if the eligible employee is enrolled in coverage. You may not be covered as both a spouse/partner and dependent by any dental coverage provided by the university. The Dental Plan will not cover a person as both a covered employee and dependent or as a dependent of more than one covered employee.
- Coverage is not automatic for newly eligible employees. To cover yourself and your Eligible Dependents, you must enroll. To enroll in the Dental Plan, use Employee Self Service online at workday.osu.edu or submit a completed Health Election Form, available at hr.osu.edu/policies-forms.
- **The university has the ability to rescind (i.e., retroactively terminate) coverage if such coverage was gained due to an individual (or person seeking coverage on behalf of the individual) performing an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact.**

ENROLLMENT

To enroll in the Dental Plan, use Employee Self Service online at workday.osu.edu or submit a completed Health Election Form, available at hr.osu.edu/policies-forms. If you decide to enroll, you must enroll:

- Within 30 days of appointment in an eligible position as reflected in the university's human resource system (Workday).
- Within 30 days of loss of other eligible coverage.
- During the annual open enrollment period.
- In connection with a qualifying status change as described in the "Change in Coverage Due to Qualifying Status Change" section of this SPD.
- In connection with an event that provides special enrollment rights as described in "Special Enrollment Rights" below.

SPECIAL ENROLLMENT RIGHTS

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

If you or your dependent(s) qualify for the special enrollment rights for medical plan coverage provided under CHIPRA, as described in The Ohio State University Faculty and Staff Health Plans Specific Plan Details Document for the 2024 Plan Year available at hr.osu.edu/benefits/medical, then you and those dependents will be permitted to enroll in the Dental Plan without having to wait for an open enrollment period.

- If you or your dependent(s) are terminated from Medicaid or state Children's Health Insurance Program (CHIP) coverage as a result of a loss of eligibility, you must request this special enrollment within 60 days of the loss of coverage.
- If you or your dependent(s) become eligible for a premium assistance subsidy under Medicaid or CHIP, you must request this special enrollment within 60 days of when eligibility is determined.
- To enroll in the Dental Plan, you and your dependent(s) must be benefits-eligible and you must use Employee Self Service online at workday.osu.edu or submit a completed Health Election Form, available at hr.osu.edu/policies-forms. Documentation of the above event is required.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

If you and your dependent(s) qualify for the special enrollment rights for medical plan coverage provided under HIPAA, as described in The Ohio State University Faculty and Staff Health Plans Specific Plan Details Document available at hr.osu.edu/benefits/medical, then you and those dependents will be permitted to enroll in the Dental Plan without having to wait for an open enrollment period.

- You must request this special enrollment within 30 days of the date of the event.
- To enroll in the Dental Plan, you and your dependents must be benefits-eligible and you must use eBenefits online at workday.osu.edu or submit a completed Health Election Form, available at hr.osu.edu/policies-forms. Documentation of the above event is required.

EFFECTIVE DATE OF COVERAGE

The effective date for all eligible employees and their eligible dependents will be determined by the university. Coverage will be communicated to Delta Dental for the purposes of claims administration. Coverage will be effective on:

- Date of hire or transfer to an eligible appointment as reflected in the university's human resource system (Workday).
- Date of a qualifying status change.
- January 1 of a new Plan Year, if the election is made during and as part of the annual open enrollment period.

ELIGIBLE DEPENDENTS

Spouse

An individual whose marriage to a covered employee is recognized by the Internal Revenue Service for federal income tax purposes. A legally separated spouse is not eligible.

Dependent child

Child of a covered employee who meets all of the following eligibility criteria:

GENERAL PLAN PROVISIONS

1. Has not reached the age limit of 26 (e.g., 26th birthday) except in cases described more fully below; and
2. Fits into one of the following categories:
 - The employee's biological child;
 - The employee's adopted child or child placed with the employee for adoption;
 - The employee's step-child; or
 - The child for whom the employee has legal guardianship or legal custody, and such child is the employee's tax dependent

Dependent child coverage beyond the age limit due to disability

A dependent child may be eligible for continued coverage as a dependent child after attaining age 26 if:

- The child is and continues to be incapable of self-sustaining employment by reason of physical handicap or intellectual disability; and
- The child is the employee's dependent as defined in Section 105(b) of the Code; and
- The child was (1) covered by a university Dental Plan when he or she reached the limiting age and the employee makes application for continuation of coverage to the university within 30 days after the child's loss of coverage due to reaching the limiting age; or (2) covered as a dependent under the Dental Plan of his or her parent's employer immediately prior to a loss of coverage under such plan (documentation of prior coverage required) and the employee makes application for continuation of coverage to the university within 31 days after such loss of coverage occurs. In each case, the employee must provide satisfactory proof of the child's incapacity and dependence upon the employee; and
- The employee provides proof of the continuance of such incapacity and dependence upon request by the university.

Note: Consult with a tax advisor with any questions regarding whether or not the child meets the Code requirements.

Grandfathered Sponsored Dependent (Enrollment in Ohio State medical coverage and Affidavit of Sponsored Dependency required)

The grandfathered sponsored dependent of a covered employee who meets all of the following criteria:

1. The individual was enrolled in The Ohio State University Faculty and Staff Health Plans as a sponsored dependent as of December 31, 2016;
2. The individual remains continuously enrolled in The Ohio State University Faculty and Staff Health Plans on and after December 31, 2016;
3. The individual meets all of the following criteria:
 - a. The individual resides at the same principal place of abode as the employee and is a member of the employee's household for the entire tax year during which grandfathered sponsored dependent coverage is provided;
 - b. The individual shares a relationship with the employee as defined by one of the following:
 - Parent, step-parent, parent-in-law, or person who stood in loco parentis to the employee as a child
 - Grandparent or grandparent of the employee's spouse
 - Sibling or sibling-in-law
 - Aunt or uncle
 - Niece or nephew
 - Son or daughter-in-law
 - Grandchild or spouse of the employee's grandchild
 - Biological, adopted, step or foster child who is not otherwise eligible for coverage under the terms of the Dental Plan
 - Opposite-sex domestic partner who is unmarried, is not related to the employee by blood to a degree of closeness which would prohibit marriage in the state in which they legally reside and who has been in a relationship with the employee for at least six (6) months and intends to remain so indefinitely
 - Dependent child of an opposite-sex domestic partner (described above);
 - c. The individual is dependent upon the employee for more than 50% of his or her support. The employee must be able to provide documentation of such support to OHR or to Trustmark for claims administration, if requested, to verify the dependent status of this individual.

Support includes:

 - i. Housing/shelter;
 - ii. Cost for his or her clothing, food, education, recreation and transportation expenses;
 - iii. Cost for his or her medical, dental and/or vision care; and
 - iv. Cost for a proportionate share of other expenses necessary to support the sponsored dependent within the employee's household (such as food and utilities), but which cannot be directly attributed to that individual;
 - d. The individual is the employee's dependent under Section 152 of the Code, without regard to subsection (d) (1) (B) of Section 152. Consult with a tax advisor with any questions regarding whether or not the individual meets the Code requirements.

Regardless of any other provision in this SPD to the contrary, a grandfathered sponsored dependent must remain enrolled in the Dental Plan for the entire Plan Year, unless the grandfathered sponsored dependent dies or the grandfathered sponsored dependent provides proof of obtaining other medical coverage.

GENERAL PLAN PROVISIONS

LIMITATIONS ON COVERAGE CHANGES

You may enroll in coverage, make changes to your coverage or disenroll from coverage during the Plan Year (i.e., outside of open enrollment) only if you experience a qualifying status change. The change in coverage must be consistent with and on account of the qualifying status change (e.g., you cover your spouse following your marriage). If you wish to change your elections due to a qualifying status change, the Office of Human Resources must receive such change within 30 days of the qualifying status change.

QUALIFYING STATUS CHANGE

- Qualifying status changes include:
 - Change in your legal marital status (marriage, death of a spouse (as defined in the Code), divorce, legal separation or annulment);
 - Termination of grandfathered sponsored dependency;
 - Change in the number of your dependents (birth, death, adoption or placement for adoption);
 - Change in your employment status (termination of employment, commencement of employment, strike, lockout, commencement of an approved family medical leave (FML), return from an approved family medical leave (FML), or change in worksite), or the employment status of your spouse or dependent, that results in the individual becoming eligible, or ceasing to be eligible, under any cafeteria plan or other employee welfare benefit plan of your employer or the employer of your spouse or dependent;
 - Change in your place of residence or change in the place of residence of your spouse or dependent that results in the individual becoming eligible or ceasing to be eligible under any cafeteria plan or other employee welfare benefit plan of your employer or the employer of your spouse or dependent;
 - Termination of your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must submit an election change within 60 days);
 - You become or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP (you must submit an election change within 60 days);
 - Entitlement to Medicare or Medicaid; or
 - Event that causes your dependent to satisfy or cease to satisfy the requirements for dependent coverage (due to attainment of age or any similar circumstances).
- In addition, you might be able to make a change under the following circumstances:
 - Judgment, decree or order requiring coverage of certain dependents (30-day time limit does not apply);
 - Commencement or return from approved family medical leave (FML);
 - Significant curtailment of coverage;
 - Certain changes in or loss of coverage under another plan; or
 - Certain additions or improvements to benefit package options.

Note: Qualifying status change determinations are made by the university in accordance with the provisions of The Ohio State University Flexible Benefits Plan and IRS rules. For questions about what constitutes a qualifying status change, contact HR Connection at 614-247-myHR(6947), 800-678-6010 or HRConnection@osu.edu, or refer to the Life Events section of the OHR website at hr.osu.edu/life-events.

If a Qualifying Status Change Occurs:

- If a qualifying status change occurs, you must make an election by using Employee Self Service at workday.osu.edu or by submitting a completed Health Election Form, available at hr.osu.edu/policies-forms to change you dental coverage. Documentation may be required for some events. The university must approve any qualifying status change.
- You may make an election in the following ways:
 - Use Employee Self Service at workday.osu.edu. The election and any required documentation must be submitted through Employee Self Service within 30 days of the qualifying status change (except as otherwise noted).
 - Complete a Health Election Form, available at hr.osu.edu/policies-forms. The completed form and any required documentation must be submitted to HR Connection within 30 days of the qualifying status change (except as otherwise noted).
- Changes in coverage will be effective as of the date of the qualifying status change. Contributions will be prorated based on the exact days of coverage because of the qualifying status change.
 - If you do not complete and submit a Health Election Form or make an election via Employee Self Service at workday.osu.edu within 30 days (except as otherwise noted above), you will not be allowed to make a change until the next open enrollment period or upon the occurrence of a future qualifying status change.

