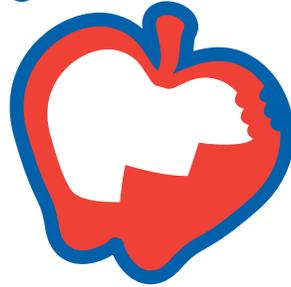


# Healthy Steps



**North Dakota's  
Children's Health  
Insurance Plan**

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## DENTAL BENEFIT PLAN



**Dental Service  
Corporation**  
of North Dakota



# **The Dental Service Corporation of North Dakota**

## **Healthy Steps**

### **Dental Benefit Plan**

The Healthy Steps Children's Health Insurance Program was created by the 1999 Legislature (N.D. Cent. Code §50-29) to provide health assistance to low-income children of the state. The Dental Service Corporation of North Dakota (DSC) has entered into an agreement with Blue Cross Blue Shield of North Dakota (BCBSND) to provide benefits and administer dental services for the Healthy Steps program.

In consideration of payment of required premium and acceptance of the membership application by the Department, The Dental Service Corporation of North Dakota (DSC), through an agreement with BCBSND, provides this Benefit Plan, including the membership application, Identification Card, Benefit Plan Attachment and any endorsements, supplements, attachments, addenda or amendments. These documents describe the dental benefits available to the Member Child. No change in this Benefit Plan is valid unless approved by the President of DSC. Changes to provisions will be sent to the address of the Member Child or the Member Child's Parent as shown on DSC records by mail no less than 31 days prior to the effective date of change.

**THE DENTAL SERVICE CORPORATION  
OF NORTH DAKOTA**

A handwritten signature in black ink that reads "Timothy Huck". The signature is written in a cursive style with a long horizontal stroke at the beginning.

Its President



## **MEMBER SERVICES**

### **Questions?**

Our Member Services staff is available to answer questions about your coverage -

### **Call Member Services:**

Monday through Friday  
7:30 a.m. - 5:00 p.m. CST

(701) 277-2227

or

1-800-342-4718

### **Office Address and Hours:**

You may visit our Home Office during normal business hours -

Monday through Friday  
8:00 a.m. – 4:30 p.m. CST

The Dental Service Corporation of North Dakota  
4510 13th Avenue South  
Fargo, North Dakota 58121

### **Mailing Address:**

You may write to us at the following address -

The Dental Service Corporation of North Dakota  
4510 13th Avenue South  
Fargo, North Dakota 58121

### **Internet Address:**

[www.nd.gov/humanservices/services/medicalserv/chip](http://www.nd.gov/humanservices/services/medicalserv/chip)

### **District Offices:**

We invite you to contact our District Office closest to you -

**Fargo District Office**  
4510 13th Avenue South  
(701) 282-1149

**Jamestown Office**  
300 2nd Avenue Northeast  
Suite 132  
(701) 251-3180

**Bismarck District Office**  
1411 Mapleton Avenue  
(701) 223-6348

**Dickinson Office**  
150 West Villard, Suite 2  
(701) 225-8092

**Grand Forks District Office**  
American Office Park  
2810 19th Avenue South  
(701) 795-5340

**Devils Lake Office**  
425 College Drive South, Suite 13  
(701) 662-8613

**Minot District Office**  
1308 20<sup>th</sup> Avenue Southwest  
(701) 858-5000

**Williston Office**  
1137 2nd Avenue West, Suite 105  
(701) 572-4535

### **Provider Directories:**

Members can obtain a Provider Directory by calling the telephone number on the back of the Identification Card.



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## **INTRODUCTION**

Benefits described in this Benefit Plan are available to Member Children and cannot be transferred or assigned.

The Member Child will receive an Identification Card displaying the Benefit Plan Number and other information about this Benefit Plan. Carry the Identification Card at all times. If the Identification Card is lost, contact DSC to request a replacement.

Allowing another individual to use your Identification Card is prohibited. If you do so, you will be investigated by the fraud and abuse unit of the North Dakota Department of Human Services which could lead to civil or criminal sanctions and termination of coverage by the Department.

Present your Identification Card to your Dentist to identify yourself as a Member Child. Participating Dentists will submit claims on your behalf. You will be notified in writing by DSC of benefit payments made for Covered Services. Please review your Explanation of Benefits and advise DSC if you were billed for services you did not receive.



**SECTION 1  
SELECTING A DENTAL PROVIDER**

**SELECTING A DENTAL PROVIDER**

At the time of enrollment, DSC will provide the Member Child or Member Child's Parent with a list of Participating Dentists and Participating Orthodontic Providers. All care and services must be sought from a Participating Dentist or Participating Orthodontic Provider to be eligible for payment as a Covered Service.

**A. Participating Dentists**

Participating Dentists agree to submit claims to DSC on behalf of the Member Child. Reimbursement for Covered Services will be made directly to the Participating Dentist according to the terms of this Benefit Plan and the participation agreement between the Dentist and DSC.

When Covered Services are received from a Participating Dentist a provider contract is in effect. This means the Allowance paid by DSC will be considered by the Participating Dentist as payment in full, except for Maximum Benefit Allowances or Lifetime Maximums.

