COUNTY OF ORANGE
DENTAL PLAN DOCUMENT

Amended and Restated
Effective January 1, 2024

COUNTY OF ORANGE DENTAL PLAN DOCUMENT

The County of Orange Dental Plan (the "Plan") assures that all benefits herein described shall be paid to eligible employees and dependents for dental expenses incurred within the inclusion of this Plan.

The Plan is subject to all terms, provisions and conditions described within this document.

The County of Orange has caused this Plan to take effect as of 12:01 a.m., January 1, 1985, at Santa Ana, California, 92701. This First Amended and Restated Plan becomes effective January 1, 2024.

The Plan will provide benefits in accordance with applicable federal laws including the Consolidated Omnibus Budget Reconciliation Act (COBRA), and the Health Insurance Portability and Accountability Act (HIPAA).

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DEFINITIONS

Terms used throughout this Plan are defined as follows:

Accidental Injury - Definite trauma resulting from a sudden, unexpected and unplanned event, occurring by chance, caused by an independent external source.

Allowable Amount - A contracted Dental Plan Administrator Allowance (as defined below) for the Service (or Services) rendered, or the provider's billed charge, whichever is less. A contracted Dental Plan Administrator Allowance is:

1. The amount a contracted Dental Plan Administrator has determined is an appropriate payment for the Service(s) rendered in the provider's geographic area, based upon such factors as a contracted Dental Plan Administrator's evaluation of the value of the Service(s) relative to the value of other Services, market considerations, and provider charge patterns; or
2. Such other amount as the Network Dentist and a contracted Dental Plan Administrator have agreed will be accepted as payment for the Service(s) rendered; or
3. If an amount is not determined as described in either (1.) or (2.) above, the amount a contracted Dental Plan Administrator determines is appropriate considering the particular circumstances and the Services rendered.

Alternate Benefit Provision (ABP) - A provision that allows benefit paid to be based on an alternate procedure, which is professionally acceptable and more cost effective.

Benefits Administrator - The Benefits Administrator is the entity that the County of Orange contracts with to perform all enrollment and eligibility services for the County of Orange employees. All enrollment and eligibility change requests must be made through this entity.

Calendar Year - A period beginning on January 1 of any year and terminating on January 1 of the following year.

Close Relative - The spouse, Domestic Partner, child, brother, sister, or parent of a Covered Person.

Co-Insurance - The percentage amount that a Covered Person is required to pay for certain Covered Services after meeting any applicable Deductible.

Covered Services (Benefits) - Those services covered by the Plan, including Dental services and supplies described herein which are incurred by a Covered Person. Such services must be incurred by a Covered Person while eligible to receive Benefits under the Plan and recommended by a Dentist. Covered Dental Expenses are subject to the applicable Deductibles and coinsurance listed in the Schedule of Benefits.

Covered Person – Eligible Employee and eligible Dependents enrolled in this Plan, who meet the requirements in the "Individual Plan Coverage Effective Dates" section or an eligible employee on an approved Leave of Absence paying full premiums, and persons enrolled under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985.

Refer to the "Eligibility and Enrollment" section.

Deductible - The Calendar Year amount which you must pay for specific Covered Services that are a Benefit of the Plan before you become entitled to receive certain Benefit payments from the Plan for those Services.

Dental Plan Claims Administrator (Claims Administrator) - A third-party administrator under contract with the County to administer claims for the Plan.

Dentist - A licensed Doctor of Dental Surgery or Doctor of Dental Medicine.

Dependents –

a) Shall include the legally married spouse or legally registered Domestic Partner of the Eligible Employee.

b) Shall include children of the Eligible Employee, spouse, or Domestic Partner. The term "children" shall include natural children, adopted children, stepchildren, and foster children between the ages of birth and 26 years and children for whom the Plan is required to provide coverage under a Qualified Medical Child Support Order (QMCSO).

    1) Shall include a Dependent child after their 26th birthday provided the child (1) was incapable of self-sustaining employment by reason of intellectual disability or physical handicap prior to age 26, and (2) is chiefly dependent upon the Covered Person for support and maintenance. Proof of such incapacity and dependency must be furnished within 31 days following the Dependent's 26th birthday.

Excluded as Dependents under a) and b) are:

1) A spouse that is legally divorced from the Eligible Employee or Domestic Partner that ended the domestic partnership with the Eligible Employee; and
2) Any person(s) while on active duty in any military of any country; however, any person meeting the requirements for service in the uniformed services as defined by Uniformed Services Employment and Reemployment Rights Act (USERRA) may elect to continue coverage under the Plan for up to 24 months, as required under USERRA; and
3) A dependent child employed by the County of Orange as a regular or limited-term employee.
4) Any legally married spouse, Domestic Partner, or child of a Covered Person's eligible Dependent child.

Domestic Partner - An opposite or same sex individual who has legally registered as a Domestic Partner with an Eligible Employee.

Eligible Employee – A regular or limited-term employee of the County scheduled 20 hours or more of work per week that are members of a collective bargaining unit for which this benefit is provided, provisions are described in the Memorandum of Understanding for the unit or in the Personnel and Salary Resolution for non-represented employees and officials.

Experimental Or Investigational in Nature - Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical/dental standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue. Services which require approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered Experimental or Investigational in Nature. Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical/dental standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered Experimental or Investigational in Nature.

Implants - Artificial materials including synthetic bone grafting materials which are implanted into, onto or under bone or soft tissue, or the removal of Implants (surgically or otherwise).

Medical Necessity (Medically Necessary) - Benefits are provided only for Services that are Medically Necessary as defined in this Section.

1. Services which are Medically Necessary include only those which have been established as safe and effective and are furnished in accordance with generally accepted national and California dental standards and which are:

    a. Consistent with the symptoms or diagnosis of the condition; and

    b. Not furnished primarily for the convenience of the Covered Person, the attending Dentist or other provider; and

    c. Furnished in a setting appropriate for delivery of the Service (e.g., a dentist's office).

2. If there are two (2) or more Medically Necessary Services that can be provided for the condition, the Claims Administrator will provide Benefits based on the most cost-effective Service.

Maximum - The greatest dollar amount the Plan will pay for covered procedures in any Calendar Year or lifetime for Orthodontic Benefits.

