

Moda Health and ODS Pediatric Dental Benefits

1. No annual or lifetime dollar limit for members under age 19, some frequency limitations will apply.
2. Dental PPO plans have an in-network Out-of-Pocket (OOP). If a member meets the annual OOP, the plan will pay 100% of covered charges for the remainder of the plan year, subject to the maximum plan allowable. Services incurred from a non-participating provider, that exceed the maximum plan allowable, copays and charges not covered by the plan will continue to be the member's responsibility even after the OOP has been met.
 - a. Oregon and Alaska: \$700 per member under age 19, \$1,400 per two or more under age 19
Note: ODS PPO plans use the Delta Dental PPO network, so the in-network OOP only applies to providers contracted under the PPO network. ODS Premier plans utilize the Delta Dental Premier network and allow for members to see any eligible dental provider, and will be treated as a contracted provider for purposes of the OOP. ODS PPO Mac plans work slightly different in that a premier dentist can balance bill the difference between the contracted fee and the PPO fee.
3. Limited Orthodontia is covered when members and their provider can document medical necessity in a predetermination of services or retrospective review for medically necessary treatment of cleft palate and/or cleft lip whose treatment began prior to turning age 19, whether or not it is completed prior to turning age 19.

Rates

1. Medical plan rates are not impacted by a policy holder having pediatric dental or not.
2. Rates for plans that include embedded pediatric dental only on policies that are age/list billed:
 - a. Ages 0-18 years: Rates will be entered and will apply until the end of the renewal period in which they turn 19.
 - b. Ages 19+ years: No rates (\$0) will apply upon enrollment if age 19+, or as of the beginning of the renewal period after they turn age 19.

Administration

1. Aging off the pediatric benefits will occur upon the member's 19th birthday and will begin receiving the adult dental benefits and coverage.
2. Contracts / handbooks must be issued for pediatric dental, even if there are no members under age 19 on the plan. This acts as proof or reasonable assurance that they obtained the exchange certified dental EHB benefit.
3. Dental and medical are filed as separate policies and issued by the appropriate legal entity.
4. If a member has pediatric dental under one carrier's dental policy and also under another medical policy normal COB rules will apply. There are no special rules related to one being a medical policy and one being a dental policy. Please note that Moda Health individual medical policies issued in Washington will include embedded indemnity pediatric dental benefits. WA does not allow indemnity products to coordinate with other coverage's members may have purchased.

Small Groups and Individual

1. Issuers of small group and individual plans are required to have reasonable assurance that pediatric dental is included when selling standalone dental or medical without embedded pediatric dental.

2. Moda Health cannot enroll or renew a small group or individual policy holder's medical plan if they do not either purchase dental coverage through ODS that includes pediatric dental, or provides Moda Health with reasonable assurance that they have such coverage through another carrier.
3. Small groups and individuals who purchase pediatric dental must be aware of how they purchase it.
 - a. If through a QHP medical policy, child coverage is subject to the pediatric dental EHB provision of the plan (pediatric dental is subject to the medical OOP, no annual benefit maximum and no dollar limits)
 - b. If through a standalone policy (which is how ODS policies are filed), child coverage must be exchange certified and subject to its own policy limits. Pediatric dental has its own \$700 annual OOP maximum, no annual benefit maximum and no dollar limits for in-network services on PPO plans.
4. Carriers will be required to obtain reasonable assurance from the group or individual policy holder that they have obtained the pediatric coverage through an exchange certified plan.
 - a. Moda Health will include statements on the member enrollment forms and master group applications so they can attest that they have pediatric dental coverage through another carrier. We cannot enroll the group or individual unless we receive reasonable assurance that they are compliant, as required by the ACA.

Large Groups

1. Large groups are not required to cover pediatric dental.
2. Large groups whose dental coverage includes children under 19 must be aware of how they buy it.
 - a. If through a medical policy, child coverage is subject to the pediatric dental EHB provisions of the plan (pediatric dental is subject to the medical OOP, no annual benefit maximum and no dollar limits).
 - b. If through a standalone dental policy (which is how ODS policies are filed), child coverage is not subject to pediatric dental EHB provisions (can have an annual benefit maximum and dollar limits).
 - c. If through a self-funded dental plan that is considered to be a HIPAA integrated dental plan, child coverage is subject to the pediatric dental EHB provisions of the plan (pediatric dental with no annual benefit maximum and no dollar limits).
3. ODS is not quoting pediatric dental, except upon request. If a large group requests such a quote, we should notify them that large groups are not required to do this as there may be some confusion.

Compliance with individual mandate if large employer policy excludes an EHB

If covered on a large group health plan, the 'individual mandate' is met even if the group doesn't cover this EHB. Federal guidance indicates members meet the requirements of the individual mandate if the policy provides minimum essential coverage. Minimum essential coverage means coverage under a government-sponsored program, an eligible employer-sponsored plan, a plan in the individual market, a grandfathered health plan, or other health benefits coverage.

An eligible employer sponsored plan means, with respect to any employee:

- Group health insurance coverage offered by, or on behalf of, an employer to the employee that is-
- A governmental plan;
- Any other plan or coverage offered in the small group or large group market within a State;
- A grandfathered health plan offered in a group market; or
- A self-insured group health plan under which coverage is offered by, or on behalf of, an employer to the employee.
- Retiree or COBRA coverage.
- Multiemployer and single employer collectively bargained plans.
- Plans offered by a professional employer organization (PEO) or leasing company.