**B. Nonparticipating Dentists or Out-of-State Dentists**

No benefits will be provided for services received from a Nonparticipating or out-of-state Dentist. Charges for such services will be the Member Child's or Member Child's Parent's responsibility.

**The Member Child's dental care is between the Member Child or the Member Child's Parent and the Member Child's Dentist. The ultimate decision on the Member Child's dental care must be made by the Member Child or the Member Child's Parent and the Member Child's Dentist. DSC only has the authority to determine the extent of benefits available for Covered Services under this Benefit Plan.**

**SECTION 2  
COVERED SERVICES**

The benefit amounts specified below only apply to Covered Services received from a Participating Dentist.

**Covered Services are paid at 100% of Allowed Charge up to a Benefit Period Maximum of \$1,000.** Orthodontic Services do not apply to this Benefit Period Maximum. Orthodontic Services are limited to a lifetime maximum of one orthodontic placement per Member Child.

A Treatment Plan is recommended for services exceeding \$1,000. All Orthodontic Services require a Treatment Plan.

The services below are identified in accordance with categorizations established by The American Dental Association. Please retain this Benefit Plan and the Benefit Plan Attachment to determine Covered Services for this Dental Benefit Plan.

DSC shall determine the interpretation and application of the Covered Services in each and every situation.

**CATEGORY 1      DIAGNOSTIC**

- A. Routine oral evaluations allowed twice during a Benefit Period.
- B. Bitewing X-rays allowed once during a Benefit Period, except when part of a full mouth survey.
- C. Full mouth survey allowed once every 3 years.
- D. Panoramic film allowed once every 3 years.
- E. Intraoral periapical X-rays.

**CATEGORY 2      PREVENTIVE**

- A. Prophylaxis allowed 4 times during a Benefit Period.
- B. Topical Fluoride applications allowed twice during a Benefit Period.
- C. Sealants on unfilled, undecayed permanent molars and bicuspids. Benefits are limited to a Lifetime Maximum of 2 sealants per tooth.
- D. Space maintainers.

**CATEGORY 3      RESTORATIVE**

- A. Fillings (pin-retention - limit 2).
- B. Inlays, onlays and Crowns (not part of a fixed partial Denture). Replacement of lost or defective inlays, onlays or Crowns is allowed once every 5 years.
- C. Veneers other than cosmetic are allowed once every 5 years.

**CATEGORY 4      ENDODONTICS**

- A. Pulpotomy, pulp capping, root canal therapy, apicoectomy, root amputation, hemisection, bleaching of endodontically treated anterior permanent teeth.

**CATEGORY 5**      **PERIODONTICS**

- A. Surgical Periodontic evaluation once for each course of treatment.
- B. Gingivectomy, Gingival Curettage, mucogingival surgery, osseous surgery.
- C. Periodontal scaling and root planing.

**CATEGORY 6**      **PROSTHODONTICS (removable)**

- A. Dentures (complete and partial). Replacement of lost or defective Dentures is allowed once every 5 years.
- B. Tissue conditioning twice per treatment sequence for relining or for new or duplicate Dentures.
- C. Relining of immediate Dentures once during the year after insertion.
- D. Relining of complete and partial Dentures other than in item above, allowed once every 3 years.

**CATEGORY 7**      **MAXILLOFACIAL PROSTHETICS**

No benefits are available.

**CATEGORY 8**      **IMPLANT SERVICES**

No benefits are available.

**CATEGORY 9**      **PROSTHODONTICS (fixed)**

- A. Fixed partial Denture. Replacement of lost or defective fixed partial Dentures is allowed once every 5 years.

**CATEGORY 10**      **ORAL AND MAXILLOFACIAL SURGERY**

- A. Simple extractions.
- B. Surgical extractions.
- C. Oral Maxillofacial Surgery including fracture and dislocation treatment, frenulectomy and cyst and abscess diagnosis and treatment.

**CATEGORY 11**      **ORTHODONTICS**

- A. The treatment of improper alignment of biting or chewing surfaces of upper and lower teeth through the installation of orthodontic appliances. Benefits are limited to a lifetime maximum of one orthodontic placement per Member Child.

**CATEGORY 12**      **ADJUNCTIVE GENERAL SERVICES**

- A. Palliative (emergency) treatment of dental pain.
- B. Anesthesia services.
- C. Occlusal guard for treatment of Bruxism allowed once every 3 years.

If, during the course of treatment, a Member Child transfers from the care of one Dentist to another, or if more than one Dentist provides services for the same dental procedure, DSC will only be liable for the amount it would have paid if only one Dentist had provided the service.

If there are alternative courses of treatment, DSC will provide benefits for the most cost-effective treatment.

## **SECTION 3 EXCLUSIONS**

No benefits are available for services listed in this section. The following list is not a complete list. In addition to these general exclusions, limitations and conditions there may be others that apply to specific Covered Services that can be found in the Covered Services section and elsewhere in this Benefit Plan. If a benefit or service is not covered, then all services, treatments, devices or supplies provided in conjunction with the benefit or services are not covered. If the Member Child receives services listed in this section, the Member Child or the Member Child's Parent will be responsible for the payment of those services. Please read this section carefully before seeking services and submitting claims. Please contact Member Services at the telephone number listed on the back of the Identification Card if you have any questions. DSC shall determine the interpretation and application of the Exclusions in each and every situation.

