SANTA BARBARA COUNTY
BOARD AGENDA LETTER

Clerk of the Board of Supervisors
105 E. Anapamu Street, Suite 407
Santa Barbara, CA 93101
(805) 568-2240

Agenda Number:

Prepared on:	11/7/08
Department Name:	Human Resources
Department No.:	064
Agenda Date:	12/9/08
Placement:	Administrative
Estimate Time:	N/A
Continued Item:	NO
If Yes, date from:	

TO:	Board of Supervisors
FROM:	Susan Paul, Assistant CEO/Human Resources Director CEO/Human Resources Department
STAFF CONTACT:	Scott Turnbull, Employee Benefits Manager x2821
SUBJECT:	**Self-Funded Dental Plan Legal Plan Document Revision**

Recommendation(s):

That the Board of Supervisors:

Approve the revised Self-Funded Dental Plan's Legal Plan Document, converting from a fiscal plan year to a calendar plan year, effective January 1, 2009.

Alignment with Board Strategic Plan:

The recommendation(s) are primarily aligned with actions required by law or by routine business necessity.

Executive Summary and Discussion:

The Self-Funded Dental Plan is a dental PPO plan funded by the County, employees and retirees. Dental plan rules are specified in the plan's legal plan document and detail who is eligible for the plan, when coverage begins and ends, how claims are paid and outlines compliance measures with federal and state health plan laws. The Self-Funded Dental Plan's legal plan document also incorporates the eligibility rules for all County medical and dental plans in a single County adopted plan document.

In anticipation of making this change to a calendar plan year, in May 2008, your Board adopted health plan premium rates, effective July 1, 2008, for an eighteen-month period. Those premium rate changes will remain in effect through December 31, 2009.

The recommended plan change is a housekeeping change to formally change the County's health plan year from a fiscal year to a calendar year to align the County's health plans with the flexible benefits plan year. This change will make it easier for employees to make decisions about health plan choices at the same time as they enroll in a flexible spending account or health savings account.

Fiscal and Facilities Impacts:

This is an administrative change and there is no fiscal impact to the County.

Special Instructions: Return one signed copy of plan document to CEO/Human Resources Department.

Concurrences: County Counsel
Auditor-Controller

cc: All Employee Organizations
All Department Heads
Health Oversight Committee

COUNTY OF SANTA BARBARA

HEALTH PLAN DOCUMENT

RESTATED JANUARY 1, 2009

PREFACE

This document sets forth the eligibility rules applicable to all the health care benefit programs provided by or through the County of Santa Barbara to its employees, retirees and their families, the benefits, limitations and exclusions of the Self-Funded Dental Plan (which was originally implemented on February 19, 1979) and, by reference, the other health care programs offered by the County of Santa Barbara.

This document is effective July 1, 2006 and replaces the County of Santa Barbara Self-Funded Medical and Dental Benefit Plan document dated May, 1987 and as subsequently amended.

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ARTICLE I. DEFINITIONS

1.01 ***Accident or Accidental***

An unforeseen and unavoidable event resulting in an *Injury.*

1.02 ***Allowable Dental Procedure***

The most cost-effective treatment of a dental condition which will provide a professionally acceptable result as determined by national standards of dental practice. Consideration is given to the current clinical oral condition based upon the diagnostic material submitted by the *Dentist.*

1.03 ***Amendment (Amend)***

A formal document signed by representative(s) of the *County.* An amendment adds, deletes or changes the provisions of the *Plan* and applies to all Covered Persons, including those persons covered before the *Amendment* becomes effective, unless otherwise specified.

1.04 ***Benefit Year***

The 12-month period beginning January 1 and ending December 31. All annual deductibles and annual benefit maximums accumulate during the benefit year.

1.05 ***Claims Administrator***

The claims administrator is the organization under contract with the County to provide claims processing services for *the Plan.*

1.06 ***Cosmetic Surgery***

A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than to restore the anatomy and/or functions of the body which are lost or impaired due to an *Illness* or *Injury.*

1.07 ***County***

The County of Santa Barbara.

1.08 ***Covered Entity*** shall have the meaning set forth at 45 C.F.R. § 160.103 and include a health plan such as the *Plan.*

1.09 ***Covered Functions*** shall have the meaning set forth at 45 C.F.R. § 164.103 and include those functions of a covered entity the performance of which makes the entity a "health plan," "health care provider," or "health care clearinghouse" as those terms are defined at 45 C.F.R. § 160.103.

1.10 ***Covered Person***

Any one who is eligible for this *Plan* and who is properly enrolled therein in accordance with Article II.

1.11 ***Dental Hygienist***

A person trained and licensed to perform dental hygiene services, such as prophylaxis (cleaning of teeth), under the direction of a licensed *Dentist.*

1.12 ***Dentist***

A person acting within the scope of his/her license, holding the degree of Doctor of Medicine (M.D.), Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.), and who is legally entitled to practice Dentistry in all its branches under the laws of the state or jurisdiction where the services are rendered.

1.13 ***Electronic Protected Health Information*** shall have the meaning set forth at 45 C.F.R. §160.103 and includes Protected Health Information that is transmitted by electronic media or maintained in electronic media.

1.14 ***Expense Incurred***

The date a dental service, treatment or appliance is performed or obtained, except for the following services or treatments:

Dentures or bridgework - the date the impressions are taken.
Crowns, inlays, onlays - the date the teeth are first prepared.
Root canal therapy - the date the pulp chamber is opened.

1.15 ***Experimental/Investigational***

Any procedure, treatment, therapy, drug, biological product, facility, equipment, device or supply which the *Plan Administrator* has determined, in the exercise of its sole discretion, not to have been demonstrated as safe and effective as compared with the standard means of treatment or diagnosis. *Experimental* also means any procedure, treatment, therapy, drug, biological product, facility, equipment, device or supply that is determined by the *Plan Administrator* to be investigational, educational, or the subject of current clinical trials.

(a) In making a determination under this Section 1.12, *the Plan Administrator* shall refer to reliable evidence, which may be derived, without limitation, from one or more of the following sources:

(1) published, authoritative peer-reviewed medical or dental and scientific literature regarding the procedure at issue as applied to the *Injury* or *Illness* at issue;

(2) publications and evaluations from national dental associations, such as the American Dental Association or specialty dental associations;

(3) regulations and other official guidelines or publications issued by U.S. Food and Drug Administration (PDA) or Department of Health and Human Services;

(4) written protocols and consent forms used by the treating *Dentist* or by another *Dentist* administering substantially the same treatment.

(b) For the *Plan Administrator* to determine that the service or supply is safe and effective as compared with the standard means of treatment or diagnosis, the service or supply must meet all of the following applicable criteria:

(1) reliable evidence must conclusively show that the service or supply is recognized or approved, in accordance with generally accepted standards in the national dental community, as being safe and effective for use in the treatment or diagnosis of the *Illness* or *Injury* at issue;

(2) any required approval of any federal government or agency, or any state government or agency, must have been obtained prior to the time of use;

(3) if it is a drug or device which cannot be lawfully marketed without the approval of the PDA, final approval must have been obtained at the time the drug or device is furnished. Interim FDA approvals for a phase I, II or III trial, pre-market applications and investigational exemptions are not sufficient. If final FDA approval has been obtained, only the uses and indications for which the drug or device was licensed will not be considered experimental/investigational.

(c) Notwithstanding the foregoing, a service or supply shall be considered *Experimental/Investigational:*

(1) if the service or supply is provided pursuant to a phase I or phase II clinical trial or as the experimental or research arm of a phase III clinical trial;

(2) if it is under study to determine maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or

(3) if its safety or efficacy, or efficacy as compared with the standard means of treatment or diagnosis, is the subject of substantial debate within the national dental community.

(d) The fact that a *Dentist* or other professional or expert may prescribe, order, recommend, recognize or approve any procedure, treatment, therapy, drug, biological product, facility, equipment, device or supply does not in itself make the service or supply non-experimental/investigational within the meaning of Section 1.12. Similarly,

the fact that the service or supply is authorized by law or otherwise for use in testing, trials or other studies on human patients shall not in itself make the service or supply *non-Experimental/Investigational* within this definition.

1.16 ***Health Care Operations*** shall have the meaning set forth at 45 C.F.R. § 164.501 and include, but not be limited to, any of the following activities of the Plan to the extent that the activities are related to Covered Functions:

(a) quality assessment and improvement activities;

(b) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

(c) rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

(d) underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);

(e) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(f) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and

(g) business management and general administrative activities of the entity, including, but not limited to:

(1) Management activities relating to implementation of, and compliance with, the requirements of HIPAA;

(2) Customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers;

(3) Resolution of internal grievances;

(4) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity; and

(5) Consistent with the applicable requirements of 45 C.F.R. § 164.514, creating deidentified health information or a limited data set and fund raising for the benefit of the covered entity.

1.17 ***Health Information*** shall have the meaning set forth at 45 C.F.R. § 160.103 and include any information, whether oral or recorded in any form or medium, that:

(a) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

(b) relates to the past, present, or future physical or mental health or condition 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.

1.18 ***HIPAA*** shall mean the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 §§ 261-62, 264, 42 U.S.C. §§ 1320d *et seq.*, and its implementing regulations codified at 45 C.F.R. § 160.101 *et seq.*

1.19 ***Illness***

Any bodily sickness or disease.

1.20 ***Individually Identifiable Health Information*** shall have the meaning set forth at 45 C.F.R. § 160.103 and include information that is a subset of Health Information, including demographic information collected from an Individual, and:

(a) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

(b) relates to the past, present, or future physical or mental health or condition 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

(c) that identifies the Individual; or

(d) with respect to which there is a reasonable basis to believe the information can be used to identify the Individual.

1.21 ***Injury***

A condition which results independently of an *Illness* and all other causes and is a result of an externally violent force or *Accident.*

1.22 ***Inpatient***

Confinement in a facility during the period when charges are made for room and board.