Note: A newborn infant must be added within 30 days of the birth. Otherwise the newborn cannot be added until the next open enrollment period. If coverage is already in effect, you must add the newborn as a covered dependent, even if you have family coverage.

Note: Your coverage level and premium contributions may be adjusted based on the qualifying status change. Contributions will be prorated based on the exact days of coverage because of the qualifying status change.

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GENERAL PLAN PROVISIONS

Coverage elections for rehires

- If your employment with the university terminates and you are rehired into a benefits-eligible position within 30 days after that termination, you will be reinstated with the same elections that you had immediately before your termination and accumulations for coverage features such as annual Deductibles and benefit limitations, as well as expenses you had accumulated towards the annual Maximum Benefit, will continue to apply as if there was no loss of coverage.
- If your employment with the university terminates and you are rehired into a benefits-eligible position more than 30 days after that termination, you will be able to make a new election. If you reenroll in the Dental Plan within the same Plan Year, the accumulations for plan features such as annual Deductibles and benefit limitations, as well as expenses you had accumulated towards the Dental Plan's annual Maximum Benefit, will continue to apply as if there was no loss of coverage.

PRIVACY OF HEALTH INFORMATION

Federal HIPAA regulations restrict how the university and the Dental Plan may use certain information about you and your family.

Permitted Uses and Disclosures

- The Dental Plan may use or disclose Protected Health Information (PHI) to the university, provided that the university does not use or disclose that information except for the following purposes:
 - To perform health plan administrative functions,
 - To obtain premium bids for group health insurance, or
 - To modify, amend or terminate the plans.
- The Dental Plan may also disclose PHI to the university pursuant to your written authorization.
- All uses and disclosures of PHI must be consistent with HIPAA.

Conditions of Disclosure

- The Dental Plan may disclose PHI to the university only upon receipt of a certification from the university, as Plan Sponsor of the Dental Plan, that the plan documents have been amended to incorporate the provisions set forth below and that the university, in its capacity as Plan Sponsor, agrees to such provisions.
- The university, as Plan Sponsor of the Dental Plan, agrees to:
 - Not use or further disclose PHI other than as permitted or required by plan documents or as required by law.
 - Ensure that any agents or subcontractors to whom it discloses PHI received from the Dental Plan agree to the same restrictions and conditions that apply to the university with respect to such PHI and that they agree to implement reasonable and appropriate security measures to protect the information.
 - Not use or disclose the PHI received from the Dental Plan for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the university (except to the extent that such other benefit or employee benefit plans is part of an organized health care arrangement of which the Dental Plan is a part).
 - Report to the Dental Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided.
 - Report to the Dental Plan any security incident of which it becomes aware.
 - Make a Covered Person's PHI available to them if they request access, in accordance with federal HIPAA regulations.
 - Incorporate any approved amendments to a covered person's PHI requested by the Covered Person, in accordance with federal HIPAA regulations.
 - Make available an accounting of disclosures of a Covered Person's PHI when requested by the Covered Person in accordance with federal HIPAA regulations.
- Make internal practices, books and records relating to the use and disclosure of PHI received from the Dental Plan available to the Secretary of Health and Human Services for purposes of determining compliance of the Dental Plan with the law.
- If feasible, return or destroy all PHI received from the Dental Plan that the university still maintains in any form and retain no copies of information when no longer needed for the purpose for which the disclosure was made. If such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information feasible.
- Ensure adequate separation between the Dental Plan and the university as required by federal law.

Permitted Uses and Disclosures of Aggregate Health Information

The Dental Plan may disclose Aggregate Health Information (see the "Definition" section) to the university, provided that the Aggregate Health Information is only used by the university for the purpose of:

- Obtaining premium bids for providing health insurance coverage; or
- Modifying, amending or terminating the Dental Plan.

Permitted Uses Enrollment and Disenrollment Information

The Dental Plan may disclose enrollment and disenrollment information and information on whether individuals are participating in the Dental Plan to the university, provided such enrollment and disenrollment information is only used by the university for the purpose of performing its administrative functions. Enrollment information held by the university in its capacity as an employer is not PHI.

Security of PHI

The university will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Dental Plan.

CONTINUED ON PAGE 11

GENERAL PLAN PROVISIONS

Adequate Separation Between Plan and Plan Sponsor

- Those employees or other persons under the control of the university involved in performing plan administration functions for, or on behalf of the Dental Plan may be given access to and use PHI. Without limiting the generality of the foregoing, such persons include, without limitation:
 - Ohio State University Wexner Medical Center: employees in Payroll who perform administrative functions for the Dental Plan.
 - OHR Benefits Services: all employees in Benefits Services who perform administrative functions for the Dental Plan and employees who review and/or make determinations regarding claims or complaints.
 - Office of the Controller employees in Payroll Services who perform administrative functions for the Dental Plan.
 - Office of the Chief Information Officer (OCIO): employees who perform administrative functions for the Dental Plan.
 - Office of Legal Affairs: employees who perform administrative functions for the Dental Plan.
 - Others: Any other employee of the university performing plan administration functions for the Dental Plan who is designated in writing by the Privacy Official of the Dental Plan as being entitled to access to PHI.
- The employees or other persons described above shall have access to PHI only to the minimum extent necessary to perform plan administrative functions, unless an individual authorization exists. In the event that any such employees do not comply with these provisions, the employee shall be subject to disciplinary action by the university for non-compliance pursuant to the discipline procedures established by the university.
- The separation provided for above will be supported by reasonable and appropriate security measures.

TERMINATION OF COVERAGE

- Coverage will terminate for the following Covered Person(s) when the following events occur:
 - For the covered employee and his/her dependents, when the employee terminates from the university. Coverage will cease on the employee's termination date as reflected in the university's human resource system (Workday). Contributions will be prorated based on the event date and the exact days of coverage prior to termination.
 - For the covered employee and his or her dependents, when the employee transfers to an ineligible appointment. Coverage will cease on the date in which the transfer occurs as reflected in the university's human resource system (Workday). Contributions will be prorated based on the event date and the exact days of coverage prior to the change in eligibility.
 - For the covered employee and his or her dependents, if the employee fails to pay the employee contributions in full. Elected benefits will be terminated for lack of payment.
 - For the spouse of the covered employee, upon decree of divorce, dissolution, or legal separation. Coverage will cease on the event date. If timely notice is provided, premiums will be prorated based on the event date and the exact days of coverage based on the event date.
 - For a dependent child reaching age 26 (except as otherwise noted), at the end of the month in which the child reaches age 26.
 - For any other dependent, when the dependent no longer qualifies as a dependent. Coverage will cease on the event date. If timely notice is provided, premiums will be prorated based on the event date and the exact days of coverage based on the event date.
 - The covered employee is responsible for notifying the university within 30 days of the date of any status change involving the eligibility of a covered dependent. The university may recover from the employee all damages sustained from losses (including paid claims and premium costs) and reasonable attorneys' fees incurred to recover such damages that are brought about as a result of the employee's failure to notify the university of status changes which affect dependent eligibility.
- Coverage may be rescinded (i.e., retroactively terminated) if such coverage was gained due to an individual (or person seeking coverage on behalf of the individual) performing an act, practice or omission that constitutes fraud or making an intentional misrepresentation of a material fact.
- Coverage may be terminated during an open enrollment period. Coverage will cease on the last day of the Plan Year in which enrolled.
- Coverage may be terminated due to a qualifying status change. Refer to the "Limitations on Change in Coverage" section of this SPD. Coverage will cease on the date of the qualifying status change if the Health Election Form, available at hr.osu.edu/policies-forms, is submitted within 30 days of the qualifying status change. Enrollment changes can also be made by using Employee Self Service online at workday.osu.edu within 30 days. Documentation of the status change may be required.
- Upon termination of coverage, individuals may be eligible for coverage continuation as described in the "Coverage Continuation" section of this SPD. However, if the university is not notified within 60 days of the last day of eligibility and/or coverage the dependent will not be eligible for coverage continuation as detailed.
- The university will determine when a Covered Person is no longer eligible under the Dental Plan. It is the responsibility of the university to make determinations as to when coverage will end for a Covered Person and to communicate all terminations of coverage to Trustmark and Delta Dental.
- Coverage under the Dental Plan will terminate for all Covered Persons on the date on which the Dental Plan terminates or is not renewed by the university. The university reserves the right to terminate the Dental Plan, in whole or in part, at any time.

COVERED SERVICES

CLASS I BENEFITS

Diagnostic and Preventive Services²	<p>Services and procedures used to evaluate existing conditions and/or to prevent the occurrence of dental abnormalities or disease. Includes oral examinations, prophylaxes (cleanings), sealants, space maintainers, brush biopsy and topical applications of fluoride.</p> <ul style="list-style-type: none"> • Benefits for oral examinations and prophylaxes (cleanings) are payable twice in a calendar year; if medically necessary¹ prophylaxes can be approved for up to four times per calendar year. • Benefits for fluoride treatments are payable twice in a calendar year up to age 19. • Benefits for a brush biopsy to detect oral cancer. • Benefits for sealants are payable for the occlusal surface of first and second permanent molars once per tooth per lifetime up to age 15. The surface must be free from decay and restorations. • Benefits for space maintainers are payable up to age 14.
Emergency Palliative Treatment	Nonspecific treatment used on an emergency basis to temporarily relieve pain.
Radiographs	<p>X-rays as required or in conjunction with the diagnosis of a specific condition.</p> <ul style="list-style-type: none"> • Benefits for bitewing radiographs are payable once per calendar year. • Benefits for full-mouth radiographs (which includes bitewing X-rays) are payable once in any five-year period.

CLASS II BENEFITS

Oral Surgery Services	Extractions and other surgical dental procedures used; includes pre-operative and post-operative care.
Endodontic Services	Procedures used for the treatment of teeth with diseased or damaged nerves (root canals).
Periodontic Services	Procedures used for the treatment of diseases of the gums and supporting structures of the teeth including gum disease. This includes periodontal maintenance following active therapy (periodontal prophylaxes).
Minor Restorative Services²	Services used to rebuild, repair, or reform the tissues of the teeth; includes amalgam, restorations (repair of crowns, or onlays), resin restorations, and relines and repairs to prosthetic appliances (bridgework and dentures).