### **3.1 EXCLUSIONS**

No benefits are available for:

1. Services not prescribed or performed by or under the direct supervision of a Participating Dentist. If services are received from a Nonparticipating Provider, the charges will be the Member Child's or the Member Child's Parent's responsibility.
2. Bacteriologic cultures for the determination of pathological agents.
3. Caries susceptibility tests.
4. Nutritional counseling for the control of dental disease, oral hygiene instruction and personal hygiene and convenience items.
5. Tobacco counseling for the control and prevention of oral disease.
6. Sealants on Deciduous teeth.
7. Interosseous and Endodontic implants.
8. Surgical procedures for isolation of a tooth with a rubber dam.
9. Cosmetic bleaching of discolored teeth.
10. Implants for Dentures.
11. Replacement of prosthetic appliances.
12. Ridge augmentation.
13. Cleft palate therapy.
14. General Anesthesia for routine procedures. (Benefits for general anesthesia are available under the Healthy Steps health plan when Medically Appropriate and Necessary.)
15. Consultations.
16. House calls.
17. Hospital calls.

18. Office visits either during or after regular scheduled office hours with no operative services performed.
19. Therapeutic drug injections.
20. Prescription medications or drugs or Medicaments. (Benefits are available for prescription medications or drugs under the Healthy Steps health plan when Medically Appropriate and Necessary.)
21. Application of desensitizing Medicaments.
22. Occlusal adjustment (limited/complete).
23. Enamel microabrasion.
24. Treatment of temporomandibular(TMJ) or craniomandibular (CMJ) joint disorders.
25. Behavioral management.
26. Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue.
27. Services not prescribed by or performed by or under the direct supervision of a Dentist and services that are beyond the Dentist's scope of licensure.
28. Services that are Experimental or Investigative.
29. Any services when benefits are provided by a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, similar person or group.
30. Surgery and related services primarily intended to improve appearance and not to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.
31. Charges for failure to keep a scheduled appointment or charges for completion of any forms required by DSC.
32. Appliances or restorations necessary to increase vertical dimensions or to restore an occlusion.
33. Services for which a Member Child incurs no charge.
34. Claims for services that exceed the amount that would have been paid by the Member Child if no coverage existed under the Benefit Plan.
35. Services provided to a Member Child prior to the effective date of the Member Child's Benefit Plan. This includes dental services in progress before and concluded after the effective date of coverage if received as part of an original Treatment Plan.
36. Services when benefits are provided by any governmental unit or social agency, except for Medicaid or when payment has been made under Medicare Part A or B. Medicare Part A and Part B will be considered the primary payor with respect to benefit payments unless otherwise required by law.
37. Services considered inconsistent with accepted dental practices as determined by DSC.

38. Illness or injury caused directly or indirectly by war or an act of war or sustained while performing military services, if benefits for such illness or injury are available under the laws of the United States or any political subdivision thereof.
39. Illness or bodily injury that arises out of and in the course of the Member Child's employment if benefits or compensation for such illness or injury are available under the provisions of a state workers' compensation act, the laws of the United States or any state or political subdivision thereof.
40. Loss caused or contributed by a Member Child's commission or attempted commission of a felony (except losses caused or contributed by an act of domestic violence or any health condition) or a Member Child's involvement in an illegal occupation following the Member Child's enrollment in this Benefit Plan.
41. Complications resulting from noncovered services received by the Member Child.
42. Services that a Member Child or the Member Child's Parent has no legal obligation to pay in the absence of this or any similar coverage.
43. Orthodontic services not received from a Participating Orthodontic Provider.
44. Dental screening assessment programs or dental education services, including all forms of communication media whether audio, visual or written.
45. Services, treatments or supplies that are not specified as a Covered Service under this Benefit Plan.

## **SECTION 4 GENERAL PROVISIONS**

### **4.1 MEMBER CHILD ELIGIBILITY**

The Department determines eligibility for Healthy Steps and furnishes the required information to DSC. Any questions regarding eligibility for Healthy Steps must be directed to the Department. The Department can be reached at 1-800-755-2604.

### **4.2 NOTICE AND PROOF OF CLAIM**

The Member Child or the Member Child's Parent is responsible for providing DSC with written notice and proof of a claim for benefits within 18 months after the occurrence of commencement of a loss for which benefits are available under this Benefit Plan. The written notice and proof of a claim must include the information necessary for DSC to determine benefits.

### **4.3 PAYMENT OF CLAIMS**

Payment of claims will be made upon receipt of written notice of a claim as provided in Section 4.3.

### **4.4 DENTAL EVALUATIONS**

DSC at its own expense may require a dental evaluation of the Member Child as often as necessary during the pendency of a claim.