1.23 ***Medicaid***

Title XIX (Grants to states for Medical Assistance Programs) of the United States Social Security Act as amended.

1.24 ***Medicare***

Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act as amended.

1.25 ***Oral Surgery***

Surgery in the oral cavity, including pre-and-post-operative care.

1.26 ***Payment*** shall have the meaning set forth at 45 C.F.R. § 164.501 and include activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits or to obtain or provide reimbursement for the provision of health care. Payment activities shall include, but not be limited to, the following:

- determination of eligibility, coverage, and cost sharing amounts (e.g., cost of a benefit, Plan maximums, and copayments as determined for an individual's claim);
- coordination of benefits;
- adjudication of health benefit claims (including appeals and other payment disputes);
- subrogation of health benefit claims;
- risk adjusting amounts due based on enrollee health status and demographic characteristics;
- billing, claims management, collection activities, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments, and related health care data processing;
- obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance) and related health care data processing;
- medical necessity reviews, or review of appropriateness of care or justification of charges;
- utilization review, including precertification, preauthorization, concurrent review and retrospective review of services; and
- disclosure to consumer reporting agencies of any of the following related to collection of premiums or reimbursement: name and address, date of birth, SSN, payment history, account number, and name and address of the provider and/or health Plan).

1.27 ***Physically Or Mentally Handicapped***

The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder and diagnosed by a *physician* as a permanent and continuing condition.

1.28 ***Plan***

The health care benefit program described in this document under Articles I through X as adopted and as may be *amended* from time to time by the *County*

1.29 ***Plan Administration Functions*** shall have the meaning set forth at 45 C.F.R. § 164.504 and include administration functions performed by the Board on behalf of the Plan and excludes functions performed by the Board in connection with any other benefit or benefit plan of the Trust.

1.30 ***Plan Administrator***

The *Plan Administrator* is the *County* and is the sole fiduciary of the *Plan,* and exercises all discretionary authority and control over the administration of the *Plan* and the management and disposition of *Plan* assets. The *Plan Administrator* shall have the discretionary authority to determine eligibility for *Plan* benefits or to construe the terms of the plan.

The *Plan Administrator* has the right to *Amend,* modify or terminate the *Plan* in any manner, at any time, regardless of the health status of any *Covered Person.*

The *Plan Administrator* may hire someone to perform claims processing and other specified services in relation to the *Plan* or otherwise delegate its discretionary authority to a third party. Any such contractor will not be a fiduciary of *the Plan* and will not exercise any of the discretionary authority and responsibility granted to the *Plan Administrator,* as described above.

1.31 ***PPO Provider***

The organization, including those health care providers who have contracted with the organization, under contract with the *County* to provide certain services to *Covered Persons* for which benefits may be considered at special levels.

1.32 ***Protected Health Information*** shall have the meaning set forth at 45 C.F.R. § 160.103 and include Individually Identifiable Health Information that is transmitted or maintained in any form or medium, but exclude Individually Identifiable Health Information in:

(a) education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. § 1232g;

(b) records described at 20 U.S.C. § 1232g(a)(4)(B)(iv); and

(c) employment records held by a covered entity in its role as employer.

1.33 ***Qualifying Event***

A Qualifying Event means any of the following:

(a) termination (other than by reason of an individual's gross misconduct) or reduction of hours, of employment of an eligible employee (including retirement);

(b) death of an employee or retiree;

(c) divorce or legal separation of an employee or retiree from his spouse;

(d) a child ceasing to meet the requirements of a dependent under *the Plan.*

1.34 ***Required By Law*** shall have the meaning for that term set forth at 45 C.F.R. § 164.103.

1.35 ***Schedule of Benefits***

Appendix A to this *Plan* document which specifies the percentages payable, deductibles and maximums under the coverage described in Article III.

1.36 ***Total Disability (Totally Disabled)***

A *Covered Person's* inability to perform all the duties of his occupation or any other type of work for wage or profit as the result of a non-occupational *Illness* or *Injury.* A dependent will be considered totally disabled if, because of non-occupational *Injury* or *Illness,* he or she is prevented from engaging in all the normal activities of a person of like age who is in good health.

1.37 ***Treatment*** shall have the meaning for that term set forth at 45 C.F.R. § 164.501 and include the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

1.38 ***Usual and Customary Charge***

With respect to *non-PPO providers,* the charge most frequently made to the majority of patients for the same service or procedure in the same or similar service area for the service or procedure as billed by other health care practitioners as determined in accordance with a schedule of maximum allowances adopted by the *County* and as may be amended from time to time. With respect to *PPO providers,* the applicable contracted charge made for the service or procedure.

ARTICLE II. ELIGIBILITY

2.01 Type of Coverage

The County offers various medical and dental plan options to employees and qualified retirees eligible to participate in this *Plan* as set forth in this document. Enrollment in a dental plan option is contingent upon enrollment in a medical plan option and vice versa, for eligible employees. Eligible employees are not permitted to enroll nor maintain medical only coverage (no dental) or dental only coverage (no medical). Medical only coverage is permitted for their dependents but dependents may not enroll in dental only coverage. Qualified retirees and their dependents are permitted to enroll and maintain medical only coverage (no dental), but are not permitted to maintain dental only coverage (no medical). When a retiree waives his/her right to enroll in dental plan coverage, it is an irrevocable waiver and the retiree may not enroll in a dental plan in the future.

2.02 Eligible Employees

An employee is eligible to participate in this *Plan* if he is a regular, full-time or permanent part-time employee of the *County*.

2.03 Eligible Retirees

A retired employee is eligible to participate in this *Plan* if he is a qualifying retiree of the *County*. Qualifying retirees must currently be receiving a retirement allowance from the *County*.

2.04 Eligible Dependents

Eligible employees and retirees who enroll in the Dental Plan may also enroll their eligible dependents in the Plan. Eligible dependents include:

(a) the employee's or retiree's lawful spouse as defined by applicable law, or, a person that is a sole spousal equivalent and is 18 years old or older, is mentally competent to contract, resides with the employee or retiree and intends to do so indefinitely, is jointly responsible with the employee or retiree for their common welfare and financial obligations, is unmarried and is not related to the employee or retiree by blood to a degree of closeness as to bar marriage in the state of residence, has registered with the employee as a domestic partner with a state, county or city agency and has not filed a Statement of Termination of Domestic Partnership within the last 6 months. The employee or retiree must also be unmarried for the sole spousal equivalent to be eligible for membership in the Dental Plan,

(b) the employee's or retiree's children under age 23, including the following: natural children, stepchildren, foster children placed with the employee or retiree by an authorized agency or by court order, and children who, before reaching the age of 18, are either adopted by the employee or retiree or placed in the employee's or

retiree's home for adoption. A dependent child must be unmarried and rely on the employee or retiree for over 50% of his or her support.

(c) any child named in a qualified medical child support order for which an eligible employee or retiree is required to provide health coverage.

(d) an unmarried person under age 23 for whom the employee or retiree has legal guardianship under a court order provided:

(1) the person was under the age of 18 at the time the court order was issued,

(2) the person is dependent upon the employee or retiree for over 50% of his or her support,

(3) if the person is not related to the employee or retiree as specified in Internal Revenue Code § 152(d)(2)(A) through (G), the person shares the employee's or retiree's principal place of abode and is a member of the household for the entire year, and

(4) the person is not the "qualifying child" of another individual. For this purpose, the term "qualifying child" is defined in Internal Revenue Code § 152(c).

Eligible dependents do **not** include any person on active duty in the Armed Forces of the United States or any person covered as an employee or retiree under the Dental Plan. If a dependent may claim dependent status by reason of a relationship to more than one eligible employee or retiree, the dependent can only be enrolled as a dependent of one of the eligible employees or retirees.

Any unmarried child (as defined in (b) above) who is a "qualifying child" of any other taxpayer as defined in Code § 152(c) (other than the child's other parent in cases of divorce or separation, as described below) is not an eligible dependent.

Special Rule for Divorce/Separation. The requirement in (b) above that the employee or retiree provide over 50% of a child's support does not apply if (i) the employee or retiree and the child's other parent are divorced or legally separated under a decree of separate maintenance, are separated under a written separation agreement, or currently live apart and lived apart at all times during the last six months of the previous calendar year; (ii) the child receives over 50% of his or her support during the calendar year from his or her parents; and (iii) the child is in the custody of one or both of his or her parents more than 50% of the calendar year.

2.05 Qualified Medical Child Support Orders

If the *County* receives a qualified medical child support order (QMCSO), it shall abide by the terms of that order with respect to health coverage. Any child named in the QMCSO for which an eligible employee or retiree is required to provide health coverage will be enrolled in this *Plan* or an alternate plan offered by the *County*. Any required self-pay contributions for such child(ren) shall be made by the eligible employee or retiree under the same terms and conditions as other self-pay contributions for dependent coverage.

Notwithstanding any other provision of the *Plan*, any payment for benefits made by the *Plan* pursuant to a QMCSO will be made to the custodial parent or legal guardian of the child named in the QMCSO unless a properly completed assignment of benefits is submitted.

2.06 **Enrollment Requirements**

(a) Eligible employees who want coverage under *this Plan* must enroll within 30 days from the start of employment. Retirees must enroll when they complete the *County's* Application for Retirement form. If dependent coverage is desired, eligible dependents must be listed on the initial enrollment form. If enrollment does not take place as stated in this section, enrollment in this *Plan* may only occur during either the *County's* annual open enrollment period as described in Section 2.06(c) or as described in Section 2.06(d).

