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**WESTERN  
STATES  
HEALTH &  
WELFARE  
TRUST  
FUND OF  
THE OPEIU,  
LOCAL 11**

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**Trust Self-Insured  
Dental Coverage**

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**Evidence of Coverage**

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# Western States Health & Welfare Trust of the OPEIU

## Trust Self-Insured Dental Coverage

### Evidence of Coverage

**Administered by: BeneSys**

This Evidence of Coverage (EOC), in conjunction with the Plan Document and attachments, comprises the complete description of the Trust-sponsored, self-insured Dental programs 10, 11, and 12 provided by the Western States Health & Welfare Trust Fund of the OPEIU. All eligibility requirements and enrollment opportunities defined in the Summary Plan Description document apply equally to this benefit.

Fully-insured dental programs offered by Kaiser Permanente and Willamette Dental Group will be described separately in their own EOCs furnished by the carrier.

There are three different Trust-sponsored self-insured dental plans. Please see your Collective Bargaining Agreement for information about the specific dental coverage provided for you.

When you or your dependents incur expenses for any eligible dental procedure performed by a legally qualified dentist, the Plan will pay the applicable percentages shown in the following schedule of Dental Procedures, not to exceed the Maximum Benefit Amount.

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#### **DENTAL PLAN 10**

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##### **SCHEDULE OF DENTAL PROCEDURES**

1. **Orthodontics:** 50% of reasonable and customary charges.
2. **Basic Services:** 80% of usual and customary and reasonable charges (UCR). Basic services include:
  1. Oral examination, including treatment plan, if necessary.
  2. Periapical and bitewing X-rays as required.
  3. Topical fluoride application for family members under the age of 15.
  4. Prophylaxis, including cleaning, scaling, and polishing.
  5. Repair of dentures and bridges.
  6. Palliative emergency treatment.
  7. Fillings consisting of silver amalgam, silicate, and plastic restoration.
  8. Extractions.
  9. Endodontics, including pulpotomy, pulp capping, and root canal treatment.
  10. Space Maintainers.
  11. Oral surgery consisting of fracture and dislocation treatment, and diagnosis and treatment of cyst and abscess.
  12. Apicoectomy.
3. **Prosthetic Services.** 50% of usual and customary and reasonable charges (UCR). Prosthetic services include:
  1. Inlays / Onlays.

2. Crowns.
3. Bridges, fixed and removable.
4. Dentures, full and partial, except that dental expense benefits for full denture replacement shall not be provided for any denture replacement made less than five years after a denture placement or replacement covered under this plan. Benefits shall be limited to the standard procedures for prosthetic services.

#### **DEDUCTIBLE AMOUNT**

The deductible amount for each covered person during each calendar year is **\$10**.

The deductible applies only once in any calendar year. So that your dental claim will not be subjected to a deductible late in one calendar year and soon again in the following year, any expenses applied against the deductible in the last three months of a calendar year may also be applied against the deductible for the next calendar year.

A separate dental deductible will apply to each insured member of your family, but the maximum deductible per family is **\$30** per calendar year.

#### **MAXIMUM BENEFIT AMOUNT**

The maximum amount payable for all covered dental procedures for each covered person shall not exceed in the aggregate:

1. \$1,000 for orthodontic treatment during the lifetime of each covered person.
2. \$1,500 for all other dental procedures during each calendar year.

The charge for a dental procedure is considered to have been incurred on the day of performance of the procedure (except for certain Orthodontic procedures). If a procedure is not completed in one day, the day upon which the procedure is completed is deemed to be the incurred date for any charges related to that procedure.

## **DENTAL PLAN 11**

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### **SCHEDULE OF DENTAL PROCEDURES**

1. **Orthodontics:** 50% of reasonable and customary charges.
2. **Basic Services:** 80% of usual and customary and reasonable charges (UCR). Basic services include:
  1. Oral examination, including treatment plan, if necessary.
  2. Periapical and bitewing X-rays as required.
  3. Topical fluoride application for family members under the age of 15.
  4. Prophylaxis, including cleaning, scaling, and polishing.
  5. Repair of dentures and bridges.
  6. Palliative emergency treatment.
  7. Fillings consisting of silver amalgam, silicate, and plastic restoration.
  8. Extractions.
  9. Endodontics, including pulpotomy, pulp capping, and root canal treatment.
  10. Space Maintainers.
  11. Oral surgery consisting of fracture and dislocation treatment, and diagnosis and treatment of cyst and abscess.
  12. Apicoectomy.
3. **Prosthetic Services.** 75% of usual and customary and reasonable charges (UCR). Prosthetic services include:
  1. Inlays / Onlays.
  2. Crowns.
  3. Bridges, fixed and removable.
  4. Dentures, full and partial, except that dental expense benefits for full denture replacement shall not be provided for any denture replacement made less than five years after a denture placement or replacement covered under this plan. Benefits shall be limited to the standard procedures for prosthetic services.