Network Dentist - A licensed Doctor of Dental Surgery or Doctor of Dental Medicine who has signed a service contract with the Claims Administrator to provide dental services to Covered Person at negotiated or discounted rates.

Non-Network Dentist - A licensed Doctor of Dental Surgery or Doctor of Dental Medicine who has not signed a service contract with the Claims Administrator to provide dental services to a Covered Person at negotiated or discounted rates.

Orthodontic Services (Orthodontics) - Dental Care Services specifically related to necessary services for the treatment for malocclusion and the proper alignment of teeth.

Plan - The Benefits and provisions for payment as described herein as The County of Orange Dental Plan.

Plan Administrator – County of Orange, Chief Human Resources Officer or /her designee Human Resources/Employee Benefits.

Usual, Customary and Reasonable (UCR) - The Maximum charge that the Plan will reimburse for an eligible expense received from a Non-Network Dentist. The UCR rate is the cost for a typical service within a specified region. The UCR rates differ depending on where you receive services. Any amount charged that exceeds UCR will be considered ineligible under this Plan. URC is determined by Claim Administrator's methodology.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY FOR COVERAGE

The County of Orange Dental Plan eligibility requirements for Eligible Employees and their Dependents are described in the definitions section of this document. For employees that are members of a collective bargaining unit for which this benefit is provided, provisions are described in the Memorandum of Understanding for the unit or in the Personnel and Salary Resolution for non-represented employees and officials. The Board of Supervisors may also define employees of other public agencies and jurisdictions as eligible.

ENROLLING FOR COVERAGE:

Procedures and guidelines for enrolling in the Plan are provided to all eligible County employees during the annual open enrollment period and when a qualifying life event is reported to the Benefits Administrator.

INDIVIDUAL PLAN COVERAGE EFFECTIVE DATES:

a. All Eligible Employees upon initiation of the Plan will be covered on the date of inception of the Plan provided they are actively at work on that date or available for work if it is not a scheduled workday on the effective date; otherwise, they will be covered on the first day they are actively at work thereafter.
b. New hire employees in an eligible classification become eligible for coverage on the first of the month following the first 30 days of employment. If an Eligible Employee's date of hire plus 30 days falls on the first of the month, an employee becomes eligible on the 30th day from date of hire.
c. New hire employees who go out on leave of absence prior to satisfying the waiting period for coverage shall not be eligible for coverage until returning to work, unless required by state/federal law. Upon return to work, coverage will become effective the first day of the month following completion the first 30 days of active employment, unless otherwise required by state/federal law.
d. Coverage for a current employee who becomes newly eligible for the Plan is effective the first day of the month following the date they become an Eligible Employee.
e. Dependents shall be covered provided the Eligible Employee makes a formal request via the Benefits Administrator at the time the employee or Dependent is newly eligible. Contributions for coverage may be required.
f. A new Dependent will be deemed to have been enrolled on the date the Dependent becomes eligible for coverage provided that a formal request to the County *via* its Benefits Administrator for coverage is submitted within 30 calendar days of the Dependent's eligibility.

TERMINATION OF COVERAGE

Coverage under the Plan shall terminate on the earliest of the following dates:

a. The date of termination of the Plan; or
b. The last day of the month that membership ceases in an eligible class, or
c. The date all coverage or certain Benefits are terminated on the Covered Person's particular class by modification of the Plan; or
d. The date the Covered Person becomes a full-time active member of the Armed Forces of any country; however, any Covered Person who is absent from work due to service in the uniformed services as defined by USERRA may elect to continue coverage, including their covered Dependents, under the Plan for up to 24 months as required under USERRA; or
e. The date the Covered Person fails to make a required contribution; or.

f. The last day of the month in which a Dependent ceases to be a qualified Dependent as defined under "Dependents" in the Definition Section.

When coverage terminates because of a Leave of Absence during which premiums were not paid for coverage for the employee or Dependents, coverage can be reinstated during the enrollment period allowed under the return from Leave of Absence qualifying life event rules.

Termination of Plan eligibility is subject to regulations under the Consolidated Omnibus Budget Reconciliation Act and regulations requiring extension of benefit eligibility.

SCHEDULE OF BENEFITS

The following Dental Benefits are provided by this Plan and administered by the Claims Administrator. Unless otherwise noted, all Covered Expenses are subject to the applicable Deductible, Coinsurance and other exclusions or limitations expressed herein.

When utilizing Non-Network Dentists, the Covered Person is responsible for all charges incurred that are above UCR amount. When you go to a Non-Network Dentist, you pay any amount above the UCR rate. The Allowable Amount for Non-Network Dentists is based off of the 90th percentile of UCR.

DENTAL BENEFITS	Network	Non-Network
CALENDAR YEAR DEDUCTIBLE (CYD) ▪ Individual ▪ Family	$50 $150	
CALENDAR YEAR MAXIMUM BENEFIT	$2,000 per covered person	
IMPLANT CALENDAR YEAR MAXIMUM BENEFIT	$1,500 per covered person	
ORTHODONTIC MAXIMUM	$1,500 Lifetime per Dependent Child	
COINSURANCE	**The PLAN pays the following percentage of Covered Services after the Covered Person pays the Deductible (except as noted below).** *When utilizing Non-Network Dentists, the Covered Person is responsible for all charges incurred that are above the Usual, Customary and Reasonable (UCR) amount.*	
Diagnostic and Preventive Services	100% (no Deductible)	100% (no Deductible)
Basic Services (CYD Applies)		
Adjunctive	90%	90%
Endodontics	90%	90%
Minor Restorative	90%	90%
Oral Surgery	90%	90%
Periodontics	90%	90%

DENTAL BENEFITS	Network	Non-Network
Major Services (CYD Applies)		
Implants	50%	50%
Major Restorative	50%	50%
Prosthodontics	50%	50%
Orthodontics for Dependent Child	50% (No deductible)	50% (No Deductible)

HOW THE PLAN WORKS

DENTAL PLAN CLAIMS ADMINISTRATOR

The Claims Administrator provides claims administration services for the Plan's Dental Benefits.

BENEFIT YEAR

The benefit year shall be a Calendar Year from January 1 through December 31. The new benefit enhancements will be effective January 1, 2024, and these new benefit provisions will continue to apply on a Calendar Year basis beginning January 1, 2024, and thereafter.