(b) **New Dependent Acquisition**

If an eligible employee or retiree acquires eligible dependents after his initial enrollment, the dependent(s) must be enrolled within 31 days of the date they are acquired. A newborn dependent child is automatically covered from birth for 31 days. In order for coverage to be continued beyond the first 31 days a completed enrollment form must be submitted to the *County* within the first 31 days following birth. If enrollment does not take place as stated in this section, enrollment in this *Plan* may only occur during either the *County's* annual enrollment period as described in Section 2.06(c) or as described in Section 2.06(d).

(c) **During Annual Open Enrollment**

If an eligible employee or retiree does not enroll himself and/or his eligible dependents in this *Plan* when first entitled to in accordance with subsections (a) and (b) above, he may enroll himself and/or his eligible dependents during the *County's* annual open enrollment period.

(d) **Special Enrollment**

(1) **Newly Acquired Spouse and/or Dependent Child(ren)**

a. **If an Eligible Employee or Retiree is enrolled for individual coverage** under this *Plan* and if he acquires a Spouse by marriage, or if he acquires any Dependent Children by birth, adoption or placement for adoption, he may request enrollment for the newly acquired Spouse and/or any Dependent Child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption.

b. **If an Eligible Employee or Retiree is not enrolled for individual coverage** under this *Plan* and if he acquires a Spouse by marriage, or if he acquires any Dependent Children by birth, adoption or

placement for adoption, he may request enrollment for himself and/or his newly acquired Spouse and/or any Dependent Child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption. If the Eligible Employee or Retiree is not already enrolled for coverage, he must request enrollment for himself in order to enroll a newly acquired Dependent.

c. **If an Eligible Employee or Retiree did not enroll his Spouse for coverage within 31 days of the date on which she became eligible for coverage under this *Plan*,** and if the Eligible Employee or Retiree subsequently acquires a Dependent Child by birth, adoption or placement for adoption, he may request enrollment for his Spouse and/or newly acquired Dependent Child and/or any Dependent Child(ren) no later than 31 days after the date of the newly acquired Dependent Child's birth, adoption or placement for adoption. If the Eligible Employee or Retiree is not already enrolled for coverage, he must request enrollment for him/herself in order to enroll a newly acquired Dependent.

(2) **Loss Of Other Coverage**

If an Eligible Employee or Retiree did not request enrollment under this Plan for himself, his Spouse and/or any Dependent Child(ren) within 31 days after the date on which coverage under the *Plan* was previously offered because he or they had health care coverage under another group health plan or health insurance policy including COBRA Continuation Coverage, certain types of individual insurance, Medicare, Medicaid, or other public program; **and** the Eligible Employee or Retiree, his Spouse and/or any Dependent Child(ren) **lose coverage** under that other group health plan or health insurance policy; he may request enrollment for himself and/or his Spouse and/or any Dependent Child(ren) within 31 days after the termination of coverage under that other group health plan or health insurance policy if that other coverage terminated because:

a. of loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of employee to pay premiums on a timely basis or termination of the other coverage for cause); or

b. of termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right); or

c. the health insurance was provided under COBRA Continuation Coverage, and the COBRA coverage was exhausted; or

d. of moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan; or

e. of the other plan ceases to offer coverage to a group of similarly situated individuals; or

f. of the loss of dependent status under the other plan's terms; or

g. of the termination of a benefit package option under the other plan, unless substitute coverage is offered; or

h. of the loss of eligibility due to reaching the lifetime benefit maximum on all benefits under the other plan. For Special Enrollment that arises from reaching a lifetime benefit maximum on all benefits, an individual will be allowed to request Special Enrollment in this Plan within 31 days after a claim is denied due to the operation of a lifetime limit on all benefits.

(e) **Self-Pay Contribution Requirement**

Enrollment in *this Plan* may require self-pay contributions from *Covered Persons.* If self-pay contributions are required from a *Covered Person* as determined by *County* policy, the *Covered Person* must agree to pay the required contribution under terms set forth by the *County* by completing the appropriate form provided by the *County* for such purpose and returning it to the *County* within the designated time period. The form must be submitted to the *County* at the time of enrollment in this *Plan.*

2.07 **When Coverage Begins**

Coverage begins on the applicable date set forth below.

(a) **New Employee Effective Date Of Coverage**

When the enrollment requirements are met, an eligible employee's coverage begins at the beginning of the month that immediately follows the employee's first pay period of employment in a regular position.

(b) **New Retiree Effective Date Of Coverage**

When the enrollment requirements are met, a qualifying retiree's coverage begins on the first of the month following his date of his retirement or if coverage has been extended in accordance with Section 2.09(d) or (e) of this Article II, on the date the extended coverage ends.

(c) **Dependent Effective Date Of Coverage**

When enrollment requirements are met, coverage for eligible dependents begins, except as provided in 2.06(d) and 2.07(d), on the latest of (1) the date the eligible employee's or retiree's coverage begins, or (2) the first day a dependent becomes an eligible dependent in accordance with Section 2.04 of this Article II.

(d) **Open Enrollment Effective Date Of Coverage**

If a person is eligible to participate in this *Plan,* but chooses instead to either participate in an alternate health plan offered by the *County* or waive health coverage, such person may enroll in this *Plan,* without providing evidence of good health during the *County's* designated annual open enrollment period. Coverage will begin with respect to an eligible employee or dependent of an eligible employee on January 1 provided all enrollment requirements are met. With respect to a qualified retiree or dependent of a qualified retiree, coverage will begin on the January 1 immediately following the open enrollment period provided all enrollment requirements are met.

2.08 **When Coverage Ends**

Coverage ends for a *Covered Person* on the earliest of:

(a) **Employment Terminates**

The last day of the month during which the eligible employee's active employment terminates or otherwise ceases to be regularly scheduled to work unless he qualifies for and elects extended coverage in accordance with Section 2.09 of this Article II or he becomes a qualified retiree and elects coverage under this *Plan* in accordance with Section 2.06(a) of this Article II.

(b) **Contributions Cease**

With respect to coverage for which self-pay contributions are required, on the last day of the month in which the period for which the last self-pay contribution is made if the subsequent self-pay contribution is not made.

(c) **Not Eligible To Participate**

With respect to eligible employees, on the last day of the month during which the employee ceases to meet the definition of an eligible employee; with respect to eligible dependents, the end of the month during which the dependent ceases to meet the definition of a dependent. Such *Covered Persons* may be entitled to elect extended coverage in accordance with Section 2.09 of this Article II.

(d) **Termination Or Amendment Of The Plan**

On the date of complete termination of this *Plan* or upon the effective date of an *amendment* to the *Plan* which excludes such *Covered Person* from such status. Upon termination of *the Plan,* the extension of coverage provisions set forth in Section 2.09 shall cease and the coverage of individuals then covered under such extensions

shall terminate as of the date *of Plan* termination, except as specifically provided under Section 2.09(c).

(e) **Dependents**

As of the date coverage for the eligible employee from which he derives his dependent status terminates.

(f) **Alternative Coverage**

With respect to a *Covered Person* who changes his health care option during the *County's* open enrollment period, as of the date coverage under the newly selected health care option becomes effective.

(g) **Voluntary Termination**

With respect to eligible employees, on the last day of the month following the date the *County* receives written authorization from the eligible employee to terminate his health coverage. Eligible employees are not permitted to maintain medical only coverage (no dental) or dental only coverage (no medical) except medical coverage only is permitted for their dependents.

With respect to qualified retirees, on the last day of the month following the date the *County* receives written authorization from the qualified retiree to terminate his health coverage. Qualified retirees and their dependents are permitted to maintain medical only coverage (no dental) but may not maintain dental only coverage (no medical). However, if dental coverage is voluntarily terminated by a qualified retiree, such coverage cannot be reinstated or added at a later date (even during an annual open enrollment).

2.09 **Special Situations, Extension Of Coverage**

(a) **Dependent Child**

If a dependent child is *Physically or Mentally Handicapped* on the date coverage would otherwise end because of age, the child's eligibility will be extended for as long as the eligible employee or qualifying retiree is a *Covered Person,* the handicap continues and the child continues to qualify for coverage in all aspects other than age. The *Plan* may require, at any time, a physician's statement certifying the *Physical or Mental Handicap.*

(b) **Leave Of Absence**

Employees may continue coverage during a leave of absence provided they continue bi-weekly contributions as agreed upon with the *County* and comply with the applicable provisions of *County* Leave of Absence Policy. If an employee is on an approved leave of absence, the *County* will continue to pay its portion of the employee's premium for the term described in the *County's* Leave of Absence

Policy. During an approved leave of absence the payment of the premiums for dependent coverage will remain the responsibility of the employee.

(c) **Uniformed Services Employment And Reemployment Rights Act (USERRA)**

If an eligible employee is covered under *this Plan* immediately prior to being called to active duty by any of the uniformed services of the United States of America, coverage of the eligible employee and his or her dependents may be continued for the period of the eligible employee's service in the uniformed services provided such employee pays any required contribution toward the cost of the coverage during the leave.

Whether or not an eligible employee elects continuation coverage under the Uniformed Services Employment and Reemployment Rights Act, coverage will be reinstated, without providing evidence of good health, on the first day he returns to *active employment* with the *County* if he is released under honorable conditions and returns to employment: on the first full business day following completion of his military service for a leave of 30 days or less; within 14 days of completing his military service for a leave of 31 to 180 days; or within 90 days of completing his military service for a leave of more than 180 days (a reasonable amount of travel time or recovery time for an *Illness* or *Injury* determined by the Veterans Administration to be service connected will be allowed). When coverage under this *Plan* is reinstated, all provisions and limitations of this *Plan* will apply to the extent that they would have applied if he had not taken military leave and his coverage had been continuous under this *Plan.* Any eligibility-waiting period will be waived as if he had been continuously covered under this *Plan* from his original effective date. This waiver of limitations does not provide coverage for any *Illness* or *Injury* caused or aggravated by military service, as determined by the Veterans Administration.