### **4.5 LIMITATION OF ACTIONS**

No legal action may be brought for payment of benefits under this Benefit Plan prior to the expiration of 60 days following DSC's receipt of a claim for Covered Services or later than 3 years after the expiration of the time within which notice of claim is required by this Benefit Plan.

### **4.6 NOTIFICATION REQUIREMENTS**

The Member Child or the Member Child's Parent is responsible for notifying DSC and the Department of any mailing address change within 31 days of the change.

The Member Child or the Member Child's Parent is responsible for notifying the Department if they move out of the State of North Dakota.

The Member Child's Parent is responsible for notifying the Department, within 31 days, of the birth of a new eligible Member Child.

### **4.7 CANCELLATION OF THIS BENEFIT PLAN**

The Department will determine when this Benefit Plan will be cancelled due to income guidelines currently in effect or eligibility requirements. Coverage will be terminated the end of the month when the Member Child reaches age 19 or when DSC receives notification of termination from the Department.

### **4.8 MEMBER CHILD - PROVIDER RELATIONSHIP**

Benefits are available only upon the recommendation and while under the care and treatment of a Dentist. Nothing herein contained shall interfere with the professional relationship between the Member Child or the Member Child's Parent and his or her Dentist.

Each Member Child or the Member Child's Parent is free to select a Dentist and discharge such Dentist. Dentists are free to provide medical care according to his or her own judgment. Nothing contained in this Benefit Plan will interfere with the ordinary relationship that exists between a Dentist and patient or obligate DSC in any circumstances to supply a Dentist for any Member Child. The provision of medical care and/or the decision not to provide medical care may have a financial impact on the Dentist. The Member Child or the Member Child's Parent should consult with his/her Dentist regarding the nature and extent of such a financial impact, if any, as well as how it might affect medical care decisions.

The Member Child's dental care is between the Member Child or the Member Child's Parent and the Member Child's Dentist, and this Benefit Plan only explains what is or is not covered, not what dental care the Member Child or the Member Child's Parent should seek.

#### 4.9 **CONFIDENTIALITY AND SECURITY**

All Protected Health Information (PHI) maintained by DSC under this Benefit Plan is confidential. Any PHI about a Member Child under this Benefit Plan obtained by DSC from that Member Child, the Member Child's Parent or from a Health Care Provider may not be disclosed to any person except:

- A. Upon a written, dated, and signed authorization by the Member Child or prospective Member Child or by a person authorized to provide consent for a minor or an incapacitated person;
- B. If PHI identifies the Health Care Provider, upon a written, dated, and signed approval by the Health Care Provider. However, DSC may disclose PHI to the Health Care Data Committee for the enhancement of price competition in the health care market. DSC may also disclose to a Health Care Provider, as part of a contract or agreement in which the Health Care Provider is a party, data or information that identifies a Health Care Provider as part of mutually agreed upon terms and conditions of the contract or agreement;
- C. If the data or information does not identify either the Member Child or prospective Member Child or the Health Care Provider, the data or information may be disclosed upon request for use for statistical purposes or research;
- D. Pursuant to statute or court order for the production or discovery of evidence; or
- E. In the event of a claim or litigation between the Member Child, prospective Member Child or the Member Child's Parent and DSC in which the PHI is pertinent.

This section may not be construed to prevent disclosure necessary for DSC to conduct health care operations, including utilization review or management consistent with state law, to facilitate payment of a claim, to analyze health plan claims or health care records data, to conduct disease management programs with Health Care Provider, or to reconcile or verify claims under a shared risk or capitation arrangement. This section does not apply to PHI disclosed by DSC as part of a research project approved by an institutional review board established under federal law. This section does not apply to PHI disclosed by DSC to the insurance commissioner for access to records of DSC for purposes of enforcement or other activities related to compliance with state or federal laws.

DSC has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Member Children's PHI that DSC creates, receives, maintains, or transmits.

#### 4.10 **NOTICE OF PRIVACY PRACTICES**

DSC maintains a Notice of Privacy Practices. This Notice of Privacy Practices outlines DSC's uses and disclosures of PHI, sets forth DSC's legal duties with respect to PHI and describes a Member Child's rights with respect to PHI. Member Children can obtain a Notice of Privacy Practices by contacting Member Services at the telephone number and address on the back of the Identification Card.

## **SECTION 5 APPEALS**

If DSC makes a determination that results in a reduction or denial of benefits, the Member Child, the Member Child's Parent and/or the Member Child's Health Care Provider may appeal the determination. The following appeals process applies:

The Member Child, the Member Child's Parent and/or the Member Child's Health Care Provider has up to 180 days to appeal DSC's benefit determination of a claim for benefits or services. Upon receipt of an appeal from a Member Child, a Member Child's Parent and/or a Member Child's Health Care Provider, DSC will notify the Member Child, the Member Child's Parent and/or the Member Child's Health Care Provider of its determination within a reasonable period of time but no later than 60 days after receiving the Member Child's, the Member Child's Parent and/or the Member Child's Health Care Provider's request for review.