CLASS III BENEFITS

Prosthodontic Services	<p>Services and appliances that replace missing natural teeth; includes fixed bridgework, partial dentures, complete dentures, and implants.</p> <ul style="list-style-type: none"> • Bridgework, partial dentures, complete dentures and implants are payable once in any five-year period.
Major Restorative Services	<p>Services used to rebuild, repair, or reform the tissues of the teeth when the teeth cannot be restored with another filling material, includes replacement of cast restorations (crowns), and jackets.</p> <ul style="list-style-type: none"> • Cast restorations including jackets, crowns and onlays are payable once in any five-year period.

CLASS IV BENEFITS

Orthodontic Services	Services, treatment, and procedures required for the correction of malposed teeth.
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¹ Two additional cleanings per Plan Year are payable for individuals with documented periodontal disease, diabetics with periodontal disease and pregnant women with periodontal disease. Two additional cleanings per Plan Year are payable for individuals with certain high-risk medical conditions such as kidney failure, organ or bone marrow transplant recipient, and for individuals receiving dialysis, chemotherapy or radiation treatment, or who are HIV positive or are at risk for infective endocarditis. For people undergoing head and neck radiation, fluoride applications by your dentist are also covered twice per Plan Year.

² Special Health Care Needs Benefit: This plan includes enhanced benefits for covered members (children and adults) with a qualifying special health care need. Special Health Care Needs, as defined by the American Academy of Pediatric Dentistry, include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, health care intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause, and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.

This benefit includes:

- Additional visits to the dentist's office and/ or consultations that can be helpful prior to the first treatment to help patients learn what to expect and what is needed for a successful dental appointment. Additional exam benefits will be allowed for this purpose.
- Up to four total dental cleanings in a benefit year.
- Treatment delivery modifications necessary for dental staff to provide oral health care for patients with sensory sensitivities, behavioral challenges, severe anxiety, or other barriers to treatment.

To help your dentist better understand the benefit and how to bill Delta Dental for services provided, we recommend having the provider contact Delta Dental's Customer Service or review the Provider information link located at <https://www.deltadentaloh.com/Dentist/Plans/Special-Health-Care-Needs-Benefit>.

Please refer to the "Benefit Exclusions and Limitations" sections of this SPD for an additional explanation of coverage.

SCHEDULE OF BENEFITS

DELTA DENTAL PPO NETWORK (INCLUDES OSU STUDENT DENTAL CLINIC)

Class I Benefits	100% of allowed amount paid, no Deductible or Balance Billing for diagnostic and preventive services, including space maintainers, fluoride treatments and prophylaxes (cleanings); emergency palliative treatment; oral examinations; bitewing radiographs; full-mouth radiographs; sealants and a brush biopsy to detect oral cancer
Class II Benefits	80% of allowed amount paid, no Deductible or Balance Billing all other radiographs, minor restorative services, including amalgam (silver) and resin (white) fillings, relines and repairs to prosthetic appliances; periodontic services; endodontic services; and oral surgery services
Class III Benefits	55% of allowed amount paid, no Deductible or Balance Billing for prosthodontic services, major restorative services, and implants
Class IV Benefits	See Orthodontics in the Dental Plan Benefit Summary

DELTA DENTAL PREMIER NETWORK

Class I Benefits	100% of allowed amount paid, no Deductible or Balance Billing for diagnostic and preventive services, including space maintainers, fluoride treatments and prophylaxes (cleanings); emergency palliative treatment; oral examinations; bitewing radiographs; full-mouth radiographs; sealants and a brush biopsy to detect oral cancer
Class II Benefits	75% of allowed amount paid after Deductible, no Balance Billing for all other radiographs, minor restorative services, including amalgam (silver) and resin (white) fillings, relines and repairs to prosthetic appliances; periodontic services; endodontic services; and oral surgery services
Class III Benefits	50% of allowed amount paid after Deductible, no Balance Billing for prosthodontic services, major restorative services, and implants
Class IV Benefits	See Orthodontics in the Dental Plan Benefit Summary

OUT-OF-NETWORK

Class I Benefits	100% of allowed amount paid, no Deductible, subject to Balance Billing for diagnostic and preventive services, including space maintainers, fluoride treatments and prophylaxes (cleanings); emergency palliative treatment; oral examinations; bitewing radiographs; full-mouth radiographs; sealants and a brush biopsy to detect oral cancer
Class II Benefits	70% of allowed amount paid, after applicable Deductible, subject to Balance Billing for all other radiographs; minor restorative services, including amalgam (silver) and resin (white) fillings, relines and repairs to prosthetic appliances, periodontic services, endodontic services, and oral surgery services
Class III Benefits	50% of allowed amount paid, after Deductible, subject to Balance Billing for prosthodontic services, major restorative services, and implants
Class IV Benefits	See Orthodontics in the Dental Plan Benefit Summary

DENTAL PLAN BENEFIT SUMMARY

	DENTAL BASIC SUMMARY CHART Effective Jan. 1 – Dec. 31, 2024			DENTAL PLUS SUMMARY CHART Effective Jan. 1 – Dec. 31, 2024		
Covered Services	Delta Dental PPO Network (includes OSU Student Dental Clinic)	Delta Dental Premier Network	Out-of-Network	Delta Dental PPO Network (includes OSU Student Dental Clinic)	Delta Dental Premier Network	Out-of-Network
Annual Deductible	\$0	\$50 per person	\$100 per person	\$0	\$25 per person	\$50 per person
Annual Maximum Benefit	\$1,500 per person ^{1,3}	\$1,200 per person ^{1,3}		\$2,500 per person ^{1,3}	\$2,000 per person ^{1,3}	
	Orthodontics has a separate lifetime maximum of \$1,200			Orthodontics has a separate lifetime maximum of \$2,000		
Preventive Services (includes: cleanings, sealants, fluoride treatments, and space maintainers; bitewing, full-mouth or panoramic X-rays), Emergency Palliative Treatments and Oral Examinations	100% of allowed amount; no deductible; no balance billing ²		100% of allowed amount; no deductible; subject to balance billing	100% of allowed amount; no deductible; no balance billing ²		100% of allowed amount; no deductible; subject to balance billing
Endodontics (root canals), Oral Surgery (includes impacted tooth extraction), Periodontics (gum disease), Restorative Services – Minor (includes fillings, and repair of bridgework crowns, dentures, and onlays) and X-rays, All Others (includes all diagnostic)	80% of allowed amount, no deductible; no balance billing ²	75% of allowed amount; after deductible; no balance billing ²	70% of allowed amount; after deductible; subject to balance billing	80% of allowed amount, no deductible; no balance billing ²	75% of allowed amount; after deductible; no balance billing ²	70% of allowed amount; after deductible; subject to balance billing
Orthodontics	100% of allowed amount, up to \$1,200 lifetime maximum; ¹ no deductible	50% of allowed amount, up to \$1,200 lifetime maximum; ¹ no deductible		100% of allowed amount, up to \$2,000 lifetime maximum; ¹ no deductible	50% of allowed amount, up to \$2,000 lifetime maximum; ¹ no deductible	
	Coverage is only available for children up to age 19. Benefits are pro-rated and paid over the course of the treatment.			Coverage is available for children and adults with no age limit. Benefits are pro-rated and paid over the course of the treatment.		
Prosthodontics (includes dentures, fixed bridgework, and implants) and Restorative Services – Major (includes cast restorations and crowns)	55% of allowed amount, no deductible; no balance billing ²	50% of allowed amount; after deductible; no balance billing ²	50% of allowed amount, after deductible; subject to balance billing	55% of allowed amount, no deductible; no balance billing ²	50% of allowed amount; after deductible; no balance billing ²	50% of allowed amount, after deductible; subject to balance billing
Temporomandibular Disorder (TMD)	No coverage under Dental. Limited coverage is available under Ohio State's medical benefits.					

¹ You are responsible for all costs over the maximums. ² For any optional treatment (defined as a service that is more expensive than what is customarily provided or for which Delta Dental does not determine that a valid dental need is shown), you are responsible for the costs over the allowed amount, regardless of whether or not the service is provided in-network. ³ Some services are excluded from the annual maximum. A list of these services can be found in this document.

USING THE BENEFITS

HOW DO I USE THE BENEFIT?

Please read this SPD carefully to familiarize yourself with the benefits and provisions of the Dental Plan.

- Make an appointment with the dentist of your choice and tell your dentist that you are covered by Delta Dental through The Ohio State University Faculty and Staff Dental Plan.
- After a routine oral examination, you and your dentist should discuss any treatments that are necessary and agree on when these services will be performed.
- Once treatment has been completed, your Network Dentist will submit the claim form to Delta Dental for payment. If you choose to visit an Out-of-Network Dentist, you will likely have to submit claims yourself and pay the entire bill up front.
- Claim forms are provided to each dental office in Ohio for your convenience and are also available from Delta Dental. You or a member of the dental office staff must fill in the information portion of the claim form with the following:
 - The Subscriber's (employee's) full name
 - The Subscriber's Social Security number or university employee identification number. Delta Dental's system requires a 9-digit alternate identification number for eligibility and claims processing; therefore, if you have an:
 - 8-digit OSU Employee ID # – your Delta Dental ID is your employee identification number with a leading zero (0) added to it.
 - 9-digit OSU Employee ID # – your Delta Dental ID is your employee identification number with no changes.
 - The name and date of birth of the Covered Person receiving the dental care
 - The group name (The Ohio State University)
 - The group number (1733)
- If you need to submit a paper claim, follow these steps:
 - Select the Delta Dental Member Portal link at hr.osu.edu/benefits/dental.
 - Sign in to your account.
 - The Home screen contains a link for the plan in which you are enrolled.
 - Select the Claims link to download the Dental Claim Form PDF.
 - Print, fill out, and mail the form. (Instructions and mailing addresses are included on the form itself.)

Claim forms and completed information requests should be mailed to Delta Dental, P.O. Box 9085, Farmington Hills, MI 48333-9085.

Payment Process

If your dentist is a Network Dentist participating with Delta Dental (PPO or Premier networks), Delta Dental will pay the dentist directly and send you an Explanation of Benefits (EOB) showing the portion of the charges paid by Delta Dental and the portion for which you are responsible. EOBs are not sent if there is no patient responsibility. This payment is based on the Maximum Approved Fee.

If your dentist is an Out-of-Network Dentist, Delta Dental will usually make the applicable payment directly to you based on the dentist's submitted fee or the Out-of-Network Dentist Fee (as defined in the "Definitions" section), whichever is less. It will be your obligation to make full payment to the dentist.