(d) **COBRA Continuation Coverage**

1. **Rights To COBRA Continuation Coverage**

A *Covered Person* may continue as a *Covered Person* without interruption if such status would otherwise terminate because of a *Qualifying Event,* subject to satisfying the notice, application and premium payment requirements of this Section 2.09(d).

2. **Notice Obligations**

The eligible employee, retiree or former dependent must inform the *County* in writing of a divorce, legal separation or a child losing dependent status under the *Plan* within 60 days after the later of:

a. the date the event occurred; or

b. the date *Covered Person* status would otherwise terminate as a result of the event.

If written notification of the event is not submitted to the *County* as specified above, continuation coverage will not be available to the individual(s) whose *Plan* coverage terminates as a result of the event.

The *County* shall determine if there has been a termination of employment, reduction of employment hours or death of an eligible employee or retiree.

Within 14 days of receiving notice from the eligible employee or retiree of a *Qualifying Event* involving divorce, legal separate, or a child losing eligibility as a covered dependent, the *County* shall notify each potential COBRA participant of the right to elect continuation coverage. If the Qualifying Event involves the employee's reduction of hours or termination, or death, the *County* shall notify each potential COBRA participant of the right to elect continuation coverage within 44 days of the date coverage is lost as a result of the Qualifying Event.

3. **Type of Coverage**

A COBRA participant may continue his "Standard Health Benefits" only, or both "Standard Health Benefits" and "Supplemental Health Benefits". In no event may a COBRA participant continue "Supplemental Health Benefits" only unless such person was covered for supplemental health benefits only immediately preceding the *Qualifying Event.*

The term "Standard Health Benefits" as used herein means all medical, prescription drug and vision care benefits provided to similarly situated *Covered Persons* for whom a *Qualifying Event* has not occurred.

The term "Supplemental Health Benefits" as used herein means the dental benefits provided to similarly situated *Covered Persons* for whom a *Qualifying Event* has not occurred.

If Supplemental Health Benefits are not elected at the time an election is made for initial continuation coverage, they cannot be elected at a later date except during the *County's* annual open enrollment.

Nothing in this Section 2.09(d)3 shall be interpreted to give a COBRA participant the right, at the time continuation coverage is elected, to change his coverage options from those in effect for him on the day preceding the day coverage would otherwise terminate as a result of the *Qualifying Event* except the right to reject Supplemental Health Benefits.

4. **Application for Continuation Coverage**

In order to continue coverage under the COBRA extension, the former *Covered Person* must apply for continuation coverage by properly completing an election form provided by the *County* and returning such form to the *County* within 60 days after the later of:

a. the date the *Covered Person* ceased to be such by reason of the *Qualifying Event;* or

b. the date the election form is sent to the potential COBRA participant.

If a properly completed election form is not submitted to the *County* as specified above, continuation coverage will not be available to the individual(s) whose coverage terminated as a result of the *Qualifying Event.*

5. **Payment of Continuation Coverage**

COBRA participants must pay the applicable premium for continuation coverage. The amount of the monthly premium shall be furnished to potential COBRA participants at the same time as the election form. Payment of the required premium must be made on the following basis:

a. all premium payments must be made by money order, cashier's check, or personal check;

b. the initial premium payment must be submitted to the *County* within 45 days of the date continuation coverage is elected and must be in an amount sufficient to cover the premiums due retroactive to the date coverage would otherwise terminate through the month the initial payment is made;

c. subsequent premium payments must be made on no less than a monthly basis and are due on the first day of each coverage month.

If the initial premium payment is not submitted to the *County* as specified above, continuation coverage will not be available to the individual(s) whose coverage terminated as a result of the *Qualifying Event.*

6. **Change in Coverage Options**

A COBRA participant enrolled who is a Qualified Beneficiary (as that term is defined by law) and who is in continuation coverage has the same rights as other *Covered Persons* with respect to changes in coverage options.

7. **Newly Acquired Dependents**

A Qualified Beneficiary enrolled in continuation coverage may enroll newly acquired eligible dependent(s) under his coverage option upon the proper application and payment of the applicable premium within 31 days from the date dependent status was met.

8. **Loss of Other Group Health Plan Coverage or Other Health Insurance Coverage**

If a Qualified Beneficiary's dependent loses coverage under another group health plan while the Qualified Beneficiary is enrolled in the COBRA extension, such dependents may be enrolled in the COBRA extension for the balance of the Qualified Beneficiary's COBRA extension period provided:

a. The dependent's other group health plan or health insurance program coverage was terminated due to-loss of eligibility for coverage or the employer ceased making contributions for said coverage; and

b. The Qualified Beneficiary requests coverage for the dependent under *this Plan* not later than 30 days after he lost coverage under the other group health plan or health insurance program.

9. **Maximum Period of Continuing Coverage**

The maximum period of continuation coverage is as follows:

a. 18 months from the date coverage would otherwise end if coverage would have been lost due to the termination of employment (includes retirement) or reduction in hours, except as follows:

(i) if a COBRA participant is totally and permanently disabled as of the date coverage would otherwise end or within 60 days following that date, due to the termination of employment or reduction in hours, the maximum period of continuation coverage for such COBRA participant and his eligible dependents is extended 11 months, to a total of 29 months from the date coverage would have been lost due to the *Qualifying Event,* provided the Social Security Administration determines that he was totally and permanently disabled at the time he would have lost coverage or within 60 days following that date, as a result of the *Qualifying Event* and provided the COBRA participant notifies the *County* in writing of his Social Security disability determination within 60 days after it is made and before the first 18 months of continuation coverage have expired;

(ii) if the eligible employee is enrolled in Medicare (Part A or Part B) as of the date coverage would otherwise end for his dependents due to the termination of employment or reduction in hours, the maximum period of continuation coverage for such dependents who qualify as Qualified Beneficiaries is the longer of 36 months from the date the eligible employee initially enrolled in Medicare or 18 months from the date his dependents' coverage would have been lost due to the *Qualifying Event.*

(iii) if a second *Qualifying Event* occurs during the 18 month coverage period, the maximum period of continuation is extended to 36 months from the date of the initial *Qualifying Event,* but only for those dependents who were Qualified Beneficiaries as of the first *Qualifying Event* and were COBRA participants at the time of the second *Qualifying Event.*

b. For any other *Qualifying Event,* 36 months from the date of the initial *Qualifying Event,* even if multiple *Qualifying Events* occur during the period of continuation coverage.

10. **Termination of COBRA Continuation Coverage**

A COBRA participant's continuation coverage and his consequent status as a *Covered Person* shall terminate on the earliest of the following dates:

a. the first day of the month for which the required applicable premium is not paid within 30 days of when it was due as set forth in Section 2.09(d)5;

b. the date the COBRA participant becomes covered under another group health plan as an employee or otherwise unless that date is before the COBRA participant's initial COBRA election date or the COBRA participant has a pre-existing health condition which is limited or excluded under the other group health plan as determined in the sole and absolute discretion of the *County* and written proof of such circumstances is provided to the *County* within 30 days of the date written proof is requested by the *County,*

c. the date the COBRA participant becomes entitled to Medicare if that date is after the COBRA participant's initial COBRA election date;

d. the date the *County* terminates all group health plans;

e. the last day of the maximum period of continuation coverage as specified in Section 2.09(d)9; or

f. with respect to a totally and permanently disabled COBRA participant (and his eligible dependents) who is extending continuation coverage an additional 11 months in accordance with Section 2.09(d)9a(i), 30 days after the month in which Social Security determines that the COBRA participant is no longer disabled. A COBRA participant must notify the *County* immediately upon receipt of such a Social Security determination.

11. **Effect on Retiree Eligibility**

If, at the time continuation coverage is offered to a potential COBRA participant, he is also eligible to continue coverage as a retiree or dependent of a retiree, an election of continuation coverage by such COBRA participant shall not constitute a

waiver of his right to enroll in this *Plan* as a retiree or a dependent of a retiree upon termination of COBRA continuation coverage.

(e) **Post-COBRA Continuation**

1. **Rights to Post-COBRA Continuation Coverage**

Coverage under this *Plan* may be continued for an employee and spouse in accordance with the following provisions. The employee and spouse may continue coverage on a self-pay basis if:

a. the employee, or the employee on behalf of himself or herself and the spouse, was entitled to and had elected COBRA continuation coverage in accordance with Section 2.09(9)(d);

b. the employee or spouse has not elected to continue coverage under any other available continuation;

c. the employee has worked for the *County* for at least the prior five years;

d. the employee is at least 60 years old on the date employment with the *County* ended; and

e. the employee and spouse meet the foregoing conditions prior to 2005.

2. **Termination of Post-COBRA Continuation**

Post-COBRA Continuation Coverage shall terminate on the earliest of the following dates:

a. the date the individual reaches age 65;

b. the date the individual is covered under any other group program;

c. the date the *County* terminates all group health plans;

d. the date the individual becomes covered by Medicare;

e. the first day of the month for which the required applicable self-pay premium is not paid within 30 days of when it was due as set forth in 2.09(d)5; or

f. for a spouse, five years from the date COBRA coverage ended.

3. **Family and Medical Leave Act**

If an employee qualifies for an approved family or medical leave as defined in the Family Medical Leave Act of 1993 (FMLA), eligibility may continue for the duration of the leave if the employee pays any required contributions towards the cost of coverage. Failure of the employee to make payment within 30 days of the due date will result in the termination of coverage. Subject to certain exceptions, if the employee fails to return to work after the leave of absence, the *County* has the right to recover from the employee any contributions it made towards the cost of coverage during the leave as outlined in the FMLA.