CALENDAR YEAR MAXIMUM BENEFIT

The Plan pays up to the Maximum payment amount as listed below per participant each Calendar Year for Covered Services and supplies (except for Implants and Orthodontic Services). Plan Maximum is set by the Plan Administrator and administered by the Claims Administrator.

Maximum for Covered Services $2,000

IMPLANT CALENDAR YEAR MAXIMUM BENEFIT

The Maximum for covered Implant Services is separate and in addition to the Calendar Year Maximum Benefit listed above. Plan Maximum is set by the Plan Administrator and administered by the Claims Administrator.

Maximum for Covered Implant Services $1,500

ORTHODONTIC MAXIMUM BENEFIT

The Maximum for covered Orthodontic Services is separate and in addition to the Calendar Year Benefit Maximum listed above. Orthodontic Benefits apply to eligible Dependent children through age 18. Orthodontic Services are not a covered benefit for employees or spouses/Domestic Partners.

Lifetime Maximum for Orthodontic Covered Services $1,500

CALENDAR YEAR DEDUCTIBLES

Annually, each Covered Person must satisfy the Calendar Year Deductible before most Covered Dental Expenses are reimbursed by the Plan. Once the Calendar Year Deductible is reached, the Plan pays for covered services according to the Schedule of Benefits. The Calendar Year Deductible is $50 for each

Covered Person in your family, up to a limit of $150 per family. The Deductible applies to all services except for diagnostic and preventive services, enhanced dental Benefits for pregnant women and Orthodontic services.

Expenses for Preventive and Diagnostic services, and Orthodontia, are not subject to the Calendar Year Deductible. Charges in excess of the Allowable Amount do not apply toward the Deductible.

NETWORK DENTISTS

Services rendered by Network Dentists are paid at the percentage of the Allowable Amount as listed in the Summary of Benefits section. Subscribers are responsible for the remaining percentage amount.

NON-NETWORK DENTISTS

Services rendered by Non-Network Dentists are paid at the percentage of the Allowable Amount as listed in the Schedule of Benefits section. Subscribers are responsible for the remaining percentage amount, as well as any charges above the Allowable Amount.

PREDETERMINATION OF BENEFITS

If a proposed dental treatment is expected to cost more than $1,200, the Dentist may submit a treatment plan to the Claims Administrator for review before providing services. The Covered Person and the Dentist will be told what is covered and how much the Covered Person will have to pay.

EXTENSION OF BENEFITS

If the dental Benefit provided for a Covered Person is terminated, the protection will be extended to cover the following dental care received within the next 30 days, provided Benefits would have been paid had the insurance remained in effect:

a. An appliance, or modification of one, for which an impression was taken before termination.
b. A crown, bridge or gold restoration for which the tooth was prepared before termination.
c. Root canal therapy provided the pulp chamber was opened before termination.

COVERED SERVICES AND SUPPLIES

Services are Benefits of the Plan when provided by a Dentist and when necessary and customary as determined by the standards of generally accepted dental practice. The Covered Services and supplies listed below are payable at the applicable Coinsurance percentage of the Allowable Amount as specified under the Schedule of Benefits and are subject to all applicable provisions of the Deductibles, Maximum Benefits, Limitations and Exclusions of the Plan.

DIAGNOSTIC AND PREVENTIVE SERVICES

- Clinical oral examinations, including consultations by a specialist (if diagnostic Service is provided by a Dentist or physician other than the practitioner providing treatment), not more than once in any period of six consecutive months.
- Oral cancer screening not more than once in any period of 12 consecutive months.
  Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures.

- Dental prophylaxis not more than once in any period of six consecutive months.
- Topical application of fluoride not more frequently than once in any period of six consecutive months and only for eligible Covered Persons through the age of 18.
- Periodontal prophylaxis (recall or maintenance visit) not more than a combined total of one periodontal and/or regular prophylaxis per each period of six consecutive months.
- X-rays:
  Bitewing film not more than once in any period of six consecutive months. Full mouth series (includes 10 to 14 periapical x-rays and supplementary bitewing films) not more than once in any period of three years. In applying this three-year limitation, a panoramic x-ray shall be considered a full mouth series. X-rays required to diagnose a specific condition that needs treatment are not subject to limitations stated above.
- Diagnostic casts not more than once in any period of 24 consecutive months. Working models taken in conjunction with a prosthetic or other appliance are not considered to be diagnostic casts.

ENHANCED DENTAL BENEFITS FOR PREGNANT WOMEN

This Plan provides additional or enhanced Benefits for women who are pregnant. When the Benefits below are available, they are not subject to the Calendar Year Deductible and fall under Diagnostic and Preventative Services.

Additional Benefits for women during pregnancy include:

- One additional routine adult prophylaxis including periodontal prophylaxis for gingivitis (Note: This prophylaxis is in addition to the prophylaxis provided under Diagnostic and Preventive Services).
- One periodontal maintenance visit if warranted by a history of periodontal treatment*; and
- One course (up to four quadrants) of periodontal scaling and root planing with a documented existing periodontal condition*.

*Note: If these services are required outside of pregnancy, coverage is available under the periodontics Benefits of this Plan

BASIC SERVICES

Anesthesia - General or intravenous sedation, only when provided in conjunction with a covered oral surgery procedure.

Endodontics - Pulp capping; therapeutic pulpotomy —deciduous teeth only (in addition to restoration); vital pulpotomy - deciduous teeth only; apexification; root canals on permanent teeth only, including pulpotomy or other palliative treatment and necessary X-rays and cultures, but excluding final restoration; root canal therapy; apicoectomy (including apical curettage).

Oral Surgery - Extractions; removal of impacted teeth; radical excision of small (to 1.25 cm) non-malignant lesions; other surgical procedures; includes local anesthesia and routine pre and post operative care.

Palliative - Emergency treatment for relief of pain or swelling to medically stabilize the dental issue or problem and can be used only once per month for same condition.

Periodontics - Emergency treatment including but not limited to periodontal abscess and acute periodontitis; root planing (not prophylaxis); subgingival curettage, debridement, gingival and osseous surgery (including post-surgical visits).

Restorative Dentistry - Amalgam restorations; synthetic restorations (i.e., silicate cement filling, porcelain filling, plastic filling and composite filling); stainless steel crowns when the tooth cannot be restored with a filling material.

Sealants - One treatment in any period of 24 consecutive months per each permanent molar and only for patients through age 17.

Space Maintainers - Includes all adjustments within six months after installation.