Claims Process

Because the amount of your benefit is not conditioned on a Predetermination decision by Delta Dental, all claims under this Dental Plan are Post-Service Claims. (See the "Predetermination" section of this SPD.) Once you or your dentist has filed your claim, Delta Dental will make a claim determination within 30 days of its receipt. All claims for benefits must be filed with Delta Dental within 12 months of the date the Dental Services were completed. If there is insufficient information to determine your claim, you or your dentist will be notified before 30 days has elapsed.

The notice will:

- Describe the information needed,
- Explain why it is needed,
- Request an extension of time in which to decide the claim, and
- Inform you or your dentist that the information must be received within 45 days or your claim will be denied.

You will receive a copy of any notice that is sent to your dentist. Once Delta Dental receives the requested information, they will have 15 days to make a claim determination. **If you or your dentist fail to supply the requested information, Delta Dental will have no choice but to deny your claim.** Once Delta Dental makes a determination about your claim, they will notify you within five days of the decision. You have the right to appeal any decision that denies your claim in whole or in part. Information related to the appeals process appears in the "Disputed Claims Procedures" section of this SPD.

Concurrent Care Claims

If you have been approved for a course of treatment, and that course of treatment is reduced or terminated before it has been completed, or if you wish to extend the course of treatment beyond what was agreed upon, you may file a Concurrent Care Claim seeking to restore the remainder of the treatment regimen previously agreed to or seeking to extend the course of treatment. All Concurrent Care Claims will be decided in sufficient time so that, should your claim be denied (in whole or in part), you will be able to appeal that decision before the course of treatment is scheduled to terminate.

PROVIDER DIRECTORY

The directory is a list of Dentists who participate in Delta Dental Plan of Ohio's Delta Dental PPO and/or Delta Dental Premier networks (i.e., Network Dentists). The Delta Dental Dentist Directory is available online at deltadentaloh.com, memberportal.com, or as a link on the Dental Plan page of the Office of Human Resources website at hr.osu.edu/benefits/dental. You can also contact Delta Dental directly to assist you in locating a Network Dentist, by calling 800-524-0149.

ANNUAL MAXIMUM BENEFIT EXCLUSIONS

The following Dental Services are excluded from the Dental Plan Annual Maximum Benefit

Surgical Extractions	D7220 removal of impacted tooth – soft tissue D7230 removal of impacted tooth – partially bony D7240 removal of impacted tooth – completely bony D7241 removal of impacted tooth – completely bony, with unusual surgical complications D7250 surgical removal of residual tooth roots (cutting procedure) D7251 coronectomy
Implant Services/ Surgical Services	D6106 guided tissue regeneration – resorbable barrier, per implant D6107 guided tissue regeneration – non-resorbable barrier, per implant
Other Surgical Procedures	D7260 oroantral fistula closure D7261 primary closure of a sinus perforation D7285 incisional biopsy of oral tissue – hard (bone, tooth) D7286 incisional biopsy of soft tissue – soft D7950 osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report D7951 sinus augmentation with bone or bone substitutes via a lateral open approach D7952 sinus augmentation via a vertical approach D7953 bone replacement graft for ridge preservation – per site
Vestibuloplasty	D7340 vestibuloplasty – ridge extension (secondary epithelialization) D7350 vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)
Oral and Maxillofacial Surgery/Other Repair Procedures	D7956 guided tissue regeneration, edentulous area – resorbable barrier, per site D7957 guided tissue regeneration, edentulous area – non-resorbable barrier, per site
Surgical Excision of Soft Tissue Lesions	D7410 excision of benign lesion up to 1.25 cm D7411 excision of benign lesion greater than 1.25 cm D7412 excision of benign lesion, complicated
Surgical Excision of Lesions	D7450 removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm D7451 removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm D7460 removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm D7461 removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm
Excision of Bone Tissue	D7471 removal of lateral exostosis (maxilla or mandible) D7472 removal of torus palatinus D7473 removal of torus mandibularis D7485 surgical reduction of osseous tuberosity
Surgical Incision	D7511 incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)

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ANNUAL MAXIMUM BENEFIT EXCLUSIONS

The following Dental Services are excluded from the Dental Plan Annual Maximum Benefit

Endodontic Surgery	<p>D3410 apicoectomy/periradicular surgery – anterior</p> <p>D3421 apicoectomy/periradicular surgery – bicuspid (first root)</p> <p>D3425 apicoectomy/periradicular surgery – molar (first root)</p> <p>D3426 apicoectomy/periradicular surgery (each additional root)</p> <p>D3430 retrograde filling – per root</p> <p>D3450 root amputation – per root</p> <p>D3471 surgical repair of root resorption — anterior</p> <p>D3472 surgical repair of root resorption — premolar</p> <p>D3473 surgical repair of root resorption — molar</p> <p>D3501 surgical exposure of root surface without apicoectomy or repair of root resorption — anterior</p> <p>D3502 surgical exposure of root surface without apicoectomy or repair of root resorption — premolar</p> <p>D3503 surgical exposure of root surface without apicoectomy or repair of root resorption — molar</p> <p>D3920 hemisection</p> <p>D3921 decoronation or submergence of an erupted tooth</p> <p>D3999 unspecified endodontic procedure, by report</p>
Periodontal Surgery	<p>D4210 gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant</p> <p>D4211 gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant</p> <p>D4240 gingival flap procedure, including root planning – four or more contiguous teeth or bounded teeth or bounded teeth spaces per quadrant</p> <p>D4241 gingival flap procedure, including root planning – one to three contiguous teeth or bounded teeth or bounded teeth spaces per quadrant</p> <p>D4245 apically positioned flap</p> <p>D4260 osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant</p> <p>D4261 osseous surgery (including flap entry and closure) – one to three contiguous teeth or bounded teeth spaces per quadrant</p> <p>D4263 bone replacement graft – first site in quadrant</p> <p>D4264 bone replacement graft – each additional site in quadrant</p> <p>D4265 biologic materials to aid in soft and osseous tissue regeneration</p> <p>D4266 guided tissue regeneration – resorbable barrier, per site</p> <p>D4267 guided tissue regeneration – nonresorbable barrier, per site (includes membrane removal)</p> <p>D4268 surgical revision procedure, per tooth</p> <p>D4270 pedicle soft tissue graft procedure</p> <p>D4273 subepithelial connective tissue graft procedures, per tooth</p> <p>D4274 distal or proximal wedge procedure (when not in conjunction with surgical procedures in the same anatomical area)</p> <p>D4275 soft tissue allograft</p> <p>D4276 combined connective tissue and double pedicle graft, per tooth</p> <p>D4277 free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft</p> <p>D4278 free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site</p> <p>D4283 autogenous connective tissue graft procedure (including donor and recipient surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in the same graft site.</p> <p>D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material)- each additional contiguous tooth, implant or edentulous tooth position in the same graft site</p>

BENEFIT EXCLUSIONS AND LIMITATIONS

No payment will be made by Delta Dental for the following services. In other words, the following services are not Covered Services under the Dental Plan. **All charges for the following services will be your responsibility.**

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Benefits or services which are available from any government agency, political subdivision, community agency, foundation, or similar entity. This provision does not apply to any programs provided under Title XIX Social Security Act (Medicaid).
2. Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations, cosmetic surgery, or dentistry for aesthetic reasons.
3. Services or appliances completed before an individual became eligible under this Dental Plan. Does not apply to orthodontic treatment in progress.
4. Prescription drugs (except intramuscular injectable antibiotics), premedications, medicaments/solutions, and relative analgesia.
5. General anesthesia and/or intravenous sedation for restorative dentistry or for surgical procedures, unless medically necessary.
6. Charges for hospitalization, laboratory tests, histopathological examinations and miscellaneous test.
7. Charges for failure to keep a scheduled visit with the dentist.
8. Services and supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated, that are specialized techniques, or that are investigational in nature as determined by the standards of generally accepted dental practice.
9. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist under the scope of his or her license.
10. Benefits excluded by the policies and procedures of Delta Dental, including the Processing Policies. Details regarding the reason a service is not covered will be listed on your Explanation of Benefits.
11. Services or supplies for which no charge is made, for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
12. Services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.
13. Services that are covered under a hospital, surgical/medical, or prescription drug program.
14. Services that are not within the classes of benefits which have been selected and are not in the policy.
15. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
16. Preventive control programs (including oral hygiene instruction, caries susceptibility, dietary control, tobacco counseling, home care medicaments, etc.).
17. Space maintainers for maintaining spaces due to the premature loss of the anterior primary teeth.
18. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers.
19. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
20. Veneers.
21. A prefabricated crown used as a final restoration on a permanent tooth.
22. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, or erosion; or for implantology techniques or periodontal splinting. This exclusion will not apply to orthodontic benefits as limited by the terms and conditions of the plan.
23. Inlays, regardless of the material used - Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.
24. A substructure to a single/abutment crown over an implant abutment supported interim fixed denture for edentulous arch.
25. A paste-type root canal filling on a permanent tooth.
26. Replacement, repair, relines, or adjustments of occlusal guards.
27. Chemical curettage.
28. Services associated with overdentures.
29. A metal base on a removable prosthesis.
30. The replacement of teeth beyond the normal complement of teeth.
31. Personalization/characterization of any service or appliance.
32. Temporary crowns used for temporization during crown or bridge fabrication.
33. A posterior bridge in conjunction with a partial denture in the same arch.
34. Precision attachments and stress breakers.
35. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular disorder (TMD).
36. Diagnostic photographs and cephalometric films, unless done for orthodontics.
37. Myofunctional therapy.
38. Mounted case analysis.
39. Biologic materials to aid in soft and osseous tissue regeneration when submitted on the same day as tooth extraction, periradicular surgery, soft tissue grafting, guided tissue regeneration and periodontal or implant bone grafting.
40. Soft occlusal guard appliances.
41. Any and all taxes applicable to the services.

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BENEFIT EXCLUSIONS AND LIMITATIONS

No payment will be made by Delta Dental for these services. In other words, the following services are not Covered Services under the Dental Plan. If you visit a Delta Dental PPO or Delta Dental Premier Network Dentist you should not be charged by the dentist for these services. If you visit an Out-of-Network dentist, you will be responsible for all charges for the following services.