2.10 Waiver of Coverage

Permanent part or full-time employees may waive health coverage by completing a "Waiver of Medical/Dental Coverage" form provided by the *County*. If coverage is waived by an employee, such employee may only enroll in the health coverage during an annual open enrollment period as set for in Section 2.06(c) or if he qualifies, as set forth in Section 2.06(d)

2.11 Certificate of Coverage

When a *Covered Person's* coverage terminates, he will receive a Certificate of Coverage. The Certificate provides information regarding the period of coverage under this *Plan*. This information may be used to reduce or eliminate a pre-existing condition limitation period under a new group health plan under which the former *Covered Person* becomes covered. A former *Covered Person* may also request a copy of the Certificate at any time within 24 months after coverage terminates. If a dependent loses coverage separately from the employee or retiree, a separate Certificate will be provided for the dependent; this Certificate may also be requested within 24 months after the dependent's coverage terminates.

A *Covered Person* may request a certificate by contacting the County of Santa Barbara, Human Resources Department at 805-568-2800, or by writing to the Human Resources Department at 1226 Anacapa Street, Santa Barbara, California 93101. A certificate may also be requested by email to the Human Resources Department at hr@co.santa-barbara.ca.us. The request should include the names of the individuals for whom a certificate is requested (including spouse or domestic partner and dependent children) and the address where the certificate should be mailed.

ARTICLE III. DENTAL BENEFITS

3.01 Dental Deductible

The dental deductible is the amount of covered expenses a *Covered Person* must pay during each *Benefit Year* before the *Plan* will consider expenses for reimbursement. The dental deductible applies to all covered expenses under this Article III unless specifically waived. The individual deductible applies separately to each *Covered Person.* The family deductible applies collectively to all *Covered Persons* in the same family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of that *Benefit Year.*

Any covered *Expenses Expenses Incurred* during the last three months of a *Benefit Year* which are applied toward the dental deductible shall also be applied toward the dental deductible for the next *Benefit Year.*

The dental deductibles are set forth in the *Schedule of Benefits.*

3.02 Benefit Maximums

Plan payments under Article III for each *Covered Person* are limited to certain maximum benefit amounts, whether or not there has been an interruption in coverage or a change in eligibility status (e.g. active to retiree or employee to dependent).

The benefit maximums applicable to Article III are shown in the *Schedule of Benefits.*

3.03 Predetermination of Benefits

If a *Covered Person* is expected to incur covered expenses of more than $300 for a course of treatment, it is recommended that the attending *Dentist* submit to the *Claims Administrator* the proposed course of treatment prior to the actual performance of services.

3.04 Dental Benefits

If a *Covered Person* incurs covered expenses which exceed the dental deductible during a *Benefit Year,* the *Plan* will, subject to the provisions hereafter stated, pay the applicable percentage specified in the *Schedule of Benefits* subject to the benefit maximums.

3.05 Covered Expenses

Covered expenses are *Usual and Customary Charges* made for the services and supplies set forth in Appendix B, Dental Schedule, which are rendered by a *Dentist or Dental Hygienist* under the supervision of a *Dentist* and which are certified by the attending *Dentist* and determined by *the Plan Administrator* to be an *Allowable Dental Procedure.* The following is a summary of covered services and supplies:

(a) **Preventive and Diagnostic Services**

The dental deductible is waived for preventive and diagnostic services listed in this subsection (a).

1. Routine Oral Examination - Preventive dental services including routine oral examination, diagnosis, X-rays and prophylaxis, but not including more than two such examinations per individual in a calendar year.

2. Prophylaxis - limited to two for a *Covered Person* in a *Benefit Year.*

3. Bitewing X-Rays - limited to one set of four for a *Covered Person* in any six month period.

4. Full-Mouth X-Rays - limited to one set for a *Covered Person* in any 24 month period and further limited to *Covered Persons* 12 years of age or older.

5. Other Necessary X-Rays - other x-rays necessary to diagnose a dental condition.

6. Fluoride - topical application of sodium or stannous fluoride for children to age 14.

7. Sealants - topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing decay. Limitation: Pit and fissure sealants are limited to Eligible Dependent children under age 16. Sealant benefits include the application of sealants only to permanent posterior molars with no caries (decay), with no restorations and with the occlusal surface intact. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three (3) years of its application.

(b) **Basic Services**

1. Space Maintainers

2. Study Models

3. Biopsy/Tissue Examination

4. Emergency Palliative Treatment - examination in connection with emergency palliative treatment.

5. Consultations - examinations for consultation purposes.

6. Injections of Antibiotics - injections of antibiotic drugs by the attending *Dentist.*

7. Desensitizing Medications - application of desensitizing medications.

8. Tooth Extractions

9. *Oral Surgery* - as provided in the Dental Schedule.

10. Fillings - other than gold

11. Endodontic Treatment

12. Periodontal Treatment

(c) **Major Services**

1. Gold Foil Restorations

2. Inlays and Onlays

3. Crowns

4. Initial Installations of/or Addition to Fixed Bridgework or Full or Partial Dentures - initial installation of/or addition to fixed bridgework (including wing attachments, inlays and crowns as abutments) to replace natural teeth which are extracted while the individual is a *Covered Person,* provided the denture or bridgework includes the replacement of a tooth so extracted and the installation is performed within 12 months of the extraction.

5. Temporary Bridges

6. Pins/Posts

7. Stress Breakers

8. Repair or Re-cementing of Crowns. Inlays, and Onlays

9. Adjustment or Replacement of Fixed Bridgework or Full or Partial Dentures - Adjustment or replacement of fixed bridgework or full or partial dentures after they have been installed for more than 5 years provided the individual has been a *Covered Person* for at least 2 consecutive years or has been covered under another County dental plan for 2 consecutive years.

10. Tissue Condition - Tissue conditioning in connection with dentures.

11. Repair of Dentures/Bridgework

12. Orthodontic Treatment - Necessary services related to orthodontic treatment including, but not limited to, tooth extractions or related surgeries, x-rays, records, and appliances. For purposes of this *Plan,* any services or supplies

related to temporomandibular joint dysfunction including surgery shall be considered orthodontic treatment and is only payable under the *Plan's* orthodontic benefits.

3.06 **Exclusions**

Article III benefits are not provided for any of the items listed below, regardless of dental necessity or recommendation of a health care provider.

(a) Any portion of a charge which exceeds the *Usual and Customary Charge* for the geographic area in which services are rendered.

(b) Any service, supply or treatment which does not meet the recommended standards accepted by the American Dental Association (ADA).

(c) Services rendered by anyone other than a *Dentist* or *Dental Hygienist* under the supervision of a *Dentist.*

(d) Services or supplies which are primarily cosmetic or *Experimental/Investigational* in nature.

(e) Complications arising from any non-covered services or treatment.

(f) Services or supplies covered under any other benefits provided by the *County.*

(g) Any course of treatment which begins prior to the date an individual becomes a *Covered Person.*

(h) Replacement of a lost or stolen prosthetic device.

(i) Medical, surgical or appliance treatment or restoration for malocclusion, prolusion or recession of the mandible, maxillary hyperplasia or maxillary hypoplasia.

(j) Travel expenses of a dental care provider or a *Covered Person.*

(k) Maxillofacial prosthetics.

(l) Any services or supplies not specifically listed in the Dental Schedule.

(m) Appliances for the correction of harmful habits, such as grinding the teeth, thumb sucking, etc.

(n) Behavior management training, educational instruction and materials (including take-home supplies) relating to dietary counseling, personal oral hygiene or dental plaque control.

(o) Treatment, by any means, of jaw joint problems including temporomandibular joint dysfunction syndrome (TMJ) and other craniomandibular disorders, or other

conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues related to that joint except under *the Plan's* orthodontic benefit.

(p) Myofunctional therapy.

(q) Tooth implants (appliances inserted into bone or soft tissue in the jaw, usually to anchor a denture). However, if implants are provided along with a covered prosthodontic appliance, the *Plan* will cover the cost of a standard partial or complete denture toward the cost of implants and the prosthodontic appliances when the prosthetic appliance is completed. If the *Plan* makes such an allowance, it will not pay for any replacement for five years following the completion of the service.

(r) Veneers.

(s) Services and supplies for personalization or characterization of prosthetic devices.

(t) Duplicate prosthetic devices or appliances.

(u) Athletic mouth guards.

(v) Hospital charges.

(w) Occupational *Injuries* or *Illnesses,* provided that the benefits will be extended solely on the terms and conditions specified subsection 3.06(gg) of this Article.

(x) Conditions caused by or arising out of an act of war, armed invasion or aggression.

(y) Any supplies or services (1) for which no charge is made; or (2) for which the *Covered Person* is not required to pay in the absence of *this Plan,* or (3) furnished by a hospital or facility owned or operated by the United States Government or any State Government or any authorized agencies thereof or furnished at the expense of such Governments or agencies except as required by federal law; or (4) which are provided without cost by any municipality or other political subdivision; or (5) court-ordered care (not applicable to benefits received under a Qualified Medical Child Support Order as provided in Article II).

(z) *Injuries* or *Illnesses* which the *Plan Administrator* determines are *Injuries* or *Illnesses* for which payment has been made by a third party, as described in subsection 3.06(gg) of this Article.

(aa) *Injuries* or *Illnesses* which the *Plan Administrator* determines are *injuries* or *Illnesses* for which payment may be made by a third party, as described in subsection 3.06(gg) of this Article, unless and until the *Plan Administrator* determines that subsection 3.06(gg) has been satisfied.

(bb) Services received by a *Covered Person* which are performed by the spouse, child, brother, sister or parent of the *Covered Person* or the *Covered Person's* spouse or are performed by a person who ordinarily resides with the *Covered Person.*

(cc) Care or treatment in any penal institution or jail facility or jail ward of any State or political subdivision.

(dd) Services or supplies resulting from or in connection with an illegal act, occupation or event including the commission of a crime.

(ee) Services or supplies resulting from voluntary self-inflicted *Injury* or *Illness,* unless resulting from an act of domestic violence or medical condition both physical and mental.