MAJOR SERVICES

Cast Restorations - Cast or other laboratory prepared restorations and crowns are covered only when teeth cannot be restored with a filling material. Cast restorations (onlays, and other laboratory prepared restorations); crowns (acrylic, composite glass, porcelain and gold); veneers; post and cores; crown buildups (on vital or non-vital teeth when functionally necessary). There is no coverage for replacement of an existing crown, onlay, or other cast restoration which is less than 5 years old. Repair or recementing of onlays and crowns is covered for six months after installation.

Implants - Calendar Year Maximum benefit of $1,500 for Implants. This maximum is in addition to and separate from the Calendar Year Maximum Benefit for Covered Services. Single tooth implant is offered for initial replacement of any missing single tooth except third molars. Failed implant and third molar replacement is not included. Benefits include the surgical implant placement, bone grafting to the site (if required), abutment that screws into the implant body (if one is utilized) and the prosthetic crown that is supported by the surgical implant. Benefits are provided for the maintenance, repair and removal of the implant.

Prosthetics - Bridges, dentures, partials and relining or rebasing dentures, adding teeth to partial denture to replace extracted teeth, full and partial denture repairs, stay plate, special tissue conditioning per denture (limited to one course of treatment per six-month period). Fees for appliances include adjustments, repairs, and relines for a six-month period following installation. An additional Benefit for one reline per immediate denture is payable during the first six months following installation. There is no coverage for replacement of an existing partial denture, full removable denture, implant or fixed bridgework which is less than 5 years old. Upgrading from a partial denture to fixed bridgework will be payable only if acceptable documentation is presented which clearly demonstrates that the patient's arch cannot be adequately restored with a partial denture.

ORTHODONTIC SERVICES

Orthodontia - Diagnosis and treatment by an orthodontist for the straightening of teeth, up to a lifetime Maximum payment of $1,500 for covered children through age of 18. This Benefit Maximum is in addition to and separate from the Maximum Calendar Year Benefit for Covered Services and supplies provided for dental care. One lifetime Maximum benefit; dual coverage excluded.

LIMITATIONS AND EXCLUSIONS

GENERAL EXCLUSIONS

Unless exceptions to the following general exclusions are specifically made elsewhere under this Plan, this Plan does not provide Benefits with respect to:

1. Charges for services in connection with any treatment to the gums for tumors, cysts, and neoplasms;
2. Charges for Implants or the removal of Implants (surgically or otherwise) and any appliances and/or crown attached to Implants unless your plan provides special implant benefits. Please see the Schedule of Benefits to determine if you have implant benefits;
3. Services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational

disease law or similar legislation. However, if the Plan provides payment for such Services, it shall be entitled to establish a lien upon such other Benefits up to the amount paid by the Plan for the treatment of such injury or disease;

4. Charges for vestibuloplasty (i.e., surgical modification of the jaw, gums and adjacent tissues), and for any procedure, service, or supply including office visits, examination, and diagnosis provided directly or indirectly to treat a muscular, neural, or skeletal disorder, diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include such conditions as temporomandibular joint syndrome (TMJ) and craniomandibular disorders or other conditions of the joint linking the jawbone and the complex of muscles, nerves and other tissues related to that joint;
5. Congenital mouth malformations or skeletal imbalances, including treatment required as the result of orthognathic surgery, Orthodontic treatment, and oral maxillofacial services, associated hospital and facility fees, anesthesia, and radiographic imaging. Congenital anomalies and developmental malformation include but are not limited to: cleft palate; cleft lip; upper or lower jaw malformations (e.g., prognathism); enamel hypoplasia (defective development); fluorosis (a type of enamel discoloration); treatment involving or required by supernumerary teeth; and anodontia (congenitally missing teeth);
6. All prescription and non-prescription drugs;
7. Charges for services performed by a Close Relative or by a person who ordinarily resides in the Covered Person's home;
8. Services, procedures, or supplies which are not reasonably necessary for the care of the Covered Person's dental condition according to broadly accepted standards of professional care or which are Experimental or Investigational in Nature, or which do not have uniform professional endorsement;
9. Services and/or appliances that alter the vertical dimension, including, but not limited to, full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method;
10. Procedures which are principally cosmetic in nature, such as bleaching, veneers, and personalization or characterization of dentures;
11. The replacement of an appliance (i.e., a denture, partial denture, space maintainer, crown, inlay or onlay, etc.) within 5 years of its installation;
12. Myofunctional therapy; biofeedback procedures; athletic mouthguards; precision or semi-precision attachments; denture duplication; treatment of jaw fractures;
13. Orthognathic surgery, including but not limited to, osteotomy, ostectomy, and other services or supplies to augment or reduce the upper or lower jaw;
14. Charges for services in connection with orthodontia, except as listed under Orthodontic Services;
15. Alloplastic bone grafting materials;
16. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable;
17. Extra-oral grafts (i.e., the grafting of tissues from outside the mouth to oral tissues);
18. Any procedure not performed in a dental office setting;
19. Dental services performed in a hospital or any related hospital fee;
20. Any service, procedure, or supply for which the prognosis for long term success is not reasonably favorable as determined by the Claims Administrator and its dental consultants;
21. Services for which the Covered Person is not legally obligated to pay, or for Services for which no charge is made;

22. Treatment as a result of accidental injury including setting of fractures or dislocation;
23. Charges for prosthetic appliances, fixed or removable, which are related to periodontal treatment;
24. Charges for onlays or crowns installed as multiple abutments;
25. Charges for dental appointments which are not kept, except as specified under the Schedule of Benefits;
26. Charges for services incident to any intentionally self-inflicted injury;
27. General anesthesia including intravenous and inhalation sedation, except when of Medical Necessity. General anesthesia is considered medically necessary when its use is:
    a. in accordance with covered oral surgery procedures and generally accepted professional standards; and
    b. not furnished primarily for the convenience of the patient, the attending Dentist, or other provider; or
    c. due to the existence of a specific medical condition;

    Patient apprehension or patient anxiety will not constitute Medical Necessity.