If the Member Child or the Member Child's Parent is not satisfied with a decision on an appeal, the Member Child or the Member Child's Parent has 20 days from the date in which the final adverse decision was made by DSC to appeal that decision to the North Dakota Department of Human Services. The appeal must be in writing and can be sent to the following address:

Appeals Supervisor  
North Dakota Department of Human Services  
600 East Boulevard Avenue  
Bismarck, North Dakota 58505-0250

To inquire on the appeals process, please contact Member Services at the telephone number and address on the back of the Identification Card.

## SECTION 6 OTHER PARTY LIABILITY

This section describes DSC's Other Party Liability programs and coordinating benefits and services when a Member Child has other dental care coverage available, and outlines the Member Child's responsibilities under these programs. DSC shall determine the interpretation and application of the following Other Party Liability provisions in each and every situation.

### 6.1 COORDINATION OF BENEFITS

This provision applies when a Member Child is enrolled under another limited group or individual contract, certificate or plan (plan), whether insured or self-funded, that also provides benefits for services covered under this Benefit Plan. If the sum of benefits payable under this Benefit Plan and the other plan exceed the total charge for Covered Services, the benefits payable under this Benefit Plan will be reduced so the sum of benefits payable under all plans does not exceed 100% of the total charge for Covered Services.

For the purposes of this coordination of benefits provision, the following definitions apply:

"Allowable expense" means a dental care expense, including deductibles, coinsurance and copayments (if required as part of a plan), that is covered at least in part by any plan covering a Member Child. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense not covered by any plan covering a Member Child is not an allowable expense. In addition, any expense that a dental care provider by law or in accordance with a contractual agreement is prohibited from charging a Member Child is not an allowable expense. The following are examples of expenses that are not allowable expenses:

- (1) If a Member Child is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
- (2) If a Member Child is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
- (3) If a Member Child is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different from the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.
- (4) The amount of any benefit reduction by the primary plan because a Member Child has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second opinions, precertifications, and preferred provider arrangements.

"Closed panel plan" means a plan that provides dental care benefits to Member Children primarily in the form of services through a panel of dental care providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other dental care providers, except in cases of emergency or referral by a panel member.

"Custodial parent" means the parent awarded physical custody by a court order or, in the absence of a court order, the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.

- A. Order of Benefits Determination Rules. The order of benefits determination rules govern the order in which this Benefit Plan and another plan will pay benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The secondary plan may reduce the benefits it pays so that the benefits payable under all plans does not total more than 100% of the total allowable expense for Covered Services.

A plan that does not contain a coordination of benefits provision that is consistent with this Benefit Plan's provision is always primary unless the rules of both plans state that this Benefit Plan is primary. An exception exists for coverage that is obtained by virtue of membership in a group that is designed to supplement part of a basic package of benefits and provides that the supplementary coverage shall be excess to any other parts of the plan provided by the policyholder.

If a claim or any other request for reimbursement is submitted under this Benefit Plan the order of payment will be the first of the following rules that apply:

1. Nondependent or dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

However, if the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

- a. Secondary to the plan covering the person as a dependent; and
- b. Primary to the plan covering the person as other than a dependent (e.g., a retired employee).

Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

2. Dependent child covered under more than one plan. Unless there is a court order stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
  - a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
    - (1) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan;  
or
    - (2) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.
  - b. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
    - (1) If a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This paragraph shall not apply with respect to any plan year during which Covered Services are paid or provided before the entity has actual knowledge of the court order provision. A copy of the court order must be provided to DSC upon request;

- (2) If a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Section 6.1(A.)(2.)(a.) shall determine the order of benefits;
  - (3) If a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Section 6.1(A.)(2.)(a.) shall determine the order of benefits; or
  - (4) If there is no court order allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
    - (a) The plan covering the custodial parent;
    - (b) The plan covering the custodial parent's spouse;
    - (c) The plan covering the non-custodial parent; and then
    - (d) The plan covering the non-custodial parent's spouse.
- c. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Section 6.1(A.)(2.)(a.) or Section 6.1(A.)(2.)(b.) as if those individuals were parents of the child.
3. Active employee or retired or laid-off employee. The plan that covers a person as an active employee that is, an employee who is neither laid off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. Also, this rule does not apply if the rule in Section 6.1(A.)(1.) can determine the order of benefits.

4. COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, policyholder or retiree or covering the person as a dependent of an employee, member, subscriber, policyholder or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Also, this rule does not apply if the rule in Section 6.1(A.)(1.) can determine the order of benefits.

5. Longer or shorter length of coverage. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within 24 hours after coverage under the first plan ended.

The start of a new plan does not include:

- a. A change in the amount or scope of a plan's benefits;
- b. A change in the entity that pays, provides or administers the plan's benefits; or
- c. A change from one type of plan to another, such as from a single employer plan to a multiple employer plan.