(ff) Charges for expenses incurred outside the United States are not covered unless they are for emergency care received while the *Covered Person* is traveling on business or vacation. Proof of payment satisfactory to the *County's Claims Administrator* such as, but not limited to, a copy of the cancelled check, money order or credit card voucher, shall be required for dental treatment or supplies obtained outside the United States when the *Covered Person* pays the provider and files a claim for reimbursement.

(gg) If a *Covered Person* or one claiming damages as a result of a legal relationship with him, e.g., family members, heirs, beneficiaries, personal representatives, or estate, etc., (hereafter "Payee") has had or may have payments inure to his benefit, from whatever source and whether completed or to occur in the future, in whole or in part and whether directly or indirectly, because of injury or illness for which benefits are otherwise provided by the *Plan* (hereafter "Payments"), such benefits shall be excluded from coverage by the *Plan* unless and until the Payee shall fulfill the *Plan* requirements set forth below. The Payee receiving the payments need not be the one receiving the benefit - it is enough that he receive payment, in whole or in part and whether directly or indirectly, because of injury or illness to a *Covered Person* for whom benefits are otherwise available. The Payee is required to:

(i) Execute and deliver to the *Claims Administrator* a lien and authorization to participate. The lien constitutes an acknowledgement of the Payee's obligation to reimburse the *Plan,* to the extent of benefits provided and to be provided by the *Plan,* immediately upon inurement of such payments to his benefit, in accordance with subsection (iii) below. The lien shall attach to any and all payments as defined above. The participation document shall authorize the full participation of the *County* in any and all proceedings or discussions whatsoever relating to payments or the incident, regardless of who may be involved in same, for the purpose of ensuring that the *County's* interest in obtaining proper reimbursement is fully protected. The lien and participation authorization may be filed with any person, organization, or otherwise, including any court of competent jurisdiction, to protect the interest of the *County.*

(ii) The Payee shall take such actions, including filing worker compensation claims, lawsuits and other types of claims and actions, all at his own expense, and execute such documents as the *County* in its sole discretion may require, in order to effectuate, acknowledge and evidence the rights of the *County* as set forth in this subsection 3.06(gg), and shall do nothing to prejudice such rights.

(iii) Payment of Lien: The *County* lien shall be payable from a Payee's "net recovery." "Net recovery" is defined as that amount of any and all payments, as defined above, subtracting the following items if same are payable by the Payee, if such items arose from the incident which resulted in the *Plan* extending benefits, and if the *County* determines them to be reasonable and reasonably necessary in this reimbursement context: (1) all legal costs and expenses to obtain the payments; (2) all costs and expenses for health care not otherwise payable by the *Plan,* (3) all other costs and expenses incurred in generating the payments.

(iv) To the extent that the Payee fails at any time, as determined by the *County* to comply with the provisions of this section, the *County* may refuse to extend any benefits, including future benefits, that would otherwise be provided by the *Plan.* This refusal right extends to all *Covered Persons* to whom the Payee's obligation is traceable.

3.07 Limitations

The Dental Plan benefits described in this booklet are limited as follows:

(a) Routine oral examinations are limited to two for a covered person in a calendar year.

(b) Periodontic evaluations are limited to one for a covered person per calendar year.

(c) Prophylaxis (teeth cleaning) are limited to two for a covered person in a calendar year.

(d) Bitewing x-rays are limited to one set of four for a covered person in any six-month period.

(e) Full mouth x-rays (including panorex) are limited to one set for a covered person in any 24-month period and benefits are available only to covered persons age 12 or over.

(f) Other necessary x-rays (other than bite-wings, full mouth and panorex) are limited to four films in any 12-month period.

(g) Fluoride treatments are limited to children to age 14.

(h) Sealants are limited to one application on first and second permanent molars with no caries (decay) and benefits are limited to children to age 16.

(i) Benefits for initial installation of/or addition to fixed bridgework or full or partial dentures are available only to replace natural teeth extracted while the individual is covered under this Plan provided the denture or bridgework includes the replacement

of a tooth so extracted and the installation is performed within 12 months of the extraction.

(j) Benefits for initial installation of/or addition to implant-supported prosthetics are available only to replace natural teeth extracted while the individual is covered under this Plan provided the implant-supported prosthetic includes the replacement of a tooth so extracted and the installation is performed within 18 months from the extractions.

(k) Benefits for adjustment or replacement of bridgework or full or partial dentures are available only after more than five years have passed since initial installation and the individual has been covered under this Plan or another dental plan provided by the County for two consecutive years.

(l) Services and supplies related to temporomandibular joint dysfunction, including surgery, are only payable under the Plan's orthodontic benefits.

3.08 **Extension of Benefits**

If a *Dentist* certifies that a *Covered Person* is undergoing a course of treatment on the date coverage would otherwise end, Dental Benefits set forth in this Article III will be extended for covered expenses directly related to the completion of the course of treatment until the earliest of (a) the date maximum benefits have been paid, (b) with respect to all benefits except orthodontia, 90 days following the date the *Covered Person's* coverage would otherwise have terminated, or (c) the date the *Plan* is terminated. For purposes of this extension, prophylaxis and x-rays are not considered part of a course of treatment.

ARTICLE IV. COORDINATION OF BENEFITS

4.01 **Benefits Subject to this Provision.** All benefits described in Article III are subject to the following additional provisions and limitations.

4.02 **Definitions**

(a) Plan - For purposes of this Article only, the term *"plan"* means (1) group, blanket or franchise insurance, (2) service plan contracts, group practice, individual practice and other pre-payment coverage, (3) labor-management trusteed plans, union welfare plans, or employee benefit organization plans, and (4) any coverage under governmental programs, and any coverage required or provided by any statute, which provides benefits or services for hospital, medical, dental, drug and vision care or treatment.

(b) This Plan - For purposes of this Article only, the term *"this Plan"* means those Articles of *the Plan* which provide and limit Dental Benefits.

(c) Allowable Expense - For purposes of this Article only, the term *"Allowable Expense"* means covered charges for dental care services or supplies for which benefits are provided by *this Plan.* A covered charge for an *Allowable Expense* shall not be more than the amount allowed under *this Plan.*

When a *plan* provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an *Allowable Expense* and a benefit paid.

4.03 **Effect on Benefits**

(a) This provision shall apply in determining the benefits due a *Covered Person* covered under *this Plan,* if, for the *Allowable Expenses* incurred as to such *Covered Person,* the sum of the benefits that would be payable under *this Plan* in the absence of this provision, and the benefits that would be payable under all other *plans* in the absence in them of provisions of similar purpose to this provision, would exceed such *Allowable Expenses.*

(b) When, in accordance with subsection 4.03(c), *this Plan* would determine its benefits after the benefits of another *plan,* then the benefits that would be payable under *this Plan* in the absence of this provision, for the *Allowable Expenses* incurred as to such *Covered Person* shall be reduced to the extent necessary so that the sum of (1) such reduced benefits and (2) all benefits payable for such *Allowable Expenses* under all other *plans,* shall not exceed the total of such *Allowable Expenses.*

When, in accordance with subsection 4.03(c), *this Plan* would determine its benefits before the benefits of another *plan,* then the benefits of *this Plan* shall not be reduced as provided in the preceding paragraph.

Benefits payable under another *plan* include the benefits that would have been payable had claim been duly made for them.

(c) For the purpose of subsection 4.03(b), the rules establishing the order of benefit determination are:

1. *A plan* which covers the person on whose expense claim is based that does not contain a coordination of benefits provision or a provision similar to the intent of a coordination of benefits provision, shall determine its benefits before the benefits of a *plan* which has such a provision.

2. The benefits of a *plan* which covers the person on whose expense claim is based as an active employee shall be determined before the benefits of a *Plan* which covers such person as a laid-off or retired employee or as a dependent.

3. The benefits *of a plan* which covers the person on whose expense claim is based as a dependent of an active employee shall be determined before the benefits *of a plan* which covers such person as a dependent of a laid-off or retired employee.

4. When both *plans* cover the person on whose expense claim is based as a dependent of an active employee, or when both *plans* cover the person on whose expense claim is based as a dependent child of a laid-off or retired employee, the benefits of the *plan* which covers the parent whose birthday (month and day only) occurs first during a calendar year shall be determined before the benefits of the *plan* which covers the parent whose birthday (month and day only) occurs later in the year, except that in the event a father and mother are legally separated or divorced, the following rules shall apply:

   a. the benefits of a *plan* which covers the person on whose expense claim is based as a dependent child of the parent with financial responsibility for the child's medical expenses by virtue of a court decree shall be determined first;

   b. if there is no court decree, the benefits of a *plan* which covers the person on whose expense claim is based as a dependent child of the parent with legal custody shall be determined first;

   c. if there is no court decree and the parent with legal custody has remarried, the order of benefit determination shall be as follows:

      i. the *plan* which covers the parent with legal custody;

      ii. the *plan* which covers the step-parent with legal custody; and

      iii. the *plan* which covers the parent without legal custody.

5. When the *other plan* which covers the person on whose expense claim is based is Medicare, then the benefits of *this Plan* shall be determined before the benefits of Medicare unless the applicable provisions of Federal Law specifically permit otherwise.

6. Payment for benefits with respect to a *Covered Person* will be made in accordance with any assignment of rights made by or on behalf of such *Covered Person* as required by a state plan for medical assistance approved under Section 1912(1)(A) of Title XIX of the Social Security Act, as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993 (a "Medicaid Plan"). The fact that an individual is eligible for or is provided medical assistance under a Medicaid Plan shall not be taken into consideration in the determination or making of any payments to or on behalf of a *Covered Person* under *this Plan.* To the extent that payment has been made under a Medicaid Plan for benefits that would otherwise be payable under *this Plan,* payment from *this Plan* shall be made in accordance with any state law that provides that the state has acquired the rights with respect to a *Covered Person* to such payment.