1. The completion of claim forms or submission of claims.
2. Emergency exam/evaluation, when any other service is done on the same date, except radiographs and/or tests necessary to diagnose the emergency condition.
3. The fee for a consultation is part of the fee for the examination and/or diagnostic procedure(s).
4. Local anesthesia.
5. Acid etching, cement bases, cavity liners, and a base or temporary filling.
6. Infection control.
7. Temporary, interim, and provisional crowns.
8. Gingivectomy as an aid to the placement of a restoration.
9. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
10. Diagnostic casts are allowed only when done in conjunction with orthodontics. They are considered to be a part of the fee for restorative or prosthodontic procedures.
11. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.
12. Postoperative radiographs, when done following any completed service or procedure.
13. Periodontal charting.
14. Pins and/or a preformed post, when done with core buildups.
15. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.
16. A pulpotomy on a permanent tooth, except on a tooth with an open apex.
17. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
18. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
19. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling in the presence of gingival inflammation.
20. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
21. Reline, rebase, or any adjustment or repair within six months of the delivery of a partial denture.
22. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.
23. Caries risk assessment performed on a Member age 2 or under.
24. Any substructure when done for inlays, onlays, and veneers.
25. Scaling in the presence of gingival inflammation when done on the same day as periodontal maintenance.
26. Prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance when done within 30 days of three or four quadrants of scaling and root planning or other periodontal treatment.
27. Full mouth debridement when done within 30 days of scaling and root planning.
28. Scaling and debridement in the presence of inflammation or mucositis of a single implant, when done on the same day as a prophylaxis, scaling in the presence of gingival inflammation, periodontal maintenance, full mouth debridement, periodontal scaling and root planing, periodontal surgery or debridement of a peri-implant defect.
29. Full mouth debridement, when done on the same day as a comprehensive evaluation.
30. Periapical and/or bitewing X-rays, when done within a clinically unreasonable period of time of performing panoramic and/or full mouth X-rays, as determined solely by Delta Dental.
31. Teledentistry fees.
32. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
33. Adjustments, temporary relines, or tissue conditioning within three months of delivery of an immediate denture.
34. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as a sealant, sealant repair, preventive resin restoration or interim caries arresting medicament performed on the same tooth.
35. Capture only images which are not associated with any interpretation or reporting.
36. Frenulectomy when performed on the same day as any other surgical procedure(s) in the same surgical area by the same dentist or dental office.
37. Implant removal when performed within three (3) months of an implant-miniimplant on the same tooth by the same dentist or dental office.
38. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

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BENEFIT EXCLUSIONS AND LIMITATIONS

The Benefits for the following services or supplies are limited as follows, unless otherwise specified. All charges for services or supplies that exceed these limitations will be your responsibility:

1. Oral examinations and evaluations (not including limited problem focused evaluations or patient screenings) are only payable twice per calendar year, regardless of the Dentist's specialty.
2. Patient screening is payable once per calendar year.
3. Space maintainers for posterior teeth are payable once in a lifetime for people under age 14. A distal shoe space maintainer is only payable for first permanent molars age 8 and under.
4. Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture (lost or mobile tooth structure).
5. Individual crowns over implants are payable at the prosthodontic benefit level once in a five-year period.
6. Substructures, porcelain, porcelain substrate, and cast restorations are not payable for people under age 12.
7. Hard full or partial arch occlusal guards are payable once in any five-year period.
8. An interim partial denture is payable only for the replacement of permanent anterior teeth for people under age 17 or during the healing period for people age 17 and over.
9. Biologic materials to aid in soft and osseous tissue regeneration are payable once per natural tooth in a 36-month period.
10. Prosthodontic Services limitations:
 - a. One complete upper and one complete lower denture, and any implant used to support a denture, are payable once in any five-year period.
 - b. A removable partial denture, endosteal implant (other than to support a denture), or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
 - c. Fixed bridges and removable partial dentures are not payable for people under age 16.
 - d. A reline or the complete replacement of denture base material is payable once in any three-year period per appliance.
 - e. Implant removal is payable once per lifetime per tooth or area.
 - f. Implant maintenance is payable once per any twelve (12) month period.
 - g. Removal of a broken implant retaining screw is payable once in a 5 year period.
 - h. A removable unilateral partial denture is payable once per quadrant in any 5 year period unless the loss of additional teeth requires the construction of a new appliance.
11. Orthodontic Services limitations:
 - a. Services are payable for Members pursuant to the age limits specified.
 - b. If the treatment plan terminates before completion for any reason, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
 - c. Upon written notification to Delta Dental and to the patient, a Dentist may terminate treatment for lack of patient interest and cooperation. In those cases, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
12. Delta Dental's obligation for payment of Benefits ends on the last day of coverage. However, Delta Dental will make payment for Covered Services provided on or before the last day of coverage, as long as Delta Dental receives a Claim for those services within one year of the date of service.
13. When services in progress are interrupted, Delta Dental will not issue payment for any incomplete services; however, Delta Dental will calculate the Maximum Approved Fee that the dentist may charge you for such incomplete services, and those charges will be your responsibility. In the event the interrupted services are completed later by a Dentist, Delta Dental will review the Claim to determine the amount of payment, if any, to the Dentist in accordance with Delta Dental's policies at the time services are completed.
14. Care terminated due to the death of a Member will be paid to the limit of Delta Dental's liability for the services completed or in progress.
15. Caries risk assessments are payable once in any 12-month period for Members age 3 to 18.
16. **Optional treatment:** If you select a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.
17. **Maximum Payment:** All Benefits available under This Plan are subject to the Maximum Payment limitations stated in the Dental Plan Benefit Summary.
18. If a Deductible amount is stated in the Dental Plan Benefit Summary, Delta Dental will not pay for any services or supplies, in whole or in part, to which the Deductible applies until the Deductible amount is met.
19. Assessments of salivary flow by measurement are payable once in any 36-month period.
20. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period.
21. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as restoration involving the occlusal surface.

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BENEFIT EXCLUSIONS AND LIMITATIONS

22. Interim caries arresting medicament is payable twice per tooth per Benefit Year and is limited to five (5) applications per day.
23. Sealants are covered once per tooth per lifetime on first and second permanent molars for Members age 14 and under.
24. One cone beam CT is allowed within a twelve (12) month period except when performed for TMD treatment.
25. Processing policies may otherwise limit payment by Delta Dental for services or supplies.
26. Bitewing X-rays are payable once per calendar year, unless a full mouth X-ray which include bitewings has been paid in that same year.
27. Panoramic or full mouth X-rays (which may include bitewing X-rays) are payable once in any five-year period.
28. Preventive fluoride treatments are payable twice per calendar year for people age 18 and under.
29. Cast restorations (including jackets, crowns and onlays) and associated procedures (such as core buildups and post substructures) are payable once in any five-year period per tooth. Porcelain and resin facings on crowns are payable on posterior teeth. Subsequent minor restorations on the same tooth are also subject to this five-year lifetime.
30. Porcelain and resin facings on bridges are payable on posterior teeth.

Listed below are services for which Delta Dental will provide an allowance for optional treatment. Remember, you are responsible for the difference in cost for any optional treatment.

1. Overdentures - Delta Dental will pay only the amount that it would pay for a conventional denture.
2. Implant/abutment supported complete or partial dentures - Delta Dental will pay only the amount that it would pay for a conventional denture.
3. Gold foil restorations - Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration.
4. Posterior stainless steel crowns with esthetic facings, veneers or coatings - Delta Dental will pay only the amount that it would pay for a conventional stainless steel crown.
5. Inlays, regardless of the material used - Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.

Delta Dental will make no payment for services or supplies that exceed the following limitations. All charges are your responsibility. However, Participating Dentists may not charge Members for these services or supplies when performed by the same Dentist or dental office. All time limitations are measured from the actual date (i.e. to the day) of the applicable prior dates of services in our records with any Delta Dental Member Plan or, at the request of your Contractor, any dental plan.

1. Amalgam and composite resin restorations are payable once in any two-year period, regardless of the number or combination of restorations placed on a surface.
2. Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.
3. Recementation of a crown, onlay, inlay, veneer, space maintainer, or bridge within six months of the seating date.
4. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.
5. Root planing is payable once in any two-year period.
6. Periodontal surgery is payable once in any three-year period.
7. A complete occlusal adjustment is payable once in any five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not payable more than three times in any five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.
8. Tissue conditioning is payable twice per arch in any three-year period.
9. The allowance for a denture repair (including relining or rebase) will not exceed half the fee for a new denture.
10. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
11. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period when performed by the same office.
12. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as restorations involving the occlusal surface when performed by the same office.
13. A sealant, sealant repair or preventive resin restoration is not payable when performed within 24 months of a sealant, sealant repair or preventive resin restoration performed on the same tooth.
14. One caries risk assessment is allowed on the same date of service.
15. Caries risk assessments are payable once in any 12-month period for Members age 3-18.
16. One assessment of salivary flow by measurement is allowed within a twelve (12) month period when done by the same dentist/dental office.
17. Processing policies may otherwise limit payment by Delta Dental for services or supplies.

COORDINATION OF BENEFITS

All benefits provided as described in this document are subject to coordination of benefits (COB). Delta Dental pays for dental care only when you follow the rules and procedures below.

COORDINATION OF BENEFITS (COB)

COB determines whether a benefit plan is primary or secondary when a Covered Person is covered by more than one benefit plan.

- If you or your family members are covered by more than one Dental Plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific Dentists, and it may be impossible to comply with both plans at the same time. Read the rules very carefully and compare them with the rules of any other plan that covers you or your family.
- COB is used to pay dental expenses when you are covered by more than one plan. Delta Dental follows rules established by Ohio law to decide which plan pays first and how much the other plan must pay. The objective of COB is to make sure the combined payments of the plans are no more than your actual bills.
- In addition to the definitions in this SPD, the following definition of “other contract” applies to this section:
 - Any arrangement providing dental benefits or services, including but not limited to: group, blanket, or franchise insurance coverage; group or individual practice or other prepayment coverage; labor management trusted plans; union welfare plans; employer organization plans, or employee benefit organization plans; or any tax supported or governmental program.

DETERMINING PRIMARY COVERAGE

- To decide which plan is primary, the university plan must consider both the COB provisions of the other contract and which member of your family is involved in a claim.
- The primary coverage will be determined by using the first of the following rules that applies:

Non-Coordinating Plan:

Another contract with no COB provision is always primary.

Employee:

- The benefit plan covering you as an employee or Subscriber (other than a dependent) is primary.