The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group must be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

6. If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.
- B. If it is determined this Benefit Plan is secondary, the benefits of this Benefit Plan will be reduced so that the total benefits paid or provided by all plans during a Benefit Period are not more than the total allowable expenses. In determining the amount to be paid for any claim, this Benefit Plan will calculate the benefits it would have paid in the absence of coverage under another plan and apply that calculated amount to the allowable expense under this Benefit Plan that is unpaid by the primary plan. The benefits of this Benefit Plan will then be reduced so that they and the benefits payable under the other plans for the claim do not total more than 100% of the total allowable expense for that claim. When the benefits of this Benefit Plan are reduced as described in this subsection, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Benefit Plan. In addition, if this Benefit Plan has a deductible and/or coinsurance, the deductible and/or coinsurance will be credited with any amounts that would have been credited in the absence of the other plan.

The ultimate responsibility of DSC for payment of Covered Services will never exceed the amount payable in the absence of other coverage.

#### RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about dental care coverage and services are needed to administer this coordination of benefits provision and to determine benefits payable under this Benefit Plan and other plans. DSC may obtain the facts it needs from or give them to other organizations or persons for the purpose of administering this provision. DSC need not tell, or obtain the consent of, any person to do this. Each Member Child claiming benefits under this Benefit Plan must provide DSC with any facts it needs to administer this provision and determine benefits payable.

#### FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this Benefit Plan. If it does, DSC may pay that amount to the organization that made the payment. The amount will then be treated as though it were a benefit paid under this Benefit Plan. DSC will not have to pay that amount again.

#### RIGHT OF RECOVERY

If payments have been made by DSC for Covered Services in excess of the amount payable under this Benefit Plan, DSC may recover the excess from any persons to or for whom such payments were made, including any Member Child, provider or other organization. The Member Child agrees to execute and deliver any documentation requested by DSC to recover excess payments.

This provision is administered in accordance with the Coordination of Benefits Regulation adopted by the North Dakota Insurance Commissioner.

### **6.2 AUTOMOBILE NO-FAULT OR DENTAL PAYMENT BENEFIT COORDINATION**

If a Member Child is eligible for basic automobile no-fault benefits or other automobile dental payment benefits as the result of accidental bodily injury arising out of the operation, maintenance or use of a motor vehicle, the benefits available under this Benefit Plan will be reduced by and coordinated with the basic automobile no-fault benefits or other automobile dental payment benefits.

### 6.3 DENTAL PAYMENT BENEFIT COORDINATION

If a Member Child is eligible for medical payment benefits provided by any other collectible insurance as a result of an injury, the benefits available under this Benefit Plan will be reduced by and coordinated with the medical payment benefits provided by any other collectible insurance not prohibited from coordination of benefits.

### 6.4 RIGHTS OF SUBROGATION, REIMBURSEMENT AND ASSIGNMENT

If DSC pays benefits for Covered Services to or for a Member Child for any injury or condition caused or contributed to by the act or omission of any third party, DSC shall have certain rights of assignment, subrogation and/or reimbursement as set forth below. DSC has full discretionary authority to determine whether to exercise any or all of said rights.

**The Member Child or the Member Child's Parent must notify DSC of the circumstances of the injury or condition, cooperate with DSC in doing whatever is necessary to enable DSC to assert these rights, and do nothing to prejudice them. The rights stated herein apply automatically in any applicable situation. DSC has no obligation to notify the Member Child or the Member Child's Parent of DSC's intent to exercise one or more of these rights and DSC's failure to provide such a notice shall not constitute a waiver of these rights.**

If a Member Child or the Member Child's Parent does not comply with these provisions or otherwise prejudices the rights of DSC to assignment, subrogation or reimbursement, DSC shall have full discretion to withhold payment of any future benefits to or for the Member Child and to set off the benefits already paid to or for the Member Child or the Member Child's Parent against the payment of any future benefits to or for the Member Child regardless of whether or not said future benefits are related to the injury or condition.

- A. Right of Assignment and/or Subrogation: If a Member Child or the Member Child's Parent fails to bring a claim against a third party (including any person, firm or corporation which may be liable for or on behalf of the third party), DSC has the right to bring said claim as the assignee and/or subrogee of the Member Child and to recover any benefits paid under this Benefit Plan even if the Member Child has not received full compensation for the injury or condition.
- B. Right of Reimbursement: If a Member Child or the Member Child's Parent makes any recovery from a third party (including any person, firm or corporation which may be liable for or on behalf of the third party), whether by judgment, settlement or otherwise, the Member Child or the Member Child's Parent must notify DSC of said recovery and must reimburse DSC to the full extent of any benefits paid by DSC, not to exceed the amount of the recovery. This right of reimbursement shall apply to any such recovery to the extent of any benefits paid under this Benefit Plan even if the Member Child or the Member Child's Parent has not received full compensation for the injury or condition. Any recovery the Member Child or the Member Child's Parent may obtain is conclusively presumed to be for the reimbursement of benefits paid by DSC until DSC has been fully reimbursed.

The Member Child and the Member Child's Parent agrees to not transfer any right to any recovery to a third party or otherwise attempt to avoid DSC's rights under this Benefit Plan. The Member Child and the Member Child's Parent agrees that any recovery shall be held in trust for DSC until DSC has been fully reimbursed and/or that DSC shall have a lien on any recovery to the full extent of any benefits paid under this Benefit Plan. The Member Child and the Member Child's Parent agrees that to enforce its rights under this section, DSC may pursue any and all remedies, legal or equitable, available under state or federal law, including subrogation, breach of contract, constructive trust, equitable lien, injunction, restitution and any other remedies.

