Deschutes County

Group No.: G0037173
Plan Name: Dental Plan
Effective: January 1, 2023

With Third Party Administrative Services Provided By:

PacificSource
HEALTH PLANS

Introduction

Deschutes County has established the Deschutes County Group Dental Plan (referred to as the or this "Plan") to provide dental coverage for Eligible Employees and their Dependents. This Plan is established effective January 1, 2023 (the "Effective Date"). Deschutes County is the Plan Sponsor.

Any words or phrases used in this Plan Document that appear with an initial capital letter are defined terms. All such words or phrases are defined in the Definitions section of this Plan Document (See the Table of Contents for exact location). The Plan Sponsor highly encourages you to read this Plan Document in its entirety and to ask any questions you may have to ensure you understand your rights, responsibilities, and the benefits available to you under the terms of this Plan.

Nature of the Plan

This Plan is an Employee welfare benefit plan. This Plan is not governed by the Employee Retirement Income Security Act ("ERISA"). This Plan is a self-insured dental Plan intended to meet the requirements of Sections 105(b), 105(h) and 106 of the Internal Revenue Code so that the portion of the cost of coverage paid by the Employer, and any benefits received by a Member through this Plan, are not taxable income to the Member. The specific tax treatment of any Member will depend on the Member's personal circumstances; the Plan does not guarantee any particular tax treatment. Members are solely responsible for any and all federal, state, and local taxes attributable to their participation in this Plan, and the Plan expressly disclaims any liability for such taxes.

This Plan is "self-insured" which means benefits are paid from the Employer's general assets and/or trust funds and are not guaranteed by an insurance company. The Plan Sponsor, which is also the Plan Administrator, has contracted with the Third Party Administrator to perform certain administrative services related to this Plan, and to generally provide administrative services to the Plan. If anything is unclear to you, please contact the Plan Sponsor or the Third Party Administrator at the number or address available in this Introduction section.

PacificSource Health Plans ("PacificSource") is the Third Party Administrator and will process claims, manage the network of dental Providers, and answer dental benefit and claim questions.

Written Plan Document and SPD

This Plan Document contains both the written Plan Document and the Summary Plan Description ("SPD"). It is very important to review this Plan Document carefully to confirm a complete understanding of the benefits available, as well as your responsibilities, under this Plan.

This Plan Document consists of several pieces, all of which work together. The Benefit Summaries provide an overview of the key benefit provisions of the Plan and can give you a general idea of what the Plan covers and how it works. However, it is important to read the entire Plan Document, including the Definitions, to fully understand the Plan's coverage and benefits.

Retention of Fiduciary Duties

The Plan Sponsor has retained all fiduciary duties under the Plan, including all interpretations of the Plan and the benefits and exclusions it contains. This means that the Plan Sponsor is solely responsible for all final decisions regarding what benefits are or will be covered, both now and in the future. The Plan Sponsor is solely responsible for the design of this Plan. Plan Sponsor is solely responsible for setting any and all criteria used to determine enrollment and eligibility.

Governing Law

This Plan must comply with both state and federal law, including required changes occurring after the Plan's effective date. Therefore, coverage is subject to change as required by law.

Additional Information

Representations not warranties: In the absence of fraud, all statements made by the Plan Sponsor will be considered representations and not warranties. No statement made for the purpose of effecting coverage will void the coverage or reduce benefits unless it is contained in a written document signed by the Plan Sponsor and provided to a Member.

Questions?

PacificSource's Customer Service team is available to answer questions or concerns regarding the Plan. Phone lines are open from 8 a.m. to 5 p.m. Monday through Friday (excluding holidays). PacificSource's Customer Service team is not authorized to interpret or change the terms of the Plan.

For enrollment or eligibility questions, please contact the Plan Sponsor.

PacificSource Customer Service

Phone 888-246-1370
Email dental@pacificsource.com

Para asistencia en español, por favor llame al número 866-281-1464.