Children:

- The Birthday Rule – When a dependent is covered by more than one plan of different parents who are not separated or divorced, the coverage of the parent whose birthday falls earlier in the calendar year (excluding year of birth) is primary.
 - If both parents have the same birthday, the plan that covered the parent longer will be primary.
 - If a dependent is covered by two benefit plans and the other (non-university) contract does not have this COB “birthday” rule, then the rule of the other contract will determine the primary and secondary contract. For example, if the other contract has a rule based on the gender of the parent, then the gender rule will determine the primary and secondary contract.
- Parents separated or divorced – If the parents are separated or divorced, and there is no court decree allocating responsibility for the child’s dental care expenses, then the following rules apply:
 - If a court decree specifies the parent who is financially responsible for the child’s dental care expenses, the coverage of that parent is primary. If the court decree states that both parents are responsible for the child’s dental care expenses, then the following rules shall apply:
 1. the plan of the parent whose birthday falls earlier in the calendar year shall be primary; or
 2. if both parents have the same birthday, the plan that has covered either parent the longest is primary.
 - If there is a court decree that orders joint custody and does not determine primary status for benefit coverage, the plan’s regular provisions establishing the primary status for children of active employees will apply.
 - If the parent with custody has not remarried, his or her coverage is primary.
 - If the parent with custody has remarried, his or her coverage is primary, the custodial stepparent’s is secondary, the non-custodial parent’s coverage would be tertiary, and the coverage of the non-custodial stepparent without custody would pay last.

Former Employee:

- When a plan covers you as an active employee or a dependent of such employee and the other contract covers you as a laid-off or retired employee or as a dependent of such person, the plan which covers you as an active employee or dependent of such employee is primary.
- When a person whose coverage is provided under a right of continuation pursuant to federal or state law (such as COBRA) also is covered under another plan, the plan covering the person as an employee or Subscriber, or retiree (or as that person’s dependent) is primary and the continuation coverage is secondary.

Other Situations:

- When the rules above do not apply, the plan that has covered you longer is primary.

How Delta Dental Pays when Primary

Delta Dental will pay the full benefit allowed by the Dental Plan as if you had no other coverage.

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COORDINATION OF BENEFITS

How Delta Dental Pays when Secondary

Payments are based on the balance left after the primary plan has paid; Delta Dental will pay no more than that balance; in no event will Delta Dental pay more than what it would have paid as primary.

- Delta Dental will pay only for dental care expenses that are covered by this Dental Plan.
- Delta Dental will pay only if you have followed all of the procedural requirements, including care obtained from or arranged by your dentist, Predeterminations, etc.
- Delta Dental will pay no more than the “allowable expenses” for the care involved. If the allowable expense is lower than the primary plan’s, Delta Dental will use the primary plan’s allowable expense. That allowable expense may be less than the actual bill.

Coordination of Benefit Disputes

- If you believe that Delta Dental has not paid a claim properly, you should first attempt to resolve the problem by contacting Delta Dental. See the “Disputed Claims Procedures” section of this SPD for additional information.
- You may also contact the Office of Human Resources for assistance. If you are still not satisfied, you may contact the Ohio Department of Insurance (ODI) for instructions on filing a consumer complaint, 614-644-2673 or 800-686-1526.

Plans that Do Not Coordinate

Delta Dental will pay benefits without regard to benefits paid by the following kinds of coverage:

- Medicaid
- Group hospital indemnity plan that pays less than \$100 per day
- School accident coverage
- Some supplemental sickness and accident policies

SPECIAL POINTS TO CONSIDER

Authorized Representative

You may appoint an authorized representative to deal with the Dental Plan on your behalf with respect to any benefit claim you file or any review of a denied claim which you wish to pursue (see the section on Disputed Claims Procedures). You may contact Delta Dental’s Customer and Claims Services Department at 800-282-0749, or send a written request to: P.O. Box 30416 Lansing, Michigan 48909-7916, to request a form to fill out designating the person you wish to appoint as your personal representative.

While in some circumstances your dentist may be treated as your authorized representative, generally only the person you have authorized on the last dated form filed with Delta Dental will be recognized. Once you have appointed an authorized representative, Delta Dental will communicate directly with your representative and will not also inform you of the status or outcome of your claim. You will have to find that information out from your authorized representative. If you have not designated an authorized representative, Delta Dental will communicate with you directly.

Predetermination of Expense

Delta Dental recommends Predetermination before any services are rendered where the total charges will exceed \$200.

Predetermination is not a prerequisite to payment, but it allows claims to be processed more efficiently and allows you to know what services will be covered before your dentist provides them. You and your dentist should review your Predetermination Notice before your dentist proceeds with treatment. Once treatment is complete, the dates of service are entered on the Predetermination Notice and it is submitted to Delta Dental for payment.

Conditions that are Medical in Nature

On occasion, your dental care provider may identify a condition and recommend further treatment. Sometimes the condition is medical in nature and therefore covered in part or totally by your medical insurance. These are typically services that do not treat the teeth, the tissue surrounding the teeth or the roots. Treatment for medical conditions is excluded under the Dental Plan. In these cases, all rules of your medical insurance apply.

- If you are enrolled in certain university-sponsored medical plan options, such as **Prime Care Advantage**, **Prime Care Connect**, or **Prime Care Choice**, you must use a provider in your **medical plan network** to receive maximum benefits.
- For additional information or assistance with coordination with your OSU medical benefits, contact the OSU Health Plan at 614-292-4700, 800-678-6269, or visit osuhealthplan.com

DISPUTED CLAIMS PROCEDURES

If you believe that Delta Dental has incorrectly denied all or part of your dental claim, follow the steps below.

Adverse Benefit Determination

After you have filed your claim, should you receive an adverse benefit determination, you or your authorized representative will be notified. An **adverse benefit determination** is any denial, reduction, or termination of the benefit for which you filed a claim, or a failure to provide or to make payment (in whole or in part) of the benefit you sought, including any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational or was not medically necessary or appropriate. If you are informed that the Dental Plan will pay for the benefit you sought but will not pay the total amount of expenses incurred, and you must make a payment to satisfy the balance, you may also treat that as an adverse benefit determination.

Your notice of an adverse benefit determination will inform you of the specific reason(s) for the denial, the pertinent Dental Plan provision(s) on which the denial is based, and an explanation of the Dental Plan's review procedures for dental claims, including applicable time limits. The notice will also contain a description of any additional materials necessary to complete your claim, an explanation of why such materials are necessary, and a statement that you have a right to bring a civil action in court if you receive an adverse benefit determination after your claim has been completely reviewed. The notice will also reference any rule, guideline, protocol, or similar document or criteria relied on in making the initial determination, and will include a statement that a copy of such rule, guideline, or protocol may be obtained upon request at no charge. Should the adverse benefit determination be based on a matter of medical judgment or medical necessity, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge.

If you receive notice of an adverse benefit determination and you think that Delta Dental incorrectly denied all or part of your claim, here are the steps you can take:

First, you or your dentist should contact Delta Dental's Customer and Claims Services department and ask them to check the claim to make sure it was processed correctly. You may do this by calling the toll-free number, (800) 282-0749, and speaking to a telephone representative. You may also mail your inquiry to the Customer and Claims Services department at P.O. Box 30416, Lansing, Michigan 48909-7916. When writing, please enclose a copy of your Explanation of Benefits (EOB) and describe the problem. Be sure to include your name, telephone number, the date, and any information you would like considered about your claim. This inquiry is not required and should not be considered a formal request for review of a denied claim. Delta Dental provides this opportunity for you to describe problems and submit explanatory information that might indicate that your claim was improperly denied and allow Delta Dental to correct this error quickly and without delay.

Disputed Claims Review Procedure

Whether or not you have asked Delta Dental informally, as described above, to recheck its initial determination, you can submit your claim to a formal first-step review through the Disputed Claims Review Procedure described here. To request a formal review of your claim, send your request in writing to Dental Director, Delta Dental, P.O. Box 30416, Lansing, Michigan 48909-7916.

Please include your name, address, and Social Security number, the reason you believe your claim was wrongly denied, and any other information you believe supports your claim. You also have the right to review the Dental Plan and any documents related to it. If you would like a record of your request and proof that it was received by Delta Dental, you should mail it certified mail, return receipt requested.

You, or your authorized representative, should seek a review as soon as possible, but you must file your request for review within 180 days of the date on which you receive your notice of the adverse benefit determination you are asking Delta Dental to review. If you are seeking review of an adverse benefit determination of a Concurrent Care Claim, you will have to seek review as soon as possible so that you may receive a decision on review before the course of treatment you are seeking to extend terminates.

The dental director, or any other person(s) reviewing your claim, will not be the same as, nor will they be subordinate to, the person(s) who initially decided your claim. The dental director will grant no deference to the prior decision about your claim, but rather will assess the information, including any additional information that you have provided, as if the dental director were deciding the claim for the first time.

The dental director will make their determination on review within 30 days of the dental director's receipt of your request. If your claim is denied on review (in whole or in part), you will be notified in writing. The notice of any adverse benefit determination by the Dental Director will:

- Inform you of the specific reason(s) for the denial
- List the pertinent Dental Plan provision(s) on which the denial is based
- Contain a description of any additional information or material that is needed to decide the claim and an explanation of why such information is needed
- Reference any internal rule, guideline, or protocol that was relied on in making the decision on review and inform you that a copy can be obtained upon request at no charge

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DISPUTED CLAIMS PROCEDURES

- Contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the dental director's decision to deny your claim (in whole or in part) and
- Contain a statement that you may seek to have your claim paid by bringing a civil action in court if it is denied again on appeal.

If the dental director's adverse benefit determination is based on an assessment of medical judgment or medical necessity, the notice of the dental director's adverse benefit determination will contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for that scientific or clinical judgment can be obtained upon request at no charge. If the dental director consulted medical or dental experts in the appropriate specialty, the notice will contain the name(s) of those expert(s) consulted.

Disputed Claims Appeal Procedure

Should you receive a notice of an adverse benefit determination by the Dental Director and you do not agree with the results of the Disputed Claim Review Procedure, you may appeal that decision to the Board of Directors of Delta Dental, or its delegate, through the Disputed Claims Appeal Procedure described here.