### 6.5 WORKERS' COMPENSATION

If benefits or compensation are available, in whole or in part, under provisions of a state workers' compensation act, laws of the United States or any state or political subdivision thereof, the benefits under this Benefit Plan will be reduced by and coordinated with such other benefits or compensation available to a Member Child.

If a Member Child is injured or suffers any condition caused or contributed to by the Member Child's employment, the Member Child must notify DSC of the circumstances of the injury and condition, cooperate with DSC and the United States or any state or political subdivision thereof in doing whatever is necessary to determine the availability of such benefits or compensation, and do nothing to prejudice them.

In the event of the failure of a Member Child to comply with this provision or if a Member Child prejudices that Member Child's right or entitlement to benefits or compensation available under such a program, DSC shall have full discretion to withhold payment of any future benefits to or for the Member Child and to offset the benefits already paid to or for the Member Child against the payment of any future benefits to or for the Member Child regardless of whether or not said future benefits are related to the injury or condition.

## SECTION 7 DEFINITION OF TERMS

This section defines the terms used in this Benefit Plan. These terms will be capitalized throughout this Benefit Plan when referred to in the context defined. DSC shall determine the interpretation and application of the definitions in each and every situation.

- 7.1 **ABUTMENT** - a tooth or implant used to support a prosthesis.
- 7.2 **ACTIVE APPLIANCE** - an orthodontic treatment device (such as a brace) that actually moves teeth.
- 7.3 **ALLOWANCE OR ALLOWED CHARGE** - the maximum dollar amount that payment for a procedure or service is based as determined by DSC.
- 7.4 **ANESTHESIA** - a medication used for the loss of pain sensation.
- A. local anesthesia (one injection per quadrant per visit).
  - B. analgesia (nitrous oxide).
  - C. general anesthesia (intravenous sedation) when rendered in connection with covered Oral Surgery services by an Anesthesiologist, Nurse Anesthetist or Oral Surgeon.
- 7.5 **BENEFIT MAXIMUM** - the total dollar amount of Covered Services that will be allowed for each Member Child during a Benefit Period or lifetime.
- 7.6 **BENEFIT PERIOD** - a specified period of time when benefits are available for Covered Services under this Benefit Plan. A claim for benefits will be considered for payment only if the date of service or supply was within a Benefit Period. All benefits are determined on a calendar year (January 1 through December 31) Benefit Period.
- 7.7 **BENEFIT PLAN** - includes the Member Child's membership application, Identification Card, this "Healthy Steps Dental Benefit Plan", the Benefit Plan Attachment and any supplements, endorsements, attachments, addenda or amendments. If there is more than one Member Child in a family, the family will receive one "Healthy Steps Dental Benefit Plan". Each Member Child will receive an Identification Card and Attachment.
- 7.8 **BENEFIT PLAN ATTACHMENT** - the statement accompanying the Identification Card that identifies current Benefit Plan information.
- 7.9 **BENEFIT PLAN NUMBER** - the number assigned by DSC and listed on the Identification Card identifying the Member Child for administrative purposes.
- 7.10 **BITEWING** - dental X-rays showing the area around the teeth.
- 7.11 **BRIDGE** - a prosthetic replacement of one or more missing teeth:
- A. a **fixed partial Denture** is cemented or attached to the Abutment teeth or implant Abutments adjacent to the space.
  - B. a **removable partial Denture** (removable Bridge) is cemented or attached to a framework that can be removed by the patient.
- 7.12 **BRUXISM** - the grinding of the teeth.
- 7.13 **CARIES** - a commonly used term for tooth decay.
- 7.14 **CAVITY** - the decay in a tooth caused by Caries.