7. When a person on whose expense claim is based is covered by *this Plan* or another *plan* under the terms of the continuation of coverage requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) and as amended from time to time, then the following order of benefit determination shall be used.

   a. the *plan* covering the person on a basis other than that of a Qualified Beneficiary under the terms of COBRA (or a dependent of a Qualified Beneficiary) pays benefits before the *plan* covering the person as a Qualified Beneficiary) (or a dependent of a Qualified Beneficiary);

   b. When both *plans* cover the person as a Qualified Beneficiary under the terms of COBRA (or a dependent of a Qualified Beneficiary), the *plan* which has covered the person for the longer period of time pays benefits before *the plan* which has covered him the shorter period of time.

   c. When the rules set forth in subsection 4.03(c) do not establish an order of benefit determination, the benefits of a *plan* which has covered the person on whose expense claim is based for the longer period of time shall be determined before the benefits of a *plan* which has covered such person the shorter period of time.

   d. When this provision operates to reduce the total amount of benefits otherwise payable as to a *Covered Person* under *this Plan,* each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit *of this Plan.*

4.04 **Right to Receive and Release Necessary Information**

For the purpose of determining the applicability of and implementing the terms of this provision of *this Plan* or any provision of similar purpose of any other *plan,* the *Claims Administrator* may, with the consent of the *Covered Person,* release to or obtain from an insurance company or other organization or person any information, with respect to any person, which the *Claims Administrator* deems to be necessary for such purposes. Any *Covered Person* claiming benefits under *this Plan* shall furnish to the *Claims Administrator* such information as may be necessary to implement this provision.

4.05 **Facility of Payment**

Whenever payments which should have been made under *this Plan* in accordance with this provision have been made under any other *plan, this Plan* shall have the right in its sole discretion to pay any organization making such payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under *this Plan* and to extent of such payments, the *County* shall be fully discharged from liability under *this Plan.*

4.06 **Right of Recovery**

Whenever payments have been made by *this Plan* with respect to *Allowable Expense* in a total amount, at any time, in excess of the maximum amount of payment necessary at the time to satisfy the intent of this provision, the *County* shall have the right to recover such payments to the extent of such excess, from among one or more of the following, as the *County* shall determine: (1) any person to or for or with respect to whom such payments were made, or (2) any other *plan.*

ARTICLE V. GENERAL PROVISIONS

5.01 Upon receipt of written proof satisfactory to the *Claims Administrator,* covering the occurrence, character and extent of the event for which claim is made, all dental benefits rendered by a *PPO Provider* will be paid by the *Plan* to the *PPO Provider* and all other benefits described in Article III will be paid by the *Plan* to the *Covered Person* as they accrue.

5.02 Benefits payable hereunder shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person: however, any *Covered Person* may direct that benefits due him be paid to any other provider of dental services or supplies in consideration for dental services rendered.

5.03 Benefits will be paid by *the Plan* only if notice of claim is made within one year from the date on which expenses with respect to which claim is made were first incurred, unless the *County* finds that there were extenuating circumstances which prevented a timely filing.

5.04 In the event the *County* determines that the *Covered Person* is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the *Covered Person* has not provided the *Claims Administrator* or the *County* with an address at which he can be located for payment, the *Claims Administrator* may during the lifetime of the *Covered Person* pay any amount otherwise payable to the *Covered Person* to the spouse or to a relative by blood of the *Covered Person,* or to any other person or institution determined by the *Claims Administrator* to be equitably entitled thereto. In the event of the death of the *Covered Person* before all amounts payable under Article III have been paid, the *Plan* may provide any such amount to any person or institution determined by the *Claims Administrator* to be equitably entitled thereto. The remainder of such amount shall be paid to one or more of the following surviving relatives of the *Covered Person:* lawful spouse, child or children, mother, father, brothers and sisters, or to the *Covered Person's* estate, as the *County* in its sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of *the Plan* and *County* hereunder to the extent of such payment.

5.05 (a) The *County* is the named fiduciary that has the discretionary authority to control and manage the administration and operation of the *Plan.* The *County* shall have full, exclusive and discretionary authority to prescribe such forms, make such rules, regulations, interpretations and computations, construe the terms of the *Plan* and determine all issues relating to coverage and eligibility for benefits and take such other action to administer the *Plan* as it may deem appropriate, including delegation of discretion to a third party. The *County's* decisions, computations, interpretations and actions shall be final and binding on all persons.

(b) Any claim for benefits under the *Plan* shall be made pursuant to the provisions and procedures as set forth in the *Plan.* No employee, participant, retired employee, beneficiary, dependent, or other person shall have any right or claim to benefits under the *Plan,* or any right or claim to payments from the *Plan,* other than as specified herein. Any disputes as to eligibility, type, amount or duration of benefits or any right or claim to payments from the *Plan* shall be resolved by the *County* under and pursuant to *the Plan,* and its decision of the dispute, right or claim shall be final and binding upon all parties thereto. No action may be brought for benefits under the *Plan* or to enforce any rights thereunder until after the claim therefore has been submitted to and determined by the *County's* Appeals Committee, and only subject to such judicial review as may be required by applicable law.

To the extent that benefits under the *Plan* are provided or administered by an insurance company, health maintenance organization, or other similar organization, no employee or other beneficiary shall have any right or claim to benefits under the *Plan,* except as specified in the policy or policies, or contract or contracts, procured or entered into pursuant to Articles VIII through X. Any dispute as to type, amount or duration of benefits shall be resolved by the appropriate insurance carrier or service organization under and pursuant to the policy or contract, and the employee or other beneficiary shall have no right or claim with respect thereto against the *Plan* or the *County.*

(c) Any person whose application for benefits under the plan has been denied in whole or in part shall be notified by the *Claims Administrator* of such denial in writing within 90 days from receipt of such claim. An extension of time not exceeding 90 days may be required by special circumstances. If so, notice of such extension, indicating what special circumstances exist therefore and the date by which a final decision is expected to be rendered, shall be furnished the claimant prior to the expiration of the initial 90 day period. The notice shall set forth in manner calculated to be understood by the claimant (1) the specific reason or reasons for the denial; (2) specific reference to pertinent *Plan* provisions on which the denial is based; (3) a description of any additional material or information necessary to perfect the claim, and an explanation of why such material or information is necessary; and (4) appropriate information as to the steps to be taken if the claimant wishes to submit his or her claim for review.

(d) Any claimant may request the *Claims Administrator* to review a denial. After the *Claims Administrator* has made a determination on the denial and if the claimant is unsatisfied with that determination, he may then petition the *County* for review of the denial. A petition for review shall be in writing, shall state in clear and concise terms the reason or reasons for disputing the denial, and shall be filed with or received by the *Claims Administrator* within 60 days after the petitioner received notice of the denial. The petition for review shall be accompanied by any and all pertinent documentary material not already furnished by the petitioner. The burden of producing evidence and information in support of the appeal is fully upon the

petitioner and the *County* shall have no duty to make an independent investigation of the claim. All such information and evidence shall be provided by petitioner to the *Claims Administrator* at the same time the petition for review is filed. A petitioner may request additional time to provide evidence and information and the *County* may grant or deny, in whole or in part, that request in its sole and unrestricted discretion. The *County's* Appeal Committee is empowered, in their sole and absolute discretion, to deny a claim for review on the basis that a petitioner has failed to timely submit sufficient evidence and information in support of the claim. The petitioner or his duly authorized representative shall be permitted to review pertinent documents and submit issues and comments in writing.

(e) Upon good cause shown, the *County's* Appeals Committee shall permit the petition to be amended or supplemented. The failure to file a petition shall constitute a waiver of the claimant's right to review the denial, provided that the *County's* Appeals Committee may relieve a claimant of any such waiver for good cause if application for such relief is made within one year after the date shown on the notice of denial.

(f) A decision by the *County's* Appeals Committee shall be made promptly and not more than 60 days after its receipt of the petition for review unless special circumstances require an extension of time for processing, in which case notice of such extension shall be furnished to the claimant prior to the expiration of the initial 60 day period. A decision shall be rendered as soon as possible, but not later than 120 days after receipt of the petition for review. The petitioner shall be advised of the decision of the *County's* Appeals Committee in writing. The decision shall be written in a manner calculated to be understood by the petitioner and shall include a specific reason for the decision, as well as specific references to the pertinent provisions in *the Plan* on which the decision is based.

(g) The decision of the *County's* Appeals Committee with respect to petition for review shall be final and binding upon all parties, including the applicant, claimant or petitioner and any persons claiming under the applicant, claimant or petitioner. The provisions of this section shall apply to and include any and every claim to benefits provided by the *Plan,* and any claim or right asserted under the *Plan,* regardless of the basis asserted. In performing its review of any claim, the *County's* Appeals Committee is expressly authorized to exercise its unrestricted discretion to interpret any provision of the *Plan* documents, the *Plan* summary, *Plan* description, and any other documentation or testimony relating to the claim.

5.06 The *County,* at its own expense, shall have the right and opportunity to physically examine the person of any *Covered Person* when and so often as it may reasonably require during the pendency of a claim, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law. Proof of claim forms, as well as other forms, and methods of administration and procedure, will be solely determined by the *County.*

5.07 The benefits provided by this *Plan* are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance Laws or similar legislation.

5.08 In the event of any conflict between the provisions contained in this *Plan* and the provisions contained in any agreement or contract with a service provider, the provisions contained in *this Plan* shall prevail.

5.09 All pronouns and any variations thereof refer to and include the masculine, feminine or neuter, singular or plural, as the context may require.

5.10 Headings in *this Plan* are for reference only and shall not affect the interpretation of this *Plan.*

5.11 If any provisions, or any portion of any provision of this *Plan* shall be held invalid or unenforceable, the remaining portions of such provision and the remaining provisions of this *Plan* shall remain valid and enforceable, and the invalid or unenforceable portions or provisions shall remain valid and enforceable as to persons or circumstances unrelated to those as to which there was a holding of invalidity or unenforceability.