### **DEDUCTIBLE AMOUNT**

The deductible amount for each covered person during each calendar year is **\$10**.

The deductible applies only once in any calendar year. So that your dental claim will not be subjected to a deductible late in one calendar year and soon again in the following year, any expenses applied against the deductible in the last three months of a calendar year may also be applied against the deductible for the next calendar year.

A separate dental deductible will apply to each insured member of your family, but the maximum deductible per family is **\$30** per calendar year.

### **MAXIMUM BENEFIT AMOUNT**

The maximum amount payable for all covered dental procedures for each covered person shall not exceed in the aggregate:

1. \$1,000 for orthodontic treatment during the lifetime of each covered person.
2. \$1,500 for all other dental procedures during each calendar year.

The charge for a dental procedure is considered to have been incurred on the day of performance of the procedure (except for certain Orthodontic procedures). If a procedure is not completed in one day, the day upon which the procedure is completed is deemed to be the incurred date for any charges related to that procedure.

## **DENTAL PLAN 12**

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### **SCHEDULE OF DENTAL PROCEDURES**

1. **Orthodontics:** 50% of reasonable and customary charges.
2. **Basic Services:** 80% of usual and customary and reasonable charges (UCR). Basic services include:
  1. Oral examination, including treatment plan, if necessary.
  2. Periapical and bitewing X-rays as required.
  3. Topical fluoride application for family members under the age of 15.
  4. Prophylaxis, including cleaning, scaling, and polishing.
  5. Repair of dentures and bridges.
  6. Palliative emergency treatment.
  7. Fillings consisting of silver amalgam, silicate, and plastic restoration.
  8. Extractions.
  9. Endodontics, including pulpotomy, pulp capping, and root canal treatment.
  10. Space Maintainers.
  11. Oral surgery consisting of fracture and dislocation treatment, and diagnosis and treatment of cyst and abscess.
  12. Apicoectomy.
3. **Prosthetic Services.** 80% of usual and customary and reasonable charges (UCR). Prosthetic services include:
  1. Inlays / Onlays.
  2. Crowns.
  3. Bridges, fixed and removable.
  4. Dentures, full and partial, except that dental expense benefits for full denture replacement shall not be provided for any denture replacement made less than five years after a denture placement or replacement covered under this plan. Benefits shall be limited to the standard procedures for prosthetic services.

### **DEDUCTIBLE AMOUNT**

The deductible amount for each covered person during each calendar year is **\$10**.

The deductible applies only once in any calendar year. So that your dental claim will not be subjected to a deductible late in one calendar year and soon again in the following year, any expenses applied against the deductible in the last three months of a calendar year may also be applied against the deductible for the next calendar year.

A separate dental deductible will apply to each insured member of your family, but the maximum deductible per family is **\$30** per calendar year.

### **MAXIMUM BENEFIT AMOUNT**

The maximum amount payable for all covered dental procedures for each covered person shall not exceed in the aggregate:

1. \$1,000 for orthodontic treatment during the lifetime of each covered person.
2. \$1,500 for all other dental procedures during each calendar year.

The charge for a dental procedure is considered to have been incurred on the day of performance of the procedure (except for certain Orthodontic procedures). If a procedure is not completed in one day, the day upon which the procedure is completed is deemed to be the incurred date for any charges related to that procedure.

## **DENTAL EXCLUSIONS AND LIMITATIONS**

These dental benefits do not cover expenses incurred by reason of:

1. Accidental bodily injury or sickness that arises out of or occurs in the course of any occupation or employment for wage or profit, unless a claim for such a loss has been properly denied by the State Industrial Commission or a private industrial carrier;
2. Expenses incurred with respect to any person while he or she was not covered under the Plan;
3. Expenses incurred for prosthetic devices (including bridges and crowns) and the fitting thereof that were ordered while the person was not insured under the plan, or that were offered while the person was insured under the plan but are finally installed or delivered to such a person more than thirty days after termination of coverage;
4. Expenses incurred for treatment by other than a duly licensed dentist or denturist, except that cleaning or scaling of teeth may be performed by a licensed dental hygienist, if treatment is rendered under the supervision and direction of the dentist;
5. Expenses incurred for any replacement of an existing partial or full removable denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework, unless evidence satisfactory to the plan is presented that:
  - The replacement or addition of teeth is required to replace one or more additional natural teeth extracted while an individual is insured under the plan; or
  - The existing denture, bridgework, crown, or inlay was installed at least five years prior to its replacement and that the existing denture, bridgework, crown, or inlay cannot be made serviceable; or
  - The existing denture is an immediate temporary denture and replacement by a permanent denture is required, and takes place within twelve months from the date of installation of the immediate temporary denture.
6. Expenses incurred for services and supplies that are partially or wholly cosmetic in nature, including charge for personalization or characterization of dentures;
7. Expenses incurred for replacement of a lost, stolen, or broken prosthetic device;
8. Services, supplies, or treatments provided by or covered under any governmental plan or law, or required or provided by any statute, or provided by any hospital or institution that does not require payment for such expenses in the absence of such group coverage.
9. Expenses incurred for care, treatment, service, or supplies that are not necessary for treatment of the disease concerned, nor to the extent that any charge for care, treatment, services, or supplies are unreasonable;
10. War or act of war (declared or undeclared) or service in the armed forces of any country.

## **CLAIMS AND APPEAL PROCEDURES**

For the fully-insured dental plans provided by Kaiser and Willamette Dental Group, claims and appeals procedures for each dental plan are available from each insurer upon request without cost in a separate document.

The claims and appeals procedures set forth in the MEMBER APPEALS AND GRIEVANCE PROCESS section in the Summary Plan Description document apply to Dental Plans 10, 11, and 12 only;

but those claims and appeals procedures are similar to those of the insurers of other benefits. Correspondence relative to the claims and appeals procedure should be addressed to:

Western States Health & Welfare Trust Fund of the OPEIU  
Administrative Office  
c/o BeneSys  
1220 SW Morrison St, Suite 300  
Portland, OR 97205-2222

## **DEFINITIONS**

**Calendar Year** The time period beginning January 1 and ending on December 31.

**Coinsurance** The percentage of the eligible charge that is the Member's responsibility to pay. For example, if the Plan provides benefits at 80 percent of the eligible charge, the other 20 percent is the Member's Coinsurance. Coinsurance does not include any Deductibles or Copayments.

**Condition** includes, but is not limited to, every illness, disease, and injury.

**Copayment** The fee that a Member is obligated to pay, if any, at the time he or she receives a Covered Service. Copayments may be a specific dollar amount or a percentage of the cost of the Covered Services. Copayments do not apply toward the Deductible.

**Deductible** is the amount of covered expenses that are paid by the member before benefits are payable by the plan.

**Dental Provider** means a duly licensed dentist, certified denturist, or registered hygienist, legally entitled to practice dentistry at the time and in the place services are performed, and to the extent that he or she is operating within the scope of his or her license, certificate, or registration as required under law within the state of practice.

**Dentally Necessary** means those services and supplies that are required for diagnosis or treatment of illness or injury, and that are:

- Consistent with the symptoms or diagnosis and treatment of the enrollee's condition;
- Appropriate with regard to standards of good dental practice;
- Not primarily for the convenience of the enrollee or a provider of services or supplies;
- The least costly of the treatment settings, alternative supplies, or levels of service that can be safely provided to a patient. That means, for example, that coverage would not be allowed for a crown when a filling would be adequate to restore the tooth appropriately.

**THE FACT THAT A PROFESSIONAL PROVIDER MAY PRESCRIBE, ORDER, RECOMMEND, OR APPROVE A SERVICE OR SUPPLY DOES NOT, OF ITSELF, MAKE THE SERVICE OR SUPPLY A COVERED EXPENSE.**

**Maximum Benefit Amount** The maximum amount payable for covered services paid at the appropriate benefit level in any one Calendar Year.

**Member** The Subscriber or any Dependent, who is eligible, enrolled, and covered.

**Subscriber** The person enrolled in the Dental Plan for whom the appropriate premiums have been received, and whose employment or other status, except for family dependency, is the basis for enrollment eligibility.

**Usual, Customary, and Reasonable Charges (UCR)**

Usual, customary, and reasonable charges for dental service, in the area where the services are rendered, are determined by the Plan subject to the following considerations:

- (a) The usual fee is the fee that the individual dentist most frequently charges to the majority of his patients for a similar service.
- (b) The customary fees are those fees that fall within the customary range of fees, charged in a given area by most dentists of similar training and experience for the performance of similar service.
- (c) A charge is reasonable when it meets the usual and customary criteria, or it may be reasonable if, in the opinion of an appropriate professional review committee, it merits special consideration based on complexity of treatment of the particular case.
- (d) The determination of the actual amount payable for any given procedure is within the sole discretion of the Plan. Charges in excess of the usual, customary, and reasonable fee, as determined by the Plan, shall be your responsibility.