- 7.15 **CLASS OF COVERAGE** - the type of coverage the Member Child is enrolled under, identifying who is eligible to receive benefits for Covered Services under this Benefit Plan. Class of Coverage is as follows:
- Single Coverage** - Member Child only.
- 7.16 **COVERED SERVICE** - services and supplies that are appropriate and necessary for the treatment of a dental disease or accident for which benefits are available when provided by a Dentist.
- 7.17 **CROWN** - the restoration covering or replacing the major part of a tooth.
- 7.18 **DSC** - The Dental Service Corporation of North Dakota.
- 7.19 **DECIDUOUS** - the primary teeth.
- 7.20 **DENTAL PLAN** - identifies the benefits and outlines the level of reimbursement for benefits available under the Member Child's Benefit Plan.
- 7.21 **DENTIST** - a Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) who is licensed to practice dentistry at the time and place Covered Services are performed.
- A. **Participating Dentist** - any Dentist who has entered into a participation agreement with DSC to provide Covered Services to a Member Child for an agreed upon payment.
- B. **Nonparticipating Dentist** - a Dentist who does not have a participation agreement with DSC.
- C. **Participating Orthodontic Provider** - a Participating Dentist who has signed a Healthy Steps Program Orthodontic Participation Addendum.
- 7.22 **DENTURE** - an artificial substitute for natural teeth and adjacent tissues.
- A. **Immediate Denture** - the prosthesis constructed for placement immediately after the removal of remaining natural teeth.
- B. **Rebase of Denture** - the process of refitting a Denture by replacing the base material.
- C. **Reline of Denture** - the process of resurfacing the tissue side of a Denture with new base material.
- 7.23 **DEPARTMENT** - the North Dakota Department of Human Services, which will pay premiums and determine eligibility and enrollment for the Healthy Steps program.
- 7.24 **ENDODONTICS** - the treatment of disease and injuries of the inner tooth (pulp) and surrounding area.
- 7.25 **EXPERIMENTAL OR INVESTIGATIVE** - the use of any treatment, procedure, facility, equipment, drug, device or supply not accepted as standard dental treatment, as determined by DSC, of a dental disease, condition or injury or any of such items requiring federal or other government agency approval not granted at the time services were provided.
- 7.26 **EXPLANATION OF BENEFITS** - a document sent to the Member Child by DSC after a claim for reimbursement has been processed. It includes the patient's name, claim number, type of service, Dentist, date of service, charges submitted for the services, amounts covered by this Benefit Plan, noncovered services and the amount of the charges that are the Member Child's or the Member Child's Parent's responsibility. This form should be carefully reviewed and kept with other important records.
- 7.27 **FILLING** - a term used for the restoration of lost tooth structure by using materials such as metal, alloy, plastic or cement.
- A. **Amalgam** - the alloy used in direct dental restorations.
- B. **Composite** - a dental restorative material made up of disparate or separate parts.

- 7.28 **FLUORIDE** - a solution that is topically applied to the teeth for the purpose of preventing dental decay.
- 7.29 **GINGIVAL CURETTAGE** - a scraping or cleaning of the walls of a cavity or gingival pocket.
- 7.30 **IDENTIFICATION CARD** - a card issued in the Member Child's name identifying the Benefit Plan Number.
- 7.31 **IMPACTED TOOTH** - an unerupted or partially erupted tooth that is positioned against another tooth, bone or soft tissue so that complete eruption is unlikely.
- 7.32 **INCLUDING** - means including but not limited to.
- 7.33 **LIFETIME MAXIMUM** - the total dollar amount of certain Covered Services an eligible Member Child may receive during a lifetime while enrolled under a Benefit Plan underwritten or administered by DSC. The benefit amounts paid under all previous DSC Benefit Plans will be applied to the Lifetime Maximum for such Covered Services under this Benefit Plan.
- 7.34 **MALOCCLUSION** - the improper alignment of biting and chewing surfaces of upper and lower teeth.
- 7.35 **MEDICAMENTS** - Includes oral antibiotics, oral sedatives and topical fluorides dispensed in the Dentist's office for home use. Prescription medications or drugs are not considered Medicaments.
- 7.36 **MEMBER CHILD(ren)** - a child who meets the eligibility requirements of the Healthy Steps Program as determined by the Department and in whose name the Identification Card and Benefit Plan Attachment are issued.
- 7.37 **MEMBER CHILD'S PARENT** - the person responsible for the care and custody of the Member Child including a natural parent, stepparent, adoptive parent, guardian or custodian of a Member Child as identified by the Department.
- 7.38 **ORAL AND MAXILLOFACIAL SURGERY** - the dental surgical services that are limited to the diagnosis, surgical and adjunctive treatment of diseases, injuries, deformities, defects and aesthetic aspects of the oral and maxillofacial area.
- 7.39 **ORTHODONTIC** - the interception and treatment of Malocclusion of the teeth and their surrounding structures.
- 7.40 **PERIODONTIC** - the practice limited to the treatment of diseases of the supporting or surrounding tissues of the teeth.
- 7.41 **PERMANENT TEETH** - the natural teeth that replace the deciduous or primary teeth.
- 7.42 **PONTIC** - the term used for the artificial tooth on a fixed partial Denture (Bridge).
- 7.43 **PROPHYLAXIS** - the scaling and polishing procedure performed to remove coronal plaque, calculus and stains.
- 7.44 **PROSTHESIS** - any device or appliance replacing one or more missing teeth and, if required, associated structures, including Abutment Crowns and Abutment inlays or onlays, Bridges or Dentures.
- 7.45 **PROTECTED HEALTH INFORMATION (PHI)** - individually identifiable health information, including summary and statistical information, collected from or on behalf of a Member Child that is transmitted by or maintained in electronic media, or transmitted or maintained in any other form or medium and that:
- A. is created by or received from a health care provider, health care employer, or health care clearinghouse;
  - B. relates to a Member Child's past, present or future physical or mental health or condition;
  - C. relates to the provision of health care to a Member Child;
  - D. relates to the past present, or future payment for health care to or on behalf of a Member Child; or
  - E. identifies a Member Child or could reasonably be used to identify a Member Child.

Educational records and employment records are not considered PHI under federal law.

7.46 **TREATMENT PLAN** - a written report prepared by the Participating Dentist that recommends the treatment of a dental disease, defect or injury for a Member Child.