5.12 Whenever payments have been made by *the Plan,* at any time, in a total amount in excess of the maximum amount of payment necessary at the time to satisfy the intent of the *Plan* provisions, the *County* shall have the right to recover such payments to the extent of such excess, from among one or more of the following, as the *County* shall determine:

(a) any person to or for or with respect to whom such payments were made, or

(b) any other plan.

ARTICLE VI. AMENDMENT AND TERMINATION

6.01 The *County* expressly reserves the right, in its sole discretion at any time and from time to time:

(a) to terminate *the Plan,* or amend in any respect any provision of *the Plan,*

(b) to alter or postpone the method of payment of any benefit;

(c) to amend or rescind any other provision of the *Plan* documents, or a decision upon a claim or any appeal of a denial of a claim under *the Plan;* and

(d) to delegate any of the foregoing to a committee established and appointed by the *County.*

ARTICLE VII. DISCLAIMER

7.01 None of the benefits described in Article III are insured by any contract of insurance. There is no liability on the *County* to provide payments over and beyond the assets of the *County's* self-funded health care program.

ARTICLE VIII. EMPLOYEE ASSISTANCE PROGRAM

8.01 All *County* employees and qualified retirees covered by a *County* sponsored medical plan and their dependents are eligible for the *County's* employee assistance program (EAP) provided through a third party vendor, regardless of which health care options such individuals are covered by. The terms and conditions of the *County's* EAP are set forth in the contract between the *County* and the applicable third party vendor.

ARTICLE IX. PREPAID MEDICAL BENEFITS

9.01 If an individual is enrolled in one of the *County's* prepaid medical options, such individual will be entitled to benefits under that plan in accordance with the terms and conditions of the applicable group policy between the *County* and the prepaid medical organization.

ARTICLE X. PREPAID DENTAL BENEFITS

10.01 If an individual is enrolled in the *County's* prepaid dental option, such individual will be entitled to benefits under that plan in accordance with the terms and conditions of the group policy between the *County* and the prepaid dental organization.

ARTICLE XI. COMPLIANCE WITH HIPAA

11.01 Purpose.

The provisions of this Article XI are intended to comply with certain administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated thereunder, as they may be amended from time to time (collectively, "HIPAA") specifically, the rules under HIPAA pertaining to: the privacy of Protected Health Information set forth in 45 C.F.R. Subtitle A, Part 164, Subpart E, as it may be amended from time to time (the "Privacy Rule"); and the security of electronic Protected Health Information set forth in 45 C.F.R. Subtitle A, Part 164, Subpart C, as it may be amended from time to time (the "Security Rule"). This Article XI shall be effective as of April 14, 2003 except that Section 11.11 shall be effective as of April 20, 2005.

11.02 Inconsistent Provisions. This Article XI shall supersede any provisions of the *Plan* to the extent those provisions are inconsistent with this Article.

11.03 Definitions

Each capitalized term used in this Article XI that is not otherwise defined in the *Plan* shall have the meaning ascribed to it under HIPAA.

11.04 Required Uses and Disclosures of Protected Health Information.

Except as otherwise set forth herein, the *Plan* (including its Business Associates) or any Health Insurance Issuer may disclose Protected Health Information to the *Plan Administrator* for the following required uses and disclosures:

(a) for disclosure to the Secretary of Health and Human Services, when required by the Secretary for its investigation or determination of the compliance of the Plan with the Privacy Rule; and

(b) for disclosure to a *Covered Person* of that individual's Protected Health Information upon the individual's written request or in appropriate response to an exercise by the *Covered Person* of any other of his or her individual rights with respect to Protected Health Information, all in accordance with the requirements of the Privacy Rule;

(c) for use by the *Plan Administrator* or disclosure to other persons, as required by HIPAA or other applicable law, provided that nothing in this Section 11.04(c) shall permit or require use by, or disclosure of Protected Health Information to, the *Plan Administrator* to the extent such use or disclosure is prohibited by HIPAA.

11.05 Permitted Uses and Disclosures of Protected Health Information.

Except as otherwise set forth herein, the Protected Health Information created or received by the *Plan* (or its Business Associates) or any Health Insurance Issuer providing benefits

under the *Plan* shall be permitted to be disclosed to the *Plan Administrator* (upon receipt from the *Plan Administrator* of a certification that it shall comply with the restrictions as to the use or disclosure of PHI and the other provisions set forth in this Article) for purposes of the plan's administration functions that the *Plan Administrator* performs on behalf of the *Plan*, or as otherwise required by HIPAA, including without limitation:

(a) for Treatment, Payment or Health Care Operations (including, but not limited to, determinations of eligibility, coverage, and cost sharing amounts; coordination of benefits; adjudication of health benefit claims (including appeals and other payment disputes); subrogation of health benefit claims; establishing employee contributions; billing and collection activities; obtaining payment under a contract of reinsurance; medical necessity reviews or reviews of the appropriateness of care or justification of charges; utilization review; population-based activities relating to improving health or reducing health care costs; case management and care coordination; the operation of wellness, prevention and disease management programs; rating provider performance; conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs; business planning and development, such as development or improvement of method of payment or coverage policies; business management and general administrative activities of the *Plan* (including customer service and resolution of internal grievances);

(b) for purposes relating to subpoenas and other court orders;

(c) pursuant to and in accordance with a valid authorization under the Privacy Rule; and

(d) as otherwise permitted by HIPAA.

Nothing in this Section 11.05 shall permit or require the disclosure of Protected Health Information to the *Plan Administrator* to the extent such disclosure is prohibited by HIPAA.

11.06 Requirements of *Plan Administrator*. The *Plan Administrator* shall:

(a) not use or disclose Protected Health Information received from the *Plan* or any Health Insurance Issuer providing benefits under the Plan other than as permitted by the *Plan* document for Plan Administration, or as otherwise required by law;

(b) take reasonable steps to ensure that any agent (including a subcontractor) to whom the *Plan Administrator* provides Protected Health Information received from the *Plan* or any Health Insurance Issuer providing benefits thereunder agrees to the same restrictions and conditions with respect to Protected Health Information as apply to the *Plan Administrator* under this Article XI;

(c) not use or disclose Protected Health Information received from the *Plan* or any Health Insurance Issuer providing benefits under the *Plan*, for employment-related actions or decisions or in connection with any employee benefit plan or

benefit provided by the *Plan Administrator* other than the *Plan* or a health benefit provided under the *Plan*;

(d) report to the *Plan* any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures required or permitted under this Article XI and of which the *Plan Administrator* becomes aware;

(e) make the Protected Health Information of a *Covered Person* available to that individual, upon the individual's written request, in accordance with the requirements of the Privacy Rule;

(f) incorporate amendments of Protected Health Information of a *Covered Person* as and to the extent required by the Privacy Rule;

(g) make available to a *Covered Person* upon the individual's written request, an accounting of disclosures of Protected Health Information as and to the extent required by the Privacy Rule;

(h) make the *Plan Administrator's* internal practices, books and records relating to the use and disclosure of Protected Health Information available to the Secretary of Health and Human Services for determinations as to the compliance of the Plan with HIPAA;

(i) if feasible, return or destroy all Protected Health Information received from the *Plan* or any Health Insurance Issuer providing benefits under the Plan, that the *Plan Administrator* maintains and retain no copies thereof; or, if such return or destruction is not feasible, limit further uses and disclosures of Protected Health Information to the purposes that make the destruction or return infeasible; and

(j) take reasonable steps to ensure that the requirements set forth in Section 11.07 are satisfied with respect to Protected Health Information.

11.07 Access to Protected Health Information.

Access. Access to and use/disclosure of Protected Health Information shall be limited to employees or agents of *Plan Administrator* who perform the functions relating to *Plan* administration on behalf of or in connection with the *Plan*, as described in Sections 11.04 and 11.05, in order to perform such activities. Employees of the *County* who may have access to Protected Health Information include the Director of Human Resources, Employee Benefits Manager, Privacy Officer, and other employees only as needed for administration of the *Plan*.

11.08 Mechanism for Resolving Non-Compliance

Issues regarding non-compliance by persons described in Section 11.07 will be resolved pursuant to the *County's* policy regarding protection of Protected Health Information and the *County's* Human Resources, employee discipline and sanctions and mitigation policies.

11.09 HIPAA Security Measures

The *Plan Administrator* will:

(a) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic Protected Health Information that is created, received, maintained, or transmitted on behalf of the *Plan*,

(b) Ensure that the access provisions discussed in Section 11.07 above, specific to electronic Protected Health Information, are supported by reasonable and appropriate security measures,

(c) Ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect the electronic Protected Health Information, and

(d) Report to the *Plan* any security incident of which it becomes aware concerning electronic Protected Health Information.

Self-Funded Dental Plan Document

As evidence of its adoption of this Self-Funded Dental Plan document, the County of Santa Barbara has caused this instrument to be signed by its officers thereunder duly authorized and its County seal attached hereto.

Executed this ___ day of _____, 2008.

COUNTY OF SANTA BARBARA

By: _____
Salud Carbajal
Chair, Board of Supervisors

Attest:

Michael Brown
Clerk of the Board of Supervisors

By: _____
Deputy Clerk

APPROVED AS TO FORM:
Dennis Marshal
County Counsel

By: _____

APPROVED AS TO FORM:
Robert W. Geis
Auditor-Controller

By: _____

APPENDIX A
SCHEDULE OF BENEFITS

	Benefit/Percent
DENTAL BENEFITS	
(1) Dental Deductible	
Per Individual	$50
Per Family	$100
(2) Benefit Maximums	
Orthodontics	$1,200 in a lifetime
All Other	$1,500 per *benefit year*
(4) Percentage Payable of Covered Expenses	
(a) Preventive and Diagnostic Services (no deductible)	100%
(b) Basic Services	80%
(c) Major Services	60%