    A contracted Claims Administrator reserves the right to review the use of general anesthesia to determine Medical Necessity;
28. Removal of 3rd molar (wisdom) teeth other than for Medical Necessity. Medical Necessity pertaining to the removal of 3rd molar, (wisdom teeth) is defined as a pathological condition which includes horizontal, mesial or distal impactions, or cystic sequelae. Removal of wisdom teeth due to pericoronitis alone is not a Medical Necessity;
29. Periodontal splinting of teeth by any method including, but not limited to, crowns, fillings, appliances or any other method that splints or connects teeth together;
30. Any service, procedure, or supply which is received or started prior to the patient's effective date of coverage. For the purpose of this limitation, the date on which a procedure shall be considered to have started is defined as follows:
    a. for full dentures or partial dentures: on the date the final impression is taken;
    b. for fixed bridges, crowns, inlays, onlays: on the date the teeth are first prepared;
    c. for root canal therapy: on the later of the date the pulp chamber opened, or the date canals are explored to the apex;
    d. for periodontal surgery: on the date the surgery is actually performed;
    e. for all other services: on the date the service is performed.
31. For services provided by an individual or entity that is not licensed or certified by the state to provide Dental Care Services, or is not operating within the scope of such license or certification, except as specifically stated herein;
32. Charges for saliva and bacterial testing when carries management procedures D0601, D0602 and D0603 are performed.
33. Any and all implant services that have not been prior authorized and approved by a contracted Claims Administrator if your plan provides special implant benefits. Implants that are used as an abutment, double abutment, or bone anchor to support or hold a fixed bridge, orthodontic appliance, removable prosthesis, or oral-maxillofacial prosthesis are not covered.
34. Service (a) furnished by or for the U.S. Government, or (b) furnished by or for any other government unless payment is legally required, or (c) to the extent provided under any governmental program or law under which the individual is, or could be, covered.

35. A denture or fixed bridge involving replacement of teeth extracted before the individual was covered, unless it also replaces a tooth that is extracted while covered, and such tooth was not an abutment for a denture or fixed bridge installed during the preceding five years.

36. Any portion of a charge for a service in excess of the reasonable and customary charge (the charge usually made by the provider) when there is no insurance, not to exceed the prevailing charge in the area for dental care of a comparable nature, by a person of similar training and experience.

ORTHODONTIC LIMITATIONS AND EXCLUSIONS

1. Treatment for a malocclusion that is not causing difficulty in chewing, speech, or overall dental functioning;
2. Surgical Orthodontics (including extraction of teeth) incidental to Orthodontic treatment;
3. Treatment for myofunctional therapy;
4. Changes in treatment necessitated by an accident;
5. Treatment for TMJ (Temporomandibular Joint disorder) or dysfunction;
6. Special Orthodontic appliances, including but not limited to lingual or invisible braces, sapphire or clear braces, or ceramic braces which are considered to be cosmetic;
7. Replacement of lost or stolen appliance or repair of same if broken through no fault of orthodontist;
8. Treatment exceeding 24 months for treatment prior approved by the Claims Administrator as Medically Necessary;
9. In the event of a Covered Person's loss of coverage for any reason, if at the time of loss of coverage, the Covered Person is still receiving Orthodontic treatment during the 24-month treatment period, the Covered Person and not the Plan Administrator will be responsible for the remainder of the cost for that treatment, at the network orthodontist's billed charges, prorated for the number of months remaining;
10. If the Covered Person is reinstated after Cancellation, there are no Orthodontic benefits for treatment begun prior to his or her reinstatement effective date;
11. If the Covered Person elects to use Invisalign® lingual or invisible braces, sapphire or clear braces, additional costs beyond what the Plan will pay for "standard" Orthodontic system of brackets and wires will be paid by the Covered Person.

MEDICAL NECESSITY EXCLUSION

All services must be of Medical Necessity. The fact that a Dentist or other Plan Provider may prescribe, order, recommend, or approve a service or supply does not, in itself, determine Medical Necessity even though it is not specifically listed as an exclusion or limitation, the Plan may limit or exclude Benefits for services which are not of Medical Necessity.

ALTERNATE BENEFIT PROVISION

If dental standards indicate that a condition can be treated by a less costly alternative to the service proposed by the attending Dentist, the dental Plan will pay Benefits based upon the less costly service.

GENERAL LIMITATIONS

The following services, if listed on the Schedule of Benefits, will be subject to limitations as set forth below:

1. One in a six-month period:
   a. periodic oral exam;
   b. routine prophylaxis;
   c. fluoride treatment, for an eligible Covered Person through the age of 18.

d. bitewing x-rays (two sets of single films or one set of two films);
e. recementations if the crown or inlay was provided by other than the original Dentist; not eligible if the Dentist is doing the recementation of a service he/she provided within 12 months;
f. periodontal prophylaxis.

2. One in a 12-month period
   a. denture (complete or partial) and occlusal guard reline;
   b. oral cancer screening;
   c. bitewing x-rays (three films or four films);
   d. filling (per tooth).

3. One in a 24-month period
   a. sealants;
   b. occlusal guards;
   c. diagnostic casts;
   d. gingival flap surgery per quad;
   e. scaling and root planing per quadrant.

4. One in a 36-month period:
   a. mucogingival surgery per area;
   b. osseous surgery per quad;
   c. gingivectomy per quad;
   d. gingivectomy per tooth;
   e. bone replacement grafts for periodontal purposes;
   f. guided tissue regeneration for periodontal purposes;
   g. full mouth series and panoramic;
   h. full mouth debridement;
   i. intraoral x-rays – complete series including bitewings;
   j. panoramic film

5. One in a five-year period:
   a. single crowns and onlays;
   b. single post and core buildups;
   c. crown buildup including pins;
   d. prefabricated post and core;
   e. cast post and core in addition to crown;
   f. complete dentures;
   g. partial dentures;
   h. fixed partial denture (bridge) pontics;
   i. fixed partial denture (bridge) abutments;
   abutment post and core buildups.

6. Space maintainers – only eligible for Covered Persons when used to maintain space as a result of prematurely lost deciduous first and second molars, or permanent first molars that have not, or will never develop; limited to one per arch/quadrant per lifetime;

7. Child fluoride and child prophylaxis – one per six-month period through the age of 18.

8. Caries Risk Management — CAMBRA (Caries Management by Risk Assessment) is an evaluation of a child's risk level for caries (decay). For each risk level the following is covered:
   a. "high risk" will be allowed up to four fluoride varnish treatments during the Calendar Year along with their biannual cleanings;
   b. "medium risk" will be allowed up to three fluoride varnish treatments in addition to their biannual cleanings; and

c. "low risk" will be allowed up to two fluoride varnish treatments in addition to biannual cleanings.