- To initiate the Disputed Claims Appeal Procedure, you must file a written request for review before the final appeal date listed in the Dental Director's notice denying your disputed claim. If no date is given in this notice, you have until the date that is 60 days from the date you received your letter denying your claim under the Disputed Claims Review Procedure, or, if later, the date that is 150 days from the date you first submitted your first request for a second level of review under this Disputed Claims Review Procedure.
- Send your written request to the same address listed above for the Dental Director, but instead of sending it to the Dental Director, address it to the Board of Directors or its delegate. Your written request must say why you are seeking further review and why you believe the Dental Director's decision was incorrect. You or your authorized representative may submit any additional materials you believe support your claim. You also have the right to review the Dental Plan and any documents related to it.
- In your written request for this second level of review, you may also ask for a hearing with the Board of Directors or its delegate. If the Board of Directors or its delegate, at its sole discretion, decides to convene a hearing, you are entitled, at your own expense, to be represented by legal counsel, to request that a court reporter transcribe the hearing, to present evidence, to request the testimony of witnesses and to cross-examine witnesses. A decision will be made as soon as possible, but in no event later than 30 days from the date the Board of Directors or its delegate receives your request for this second-level review.
- You will receive written notice of the Board of Director's or its delegate's determination. The notice of any adverse benefit determination by the Board of Directors or its delegate will (a) inform you of the specific reason(s) for the denial, (b) list the pertinent Dental Plan provisions on which the denial is based, (c) reference any internal rule, guideline, or protocol that was relied on when making the decision on review and inform you that a copy can be obtained upon request at no charge, (d) contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the Board of Director's or its delegate's decision to deny your claim (in whole or in part) and (e) contain a statement that you may seek to have your claim paid by bringing a civil action in court.
- If the adverse benefit determination on this second-level review is based on an assessment of medical judgment or medical necessity, the notice of the Board of Director's or its delegate's adverse benefit determination will contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge. If the Board of Directors or its delegate consulted medical or dental experts in the appropriate specialty, the notice will contain the name(s) of those expert(s) consulted.

Civil Action

If your claim is denied in whole or in part after both stages of these required Disputed Claims Procedures have been completed, you have the right to seek to have your claim paid by filing a civil action in court, but you will not be able to do so unless you have completed both of the levels of review described above. If you wish to file your claim in court, you must do so within one year of the date on which you receive notice of the final denial of your claim.

If, however, Delta Dental fails to comply with any of the deadlines described above, or fails to adequately inform you of your procedural rights under these Disputed Claims Procedures, you may treat these Disputed Claims Procedures as having been completed and file your claim directly in court. You must, however, file your claim in court within one year of the date you knew, or should have known, of Delta Dental's material failure to comply with the Disputed Claims Procedures.

Office of Human Resources Appeal Committee

For adverse benefit determinations related to eligibility and enrollment, you may submit a written appeal to the university's Benefits Appeals Committee. Appeal forms are available upon request from HR Connection at HRConnection@osu.edu or by calling 614-247-myHR(6947).

Department of Insurance

If you are still not satisfied, you may contact the Ohio Department of Insurance for instructions on filing a consumer complaint by calling 614-633-2673 or 800-686-1526. You may also write to the Consumer Services Division of the Ohio Department of Insurance, 2100 Stella Court, Columbus, OH 43216-1067.

CONTINUATION OF COVERAGE

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 is a federal law commonly referred to as COBRA. COBRA requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called coverage continuation) at group rates in certain instances where coverage under the Dental Plan would otherwise end. This section is intended to summarize your rights and obligations under the coverage continuation provisions of the law.

Note: COBRA or COBRA-like coverage is available to the employee, spouse and eligible dependents if coverage under the Dental Plan ends.

Employee

If you are an employee covered by the Dental Plan, you have a right to choose this coverage continuation for up to 18 months if you lose your dental coverage due to:

- Reduction in your hours of employment that affects benefit eligibility; or
- Termination of your employment (for reasons other than gross misconduct on your part).

Coverage may be continued for up to 24 months if you are on a leave of absence for United States uniformed service.

Note: For all other qualifying events (divorce or legal separation or a dependent losing eligibility for coverage as a dependent), you must notify the Office of Human Resources, within 60 days after the qualifying event occurs.

Spouse

If your spouse is covered by the Dental Plan, he or she has the right to choose this coverage continuation if coverage under the Dental Plan is terminated for any of the following reasons:

- Coverage may be continued for up to 18 months due to:
 - Termination of your employment (for reasons other than gross misconduct); or
 - Reduction in your hours of employment that affects benefit eligibility.
- Coverage may be continued for up to 24 months if you are on a leave of absence for United States uniformed service.
- Coverage may be continued for up to 36 months due to:
 - Death of the covered employee; (If you enroll in coverage through COBRA as a result of the death of an employee, COBRA coverage is paid by the university for two months following the date of the covered employee's death.);
 - Divorce, or legal separation; or
 - Termination your employment (for reasons other than gross misconduct on your part) or reduction in your hours of employment, coupled with your entitlement to Medicare benefits less than 18 months before your termination of employment or reduction in hours of employment. In this case, coverage may be continued for up to 36 months from the date of your Medicare entitlement.

Dependent Child/Other Eligible Individuals as Defined by the University

In the case of a dependent child or other eligible individual as defined by the university (refer to the "General Plan Provisions – Eligible Dependents" section of this SPD) covered by the Dental Plan, he or she has the right to choose this coverage continuation if coverage under the Dental Plan is terminated for any of the following reasons:

- Coverage may be continued for up to 18 months due to:
 - Termination of your employment (for reasons other than gross misconduct) or
 - Reduction in your hours of employment that affects benefit eligibility.
- Coverage may be continued for up to 24 months if you are on a leave of absence for United States uniformed service.
- Coverage may be continued for up to 36 months due to:
 - Death of the covered employee (If you enroll in coverage through COBRA as a result of the death of an employee, COBRA coverage is paid by the university for two months following the date of the covered employee's death.);
 - Divorce, legal separation, or termination of grandfathered sponsored dependency;
 - The dependent ceases to meet the eligibility requirements of a dependent (refer to the "Eligible Dependents" section of this SPD);or
 - Termination of your employment (for reasons other than gross misconduct on your part) or reduction in your hours of employment, coupled with your entitlement to Medicare benefits less than 18 months before your termination of employment or reduction in hours of employment. In this case, coverage may be continued for up to 36 months from the date of your Medicare entitlement.

Although your eligible dependents other than your dependent children are not "qualified beneficiaries" for purposes of COBRA, the Dental Plan extends COBRA-like continuation rights to such dependents that are equivalent to the rights that a dependent child would have under COBRA.

Notification

- The employee or a family member is required to complete a COBRA Election Form, available from Trustmark, for a divorce, legal separation, termination of grandfathered sponsored dependency, or a child ceasing to be an eligible dependent under the Dental Plan. If such an event occurs, you should notify Trustmark within 60 days of the date the event occurs.
- If such notice is not provided within 60 days, the affected individuals will lose their right to elect coverage continuation under the Dental Plan with respect to such event.

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CONTINUATION OF COVERAGE

- When the university is notified that one of these events has happened, or if any other qualifying event occurs, then Trustmark will notify you and your family of the right to choose coverage continuation.

Election Period

- You have 60 days from the later of (i) the date you lose coverage, as described in the previous section, or (ii) the date Trustmark provides the COBRA notice (i.e. a COBRA Election Form).

Dental Coverage

- If you do not elect coverage continuation, your Dental Plan coverage will end on your termination date as reflected in the university's human resource system (Workday).
- If you elect coverage continuation, your Dental Plan coverage will continue and will be identical to the same benefit as provided under that plan to similarly situated employees or family members (such as active employees and their dependents).

Disability Extension

- If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify Trustmark in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months.
 - The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.
 - You must notify the Office of Human Resources within 60 days of the date the individual is determined to be disabled under the Social Security Act and within 31 days of the date he or she is finally determined not to be disabled. (Coverage will end on the first day of the month beginning at least 31 days after the covered individual is determined not to be disabled.)

Other Coverage Options

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Termination of Coverage Continuation

You are no longer eligible for coverage continuation and may be terminated from the Dental Plan for any of the following reasons:

- The premium for your coverage continuation is not paid on time (See the "Payment" section below.).
- After first electing coverage continuation, you become covered under another group dental plan that does not contain any exclusion or limitation with respect to any pre-existing condition.
- After first electing coverage continuation, you become entitled to Medicare.
- You reach the end of your coverage continuation period.
- In the event that you are receiving extended coverage continuation as a result of your being disabled under the Social Security Act, your extended coverage continuation may be terminated on the first day of the month at least 30 days after a final determination that you are no longer disabled. You must notify the Dental Plan within 30 days of the date of any final determination under the Social Security Act that you are no longer disabled.
- The university no longer provides group dental coverage to any of its employees.

Evidence of Insurability (EOI)

It is not necessary for you to show that you are insurable to choose coverage continuation.

Payment

All payments are due by the first day of each month to Trustmark. The full premium for coverage continuation plus an administrative charge must be paid. (Although monthly payments are due on the first day of every month, you will be given a grace period of 30 days to make each monthly payment. If you pay a monthly payment later than the first day of the month, but before the end of the grace period for the coverage period, your coverage may be suspended and then retroactively reinstated when the monthly payment is received. If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to continuation coverage.) The premium for an extended coverage continuation period due to a total disability may be higher than the premium due for the first 18 months.

Changes

Notify Trustmark if there are changes in the following:

- The Covered Person becomes entitled to other group health coverage or Medicare.
- The Social Security Administration determines the Covered Person is no longer disabled.
- The Covered Person's marital status.
- The Covered Person's home mailing address.

GENERAL CONDITIONS

Actions

No action on a legal claim arising out of or related to this document may be brought until 30 days after notice of the legal claim has been given to Delta Dental. In addition, no action can be brought more than one year after the legal claim first arose. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim.

Assignment

Services and/or benefit payments to eligible people are for the personal benefit of those individuals and cannot be transferred or assigned other than to the extent necessary to allow direct payments to Network Dentists.

Dentist-Patient Relationship

The eligible person has freedom of choice of any licensed dentist. Each dentist rendering service under this document is an independent contractor and will maintain the dentist-patient relationship with his or her patient and will be solely responsible to the patient for dental advice and treatment and any resulting liability.

Late Claims Submission

Delta Dental will not honor and no payment will be made for services if a claim for those services has not been received by Delta Dental within 12 months after the services were completed.

Loss of Eligibility during Treatment

If you or your eligible dependent should lose eligibility for coverage under the Dental Plan while receiving dental treatment, only those Covered Services actually received while you or your eligible dependent were covered under the Dental Plan will be considered a covered expense. Certain procedures begun before the loss of eligibility may be covered provided that the services were completed within a 60-day period measured from the date of loss of eligibility. In those cases, Delta Dental investigates those services in progress to determine what portion, if any, is payable by Delta Dental. Any balance of the total fee not paid by Delta Dental is your responsibility.

Obtaining and Releasing Information

To determine how the terms of this document will be applied and implemented, Delta Dental may, without the consent of or notice to any eligible person, release to or obtain from any insurance company, group hospitalization plan or dental care plan any information about payments or benefits that it deems to be necessary for such purposes. Any eligible person claiming benefits under this Dental Plan will furnish Delta Dental any information that is necessary to implement this provision.