When requesting additional fluoride varnish treatments, the provider must provide a copy of the completed American Dental Association (ADA) CAMBRA form (available on the ADA website);

9. An Alternate Benefit Provision (ABP) may be applied if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the Dentist. For example, an alternate benefit of a partial denture will be applied when there are bilaterally missing teeth or more than 3 teeth missing in one quadrant or in the anterior region. The ABP does not commit the Covered Person to the less costly treatment. However, if the Covered Person and the Dentist choose the more expensive treatment, the Covered Person is responsible for the additional charges beyond those allowed for the ABP;

10. General or IV sedation is covered for:
    a. three or more surgical extractions;
    b. any number of Medically Necessary impactions;
    c. full mouth or arch alveoloplasty;
    d. surgical root recovery from sinus;
    e. medical problem contraindicates the use of local anesthesia;
    f. children under the age of 7 years old.

    General or IV sedation is not a covered Benefit for dental phobic reasons. Deep sedation/general anesthesia is covered for up to one hour per visit;

11. Restorations, crowns, inlays and onlays - covered only if necessary to treat diseased or accidentally fractured teeth and when the tooth cannot be restored with a filling material;

12. Root canal treatment – one per tooth per lifetime;

13. Root canal retreatment – one per tooth per lifetime;

14. For mucogingival surgeries, one site is equal to two consecutive teeth or bounded spaces;

15. Scaling and root planing – covered once for each of the four quadrants of the mouth in a 24-month period. Scaling and root planing is limited to two quadrants of the mouth per visit;

16. You must be age 21 or older to be eligible for dental Implant Benefits due to continued growth and development of the mid face and jaws;

17. Cone Beam CT (D0367) is a Benefit only when placing an Implant. This procedure cannot be used for Orthodontics or Periodontics. This is a once in a lifetime benefit and is limited to projection of upper and lower jaws only.

REDUCTIONS - THIRD PARTY LIABILITY

If a Covered Person is injured or becomes ill due to the act or omission of another person (a "third party"), the Plan shall, with respect to services required as a result of that injury, provide the Benefits of the Plan and have an equitable right to restitution, reimbursement or other available remedy to recover the amounts the Plan paid for services provided to the Covered Person paid by the Claims Administrator on a fee-for-service basis from any recovery (defined below) obtained by or on behalf of the Covered Person, from or on behalf of the third party responsible for the injury or illness or from uninsured/underinsured motorist coverage. This right to restitution, reimbursement or other available remedy is against any recovery the

Covered Person receives as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from uninsured or underinsured motorist coverage, related to the illness or injury (the "Recovery"), without regard to whether the Covered Person has been "made whole" by the Recovery. The right to restitution, reimbursement or other available remedy is with respect to that portion of the total Recovery that is due for the Benefits paid in connection with such injury or illness, calculated in accordance with California Civil Code Section 3040.

The Covered Person is required to:

1. Notify the Claims Administrator in writing of any actual or potential claim or legal action which such Covered Person expects to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and,
2. Agree to fully cooperate with and execute any forms or documents needed to enforce this right to restitution, reimbursement or other available remedies; and,
3. Agree in writing to reimburse the Plan for Benefits paid by the Plan from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage; and,
4. Provide a lien calculated in accordance with California Civil Code section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,
5. Periodically respond to information requests regarding the claim against the third party and notify the Claims Administrator or their representatives, in writing, within 10 days after any Recovery has been obtained.

A Covered Person's failure to comply with items 1 through 5 above, shall not in any way act as a waiver, release, or relinquishment of the rights of the Plan or the Claims Administrator.

COORDINATION OF BENEFITS

Coordination of benefits is designed to provide maximum coverage for dental bills at the lowest cost by avoiding excessive payments.

When a Covered Person who is covered under the Plan is also covered under another group plan, or selected group, or blanket disability insurance contract, or any other contractual arrangement or any portion of any such arrangement whereby the Covered Person is entitled to payment of or reimbursement for dental expenses, such Covered Person will not be permitted to make a "profit" on a disability by collecting benefits in excess of actual cost during any Calendar Year. Instead, payments will be coordinated between the plans in order to provide for "allowable expenses" (these are the expenses that are incurred for services and supplies covered under at least one of the plans involved) up to the Maximum benefit amount payable by each plan separately. In no case will you be entitled to benefits totaling more than 100% of the covered charges incurred or, where this Plan pays primary, the covered charges otherwise payable under this Plan.

Benefits received under the conditions below, will not be coordinated with the benefits of the Plan.

1. If the Covered Person is also entitled to Medi-Cal, the Plan will be primary.
2. If the Covered Person is also covered by another governmental agency, the combined benefits from that coverage and the Plan will equal, but not exceed, what the Plan would have paid if not eligible to receive benefits under that coverage.

ORDER OF BENEFIT DETERMINATION

The following rules determine the order of benefit payments:

When the other plan does not have a coordination of benefits provision it will always provide its benefits first. Otherwise, the plan covering the patient as an Employee will provide its benefits before the plan covering the patient as a Dependent.

The plan which covers the Dependent child of a person whose date of birth, (excluding year of birth), occurs earlier in a Calendar Year, shall determine its benefits before a plan which covers the Dependent child of a person whose date of birth, (excluding year of birth), occurs later in a Calendar Year. If either plan does not have the provisions of this paragraph regarding Dependents, which results either in each plan determining its benefits before the other or in each plan determining its benefits after the other, the provisions of this paragraph shall not apply, and the rule set forth in the plan which does not have the provisions of this paragraph shall determine the order of benefits.

1. In the case of a claim involving expenses for a Dependent child whose parents are separated or divorced, plans covering the child as a Dependent shall determine their respective benefits in the following order:

   First, the plan of the parent with custody of the child; then, if that parent has remarried, the plan of the stepparent with custody of the child; and finally, the plan(s) of the parent(s) without custody of the child.

2. Notwithstanding (1.) above, if there is a court decree which otherwise establishes financial responsibility for the medical, dental or other health care expenses of the child, then the plan which covers the child as a Dependent of the parent with that financial responsibility shall determine its benefits before any other plan which covers the child as a Dependent child.

3. If the above rules do not apply, the plan which has covered the patient for the longer period of time shall determine its benefits first, provided that:

   a. a plan covering a patient as a laid-off or retired Employee, or as a Dependent of such an Employee, shall determine its benefits after any other plan covering that person as an Employee, other than a laid-off or retired Employee, or such Dependent; and

   b. if either plan does not have a provision regarding laid-off or retired Employees, which results in each plan determining its benefits after the other, then the provisions of (a.) above shall not apply.

If the Plan is the primary carrier with respect to a Covered Person, then the Plan will provide its benefits without reduction because of benefits available from any other plan, except that Participating Dentists may collect any difference between their Billed Charges and the Plan's payment, from the secondary carrier(s).

When the Plan is secondary in the order of payments, the Plan's benefits are determined after those of the primary plan and may be reduced because of the primary plan's benefits. In such cases, the Plan pays the lesser of either the amount that it would have paid in the absence of any other coverage, or the enrollee's total out- of-pocket cost payable under the primary plan for benefits covered under the Plan.

When the Plan is secondary in the order of payments, and the Claims Administrator is notified that there is a dispute as to which plan is primary, or that the primary plan has not paid within a reasonable period of time, the Plan will pay the benefits that would be due as if it were the primary plan, provided that the Covered Person (1) assigns to the Claims Administrator or the Plan the right to receive benefits from the other plan to the extent of the difference between the benefits which the Plan actually pays and the amount that the Plan would have been obligated to pay as the secondary plan, (2) agrees to cooperate fully with the Claims Administrator in obtaining payment of benefits from the other plan, and (3) allows the Claims Administrator to obtain confirmation from the other plan that the benefits which are claimed have not previously been paid.

If payments which should have been made under the Plan in accordance with these provisions have been made by another plan, the Claims Administrator may pay to the other plan the amount necessary to satisfy

the intent of these provisions. This amount shall be considered as benefits paid under the Plan and will operate to discharge the Plan from liability to the extent of such payments.

If payments have been made in excess of the Maximum amount of payment necessary to satisfy these provisions of this plan, the Claims Administrator shall have the right to recover the excess from any person or other entity to or with respect to whom such payments were made.

The Claims Administrator may release to or obtain from any organization or person any information which the Claims Administrator considers necessary for the purpose of determining the applicability of and implementing the terms of these provisions or any provisions of similar purpose of any other plan. Any person claiming benefits under the Plan shall furnish the Claims Administrator with such information as may be necessary to implement these provisions.

GENERAL PROVISIONS

CLAIM PAYMENT DETERMINATION

Claims will be processed, paid and applied to Calendar Year Deductible and Calendar Year Maximum Benefits in the order they are received by the Claims Administrator without regard to sequence of dates incurred. Adjustments will not be made for claims received later but with an earlier incurred date to be applied to Deductibles or Maximum payment level.

DETERMINATION OF PAYMENT

If, in the opinion of the Claims Administrator, a valid release cannot be rendered for the payment of any benefit payable, under this Plan, the Claims Administrator may, at its option, make such payment to the individual or individuals as have, in the Claims Administrator's opinion, assumed the care and principal support of the Covered Person and are, therefore, equitably entitled thereto. In the event of the death of the Covered Person prior to such time as all benefit payments due him have been made, the Claims Administrator, may at its sole discretion and option, honor benefit assignments, if any, made prior to the death of such Covered Person.

Any payment made by the Claims Administrator in accordance with the above provisions shall fully discharge the Plan Administrator to the extent of such payments.

ASSIGNMENT

The Covered Person's Benefits may not be assigned except by consent of the Plan Administrator.

RIGHT OF RECOVERY

Whenever payment on a claim has been made in error, the Claims Administrator will have the right to recover such payment from the Covered Person or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. Claims Administrator reserves the right to deduct or offset any amounts paid in error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment of a claim in error include, but are not limited to, payment of Benefits in excess of the Benefits provided by the health plan, payment of amounts that are the responsibility of the Covered Person (Deductibles, Copayment, Coinsurance amounts or similar charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Covered Person's eligibility, or payments on fraudulent claims.

CONFORMITY WITH STATE STATUTES

Any provision of the Plan, which on its Effective Date, is in conflict with the statutes of the jurisdiction of California, which relate to Self-Funded Plans of public entities is hereby amended to conform to the minimum requirements of such statutes.

NOTICE AND PROOF OF CLAIM

Written notice of claim hereunder must be given to the Plan at the claims address printed on the dental identification card (ID card) provided to the Covered Person following their enrollment in the Plan, with particulars sufficient to identify the Covered Person, within 365 calendar days following the date such claim was incurred.

The Claims Administrator upon receipt of notice required by the Plan will furnish to the Covered Person or to any other person notifying the Plan Administrator of claim on such forms as are usually furnished by it for filing proof of claim.

If such forms are not furnished within 15 days after receipt of such notice, the Covered Person shall be deemed to have complied with the requirements of the Plan, as to proof of claim, upon submitting written proof fully describing the occurrence for which claim is made.

Failure to furnish notice or proof of claim within the time provided in the Plan shall not invalidate or reduce any claims if it shall be shown not to have been reasonably possible to furnish such notice or proof and that such notice or proof was furnished as soon as possible.

MISSTATEMENTS AND MISREPRESENTATIONS

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force. If you or your Dependent(s) receive benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation, you may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. If you make any intentional misrepresentation or use fraudulent means concerning eligibility for coverage, changing your existing coverage, or benefits under the Plan, your coverage (and your Dependents' coverage) may be terminated irrevocably (retroactively to the extent permitted by law). Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

CLAIM APPEAL PROCEDURES

If a claim is denied in whole or part, a Covered Person or his authorized representative can request a review of (or "appeal") the denied claim within the time limits set forth below. The review will take into account all comments, documents, records, and other information submitted by the Covered Person relating to the denied claim.

Time Limits – Appeals

The Covered Person or his authorized representative has 180 calendar days from the claim payment date or the date of the notice of denial of benefits to initiate a review or "appeal" with the Claims Administrator.

Appeals of Claims Involving the Benefits of the Plan

Generally, there may be two levels of appeal for claims involving the Benefits of the Plan, other than decisions regarding eligibility matters.