SUBROGATION AND REIMBURSEMENT RIGHTS

A Covered Person may incur dental expenses due to an illness or injury that may be caused by the act or omission of a third party. Also, a third party (such as an insurance company) may be responsible for payment or agree to compensate a Covered Person on account of the actions of another person or entity. To the extent that the Dental Plan previously paid for such dental expenses, the Dental Plan has a right to subrogation and/or reimbursement, as described below.

Third Party

For purposes of this section, “third party” means any person, entity or organization that is or may be liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person’s illness or injury. A third party includes, but is not limited to: the party or parties alleged to have caused or that caused the illness or injury; the insurer, guarantor or other indemnifier of the party or parties alleged to have caused or that caused the illness or injury; a Covered Person’s own insurer (e.g., automobile, medpay, uninsured/underinsured motorist, homeowners or other insurance policies); and any other person, entity or organization that is or may be liable or legally responsible for payment in connection with the illness or injury.

Subrogation Rights

If a third party is or may be responsible for paying the expense of, or agrees to compensate a Covered Person for, any illness or injury covered by this Dental Plan and for which this Dental Plan has already paid, the Dental Plan has the right to take the Covered Person’s place in recovering payments directly from the third party. The Dental Plan’s right to do this is called its right of subrogation.

Reimbursement Rights

If a Covered Person receives a settlement or is otherwise compensated by a third party for any illness or injury covered by this Dental Plan, the Covered Person is required to reimburse the Dental Plan for the payments made by the Dental Plan. This is called the Dental Plan’s right of reimbursement.

Amounts Subject to Subrogation and/or Reimbursement

Subject to Section 2323.44 of the Ohio Revised Code:

- All amounts recovered will be subject to subrogation and/or reimbursement.
- In no case will the amount subject to subrogation or reimbursement exceed the amount of benefits paid for the injury or illness under the plan and the expenses incurred by the plan in collecting this amount.
- The Dental Plan has a priority over you and your dependent(s) as to any funds recovered.
- The Dental Plan has a right to recover in full, regardless of how amounts received from a third party may be characterized and regardless of whether or not the Covered Person(s) have been made whole.
- The Dental Plan has a right to recover in full, regardless of whether the amounts received from a third party are paid directly to the Covered Person, or placed in a trust or structured settlement for the benefit of the Covered Person.
- The Dental Plan’s subrogation and reimbursement rights will not be reduced to reflect any cost or attorneys’ fees incurred in obtaining the compensation unless separately agreed to, in writing, by the university in the exercise of its sole discretion.
- If a Covered Person fails to comply with any of the terms of the Dental Plan governing subrogation and reimbursement, in addition to any amount the Covered Person owes to the Dental Plan for subrogation and/or reimbursement, the Covered Person will be liable to the Dental Plan for its reasonable costs to enforce those terms, including but not limited to attorneys’ fees incurred by the plan.

Authorization by Covered Person

As a Covered Person under the Dental Plan, you agree to all of the terms of the Dental Plan regarding subrogation and reimbursement, including, but not limited to, the following:

- You agree that the Dental Plan has rights of subrogation and reimbursement.
- You will promptly refund to the Dental Plan any amount that is subject to the Dental Plan’s rights of subrogation and/or reimbursement.
- You, your dependent(s) and representative(s) will cooperate fully to help the Dental Plan enforce its rights of subrogation and reimbursement, and will not do anything that prejudices or impairs those rights.
- You will provide all information needed under the Dental Plan to recover the amount of dental or other benefits paid for the illness or injury under the Dental Plan and expenses incurred by the Dental Plan in collecting this amount, and execute and deliver any papers necessary for such recovery.
- To the extent you fail to reimburse the Dental Plan pursuant to this section, the Dental Plan may reduce any future benefits otherwise available to you and your dependent(s) under the Dental Plan by the full amount of the compensation received from the third party.
- You understand and agree that the third party may be sued in order to recover the payments made for you under the Dental Plan.
- You will notify the Dental Plan of any proposed settlement and obtain the Dental Plan’s written consent before signing any release or agreeing to any settlement. If a Covered Person or the Covered Person’s representative chooses to recover payment from a third party, the Covered Person or representative must include the amount paid by the Dental Plan in the requested settlement.

DEFINITIONS

Aggregate Health Information

Information that may be individually identifiable health information that:

- Summarizes claim history, claim expenses, or types of claim experienced by individuals for whom the university has provided health benefits under a group dental plan; and
- From which all identifiers described above have been deleted. Geographic information need only be aggregated to a five digit zip code level.

Allowed Amount

The amount permitted under the applicable fee schedule for this Plan, which was selected by your Contractor, and upon which Delta Dental will base its payment for a Covered Service.

Balance Billing

When a dentist bills you for the difference between the provider's charge and the eligible expense.

Completion Dates

- The delivery date for dentures and partial dentures.
- The cementation date for crowns and bridgework.
- The date of the final procedure that completes treatment for root canals and periodontal treatment.

Coinsurance

The percentage of the charge, if any, that you will have to pay for Covered Services.

Concurrent Care Claims

Claims for benefits where an ongoing course of treatment has been agreed to by Delta Dental and/or Ohio State and the coverage for that ongoing treatment is reduced or terminated before the Completion Date applicable to the agreed-to course of treatment. A Concurrent Care Claim may also arise should you request the Dental Plan extend coverage beyond the time period or number of treatments that were previously agreed to.

Covered Person

A person covered by the Dental Plan.

Covered Services

The dental services which a Covered Person is entitled to receive by virtue of coverage under this Dental Plan, as defined in this Specific Plan Details document.

Deductible

The amount that a person will be obligated to pay toward Covered Services before Delta Dental pays for services under this Dental Plan.

Delta Dental/Delta Dental of Ohio, Inc.

Delta Dental Plan of Ohio, Inc., a health-insuring corporation providing dental benefits programs. Delta Dental is not a commercial insurance company.

Dental Plan

The dental benefit plan described in this booklet which is administered by Delta Dental.

Dental Services

Care and procedures employed by Dentists for diagnosis or treatment of dental disease, injury, or abnormal condition. These Dental Services are based on valid dental need according to accepted standards of dental practice. Dental Services are services that treat the teeth, tissue surrounding the teeth and roots of the teeth.

Dentist

A person licensed to practice dentistry in the state or country in which Dental Services are rendered.

Eligible Dependent

Any dependent of a subscriber who meets the criteria for eligibility set forth in this Specific Plan Details document.

Maximum Approved Fee

The Maximum Approved Fee is the lowest of:

- The Submitted Amount
- The lowest fee regularly charged, offered, or received by an individual Dentist for a dental service or supply, irrespective of the Dentist's contractual agreement with another dental benefits organization.
- The maximum fee that the local Delta Dental Member Plan approves for a given procedure in a given region and/or specialty based upon applicable Participating Dentist schedules and internal procedures.

Maximum Benefit

The maximum dollar amount Delta Dental will pay in any benefit Plan Year or lifetime for covered dental services.

Network Dentist

A licensed dentist who has signed an agreement with Delta Dental to participate in Delta Dental PPO or Delta Dental Premier Network. A Network Dentist has agreed to accept Delta Dental's payment and the patient's Deductible and Coinsurance, if any, as payment in full.

Out-of-Network Dentist

A licensed dentist who has not signed an agreement with Delta Dental to participate in Delta Dental PPO or Delta Dental Premier.

Out-of-Network Dentist Fee

The maximum fee allowed per procedure for services rendered by a Out-of-Network Dentist.

Optional Treatment

A service that is more expensive than what is customarily provided or for which Delta Dental does not determine that a valid dental need is shown. You are responsible for the costs over the allowed amount, regardless of whether or not the service is provided by a network dentist.

Plan Administrator

The Ohio State University or the person(s) designated by the university as the plan administrator.

DEFINITIONS

Plan Sponsor

The Plan Sponsor is The Ohio State University.

Plan Year

The Plan Year is the 12-month calendar year, beginning on January 1 and ending on December 31.

Post-Service Claims

These are claims for benefits that are not conditioned on your seeking advanced approval, certification, or authorization in order for you to receive the full amount of any covered benefit. In other words, Post-Service Claims arise when you receive the dental service or treatment before you file a claim for the benefit payment.

Predetermination Notice

An optional notice which provides an estimate of the costs of Covered Services to be provided. Dentists may submit their treatment plans to Delta Dental before procedures are started. Delta Dental reviews the treatment plan and advises the patient and the dentist of what services are covered by the Dental Plan and what Delta Dental's payments may be. Delta Dental's payment for predetermined services depends on continued eligibility and the annual or lifetime maximum payments available under the Dental Plan. You are not required to seek a Predetermination.

The Covered Services you are entitled to receive under the Dental Plan are not conditioned upon any Predetermination made by Delta Dental. You will receive the same benefits under the Dental Plan whether or not you or your dentist request a Predetermination. Predetermination is merely a convenience so that you will know before the dental service is provided how much, if any, of the cost for the services the dentist is proposing to perform is not covered under the Dental Plan. Since you may be responsible for any cost not covered under the Dental Plan, this will likely be useful information to know when deciding whether to incur those costs.

Processing Policies

Delta Dental's policies and guidelines used for Predetermination and payment of claims. The Processing Policies may be amended from time to time.

Protected Health Information (PHI)

Information that is created, received, transmitted, or maintained by the Dental Plan and relates to the past, present or future physical or mental health of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and that identifies the individual or there is a reasonable basis to believe that the information could be used to identify the individual. It includes information about living or deceased people.

The following components of an individual's health information when created, received, transmitted, or maintained by the Dental Plan are also considered PHI:

- Names
- Street address, city, county, precinct, zip code
- Dates directly related to an individual (including birth dates, admission dates, discharge dates, date of death)
- Telephone numbers, fax numbers and electronic mail addresses
- Social Security numbers
- Medical record numbers
- Account numbers
- Certificate/license numbers
- Vehicle identifiers, serial numbers and license plate numbers
- Device identifiers and serial numbers
- Web Universal Resource Locators (URLs)
- Biometric identifiers (including finger and voice prints)
- Full face photographic images or comparable images
- Any other unique identifying number, characteristic or code
- Internet protocol (IP address numbers)

Submitted Amount

The fee a dentist bills to Delta Dental for a specific treatment.

Subscriber

You, as the enrolled employee, who is eligible to receive dental benefits from Delta Dental, as determined by The Ohio State University.



THE OHIO STATE UNIVERSITY
HUMAN RESOURCES