1. Level One Appeal – To initiate a Level One appeal, the Covered Person or his representative should contact the Claims Administrator, in writing, within 180 calendar days from the claim payment date or the date of the notice of denial of Benefits. The appeal must state in clear and concise terms the reason or reasons for the Covered Person's disagreement with the Claim Administrator's claim determination and should include any additional documentation supporting the Covered Person's appeal. The Claims Administrator will provide the Covered Person with a written response to the appeal within 30 calendar days following receipt of the appeal.

2. Level Two Appeal – If the Covered Person is dissatisfied with the Claims Administrator's Level One appeal decision, they may submit a written request for a Level Two appeal to the Claims Administrator within 180 calendar days of receipt of the Claims Administrator's written response to the Level One appeal. The Covered Person will have the option to submit additional information with the Level Two appeal. Level Two appeals will not be reviewed by the person that made the initial determination. The Covered Person will be notified promptly of the findings, but not later than 30 calendar days after receipt of the Covered Person's appeal and a properly executed HIPAA release form.

    - If the Covered Person does not have additional information and disagrees with the outcome, the Covered Person may file a request for External Review by completing and returning an external review application within four months of the Level Two determination letter.

HIPAA PRIVACY AND HIPAA SECURITY

The Health Insurance Portability and Accountability Act of 1996, ("HIPAA"), and the regulations issued thereunder at 45 CFR Parts 160 and 164 ("the HIPAA regulations"), impose privacy and security obligations on group health plans that restrict the use and disclosure of protected health information ("PHI") and electronic protected health information ("ePHI"). The County of Orange as Plan Sponsor, and/or its representative agents (collectively the "County"), desires to permit the Plan (including its Business Associates, health insurance issuers, HMOs, and their agents) to disclose or to provide for or permit the disclosure of protected health information to the County from time to time.

1. **Uses and Disclosures of PHI**. The Plan may disclose a Plan Participant's PHI to the County, for the Plan administration functions under 45 CFR 164.504(a), to the extent not inconsistent with HIPAA regulations. This includes summary health information for the purposes set forth in Section 164.504(f)(1)(ii) and (iii) of the Privacy Rule.

2. **Restriction on Plan Disclosure to the County of Orange**. Neither the Plan nor any of its Business Associates will disclose PHI to the County except upon the Plan's receipt of the County certification that the Plan incorporates the agreements of the County under paragraph 4, except as otherwise permitted or required by law.

3. **Privacy Agreements of the County of Orange**. As a condition for obtaining PHI from the Plan and its Business Associates, the County agrees it will not use or further disclose such PHI other than as permitted by paragraph 2 of this provision, as permitted by 45 CFR 164.508, 45 CFR 164.512, and other sections of the HIPAA regulations, or as required by law;

    a. Ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to the same restrictions and conditions that apply to the County with respect to such information;

b. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the County;

c. Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which the County becomes aware;

d. Make the PHI of a particular Participant available for purposes of the Participant's requests for inspection, copying and amendment, including the incorporation of any amendments to PHI, and to carry out such requests in accordance with HIPAA regulation 45 CFR 164.524 and 164.526;

e. Make the PHI of a particular Participant available for purposes of required accounting of disclosures by the County pursuant to the Participant's request for such an accounting in accordance with HIPAA regulation 45 CFR §164.528;

f. Make the County internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA regulation 45 CFR §164.501(f);

g. If feasible, return or destroy all PHI received from the Plan that the County maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the County agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

h. Ensure that there is adequate separation between the Plan and the County by implementing the terms of subparagraphs 5.i. (1) through (3), below:

(1) *Employees With Access to PHI*: The employees or other individuals under the control of the County that are the individuals that may access PHI received from the Plan are referenced within section 6.02 (c) in the HIPAA Policies and Procedures Manual, including but not limited to County Benefits staff and select Human Resources staff members.

(2) *Use Limited to Plan Administration*: The access to and use of PHI by the individuals described in (1), above, is limited to Plan Administration functions as defined in HIPAA regulation 45 CFR §164.504(a) that are performed by the County for the PLAN.

(3) *Mechanism for Resolving Noncompliance*: If the County determines that any person described in (1), above, has violated any of the restrictions described in this provision, then such individual shall be subject to discipline or sanctions in accordance with the practices of the County, taking into account the Privacy Rules standards. The County shall document such discipline or sanctions as required under the Privacy Rules, including the requirement that such documentation be retained for six years.

4. **Security Agreements of the County of Orange**. As a condition of obtaining e-PHI from the Plan, its Business Associates, Insurers and HMOs, the County agrees it will:

a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that the County creates, receives, maintains, or transmits on behalf of the Plan;

b. Ensure that the adequate separation between the Plan and County as set forth in 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures.

c. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information.

d. Report to the Plan any Security Incident of which it becomes aware. "Security Amendment" shall mean unauthorized access to, use, disclosure, modification, or destruction of, or interference with ePHI.

e. Upon request from the Plan, the County agrees to provide information on unsuccessful unauthorized access, use, disclosure, modification, or destruction of ePHI, to the extent such information is available to the County.

5. **Breach Notifications**. Following the discovery of a Breach of unsecured PHI caused by the County or its agents, the County or its agents shall provide a written notification in plain language of the breach to all individuals whose unsecured PHI has been breached in accordance with 45 CFR § 164.404. A breach is the same definition as stated in 45 CFR 164.402. The County or its agent's notification must include the following information, to the extent possible:

   a. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;

   b. A description of the types of Unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

   c. Any steps individuals should take to protect themselves from potential harm resulting from the breach;

   d. A brief description of what the County or its agent is doing to investigate the breach, to mitigate harm to individual, and to protect against any further breaches; and

   e. Contact procedures for individual to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, Web site, or postal address.

6. **Definitions**. All capitalized terms within this provision not otherwise defined by the provisions of this provision shall have the meaning given them in the Plan or, if no other meaning is provided in the Plan, the term shall have the meaning provided under HIPAA Privacy Rule or the HIPAA Security Rule.

SIGNATURE PAGE

The effective date of benefits, as described in this Plan Document is January 1, 2024.

It is agreed by the County of Orange that the provisions contained in this Dental Plan Document are acceptable and will be the basis for the administration of said County of Orange Dental Plan described herein.

IN WITNESS WHEREOF, the County of Orange has executed this Dental Plan Document this twelfth day of September 2024.

COUNTY OF ORANGE

By: 

Name: Kim Derrick

Title: Director of Employee Benefits-Human Resource Services