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PacificSource Website

PacificSource.com

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DENTAL BENEFIT SUMMARY
Dental Plan

Group Name: Deschutes County
Group Number: G0037173
Provider Network: Advantage
Benefit Year: Calendar Year

Employee Eligibility Requirements

Minimum Hour Requirement: Twenty (20) hours per week

Waiting Period Requirement: First of the month following hire

- In the case of weekends and holidays, if the Employee starts on the first business day of the month, he or she will be treated as having been hired on the first day of the calendar month or the first shift of the month for certain classes of Employees (immediate benefits, either that day or back to the first of the month).

- If you are hired after the first business day of the month, your benefits will start on the first day of the following month.

- After satisfying the waiting period, elected officials* of the County and their eligible dependents are eligible for the Plan without regard to the number of hours worked by each such Official. Coverage will end at the end of the month in which they are no longer serving as an elected official of the County.

  *Elected Officials:

  - Three County Commissioners,
  - County Sheriff,
  - District Attorney,
  - County Assessor,
  - County Clerk,
  - Justice of the Peace,
  - County Treasurer.

This Plan covers the following services when performed by a Provider to the extent that they are operating within the scope of their license as required under law in the state of issuance, and when determined to be necessary, usual, and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for Accidental Injury, including masticatory function (chewing of food).

In-network Providers contract with PacificSource to furnish services and supplies for a set fee. That fee is called the Allowable Fee. In-network Providers agree not to collect more than the Allowable Fee. When you use an In-Network Provider, you will pay only the in-network amounts below. If you choose not to use an In-Network Provider, or don't have access to one, payment is based on the Allowable Fee. If Provider charges exceed the Allowable Fee, the excess charges are your responsibility. Please see Allowable Fee in the Definitions section of the Plan Document.

Benefit Maximum Per Benefit Year
$2,000 per Member. Applies to all Covered Services. For Members age 18 and younger, Class I Services do not apply toward the benefit maximum.

Payment

All Covered Services: Services during the first year of eligibility will have 20% Coinsurance, in addition to the Copayment amounts listed below. In the second year of eligibility, the Member will only pay the Copayment amounts listed below.

The Member is responsible for any amounts shown above, in addition to the following amounts:

Service/Supply	In-Network Member Pays	Out-of-Network Member Pays
Class I Services		
Examinations	$15	$15
Bitewing films, full mouth X-rays, cone beam X-rays, and/or panorex	$15	$15
Dental cleaning (Prophylaxis)	$15	$15
Fluoride (topical or varnish applications)	$15	$15
Sealants	$15	$15
Space maintainers	$15	$15
Athletic mouth guards	Not covered	Not covered
Brush biopsies	$15	$15
Initial orthodontic exam	$15	$15
Class II Services		
Fillings	$25	$25
Dental cleaning (Periodontal Maintenance)	$25	$25
Simple extractions	$25	$25
Periodontal Scaling and Root Planing	$25	$25
Full mouth debridement	$25	$25
Complicated oral surgery	$25	$25
Pulp capping	$25	$25
Pulpotomy	$25	$25
Root canal therapy	$25	$25
Periodontal surgery	$25	$25
Tooth desensitization	$25	$25

Service/Supply	In-Network Member Pays	Out-of-Network Member Pays
Nitrous oxide and oral conscious sedation	$25	$25
Class III Services		
Crowns	$25	$25
Dentures	$25	$25
Bridges	$25	$25
Replacement of existing prosthetic device	$25	$25
Implants	$25	$25
Night guards	$25	$25

This is a brief summary of benefits. Refer to the Plan Document for additional information or a further explanation of benefits, limitations, and exclusions.

Additional information

What is the benefit maximum?

The benefit maximum is the maximum amount payable by this Plan for Covered Services received each Benefit Year. For Members age 18 and younger, Class I Services do not apply toward the benefit maximum.

Predetermination

Coverage of certain dental services and surgical procedures are by review. When a planned dental service exceeds $300, PacificSource recommends a Predetermination to determine if certain services and supplies are covered under this Plan, and if you meet the Plan's eligibility requirements. Predeterminations are not a guarantee of payment and do not change your out-of-pocket expense.

Prior authorization

Coverage of certain services and surgical procedures requires a Benefit Determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this Plan, and if you meet the Plan's eligibility requirements. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business).

Discrimination is against the law

Both the Plan Sponsor and PacificSource Health Plans comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan Sponsor and PacificSource do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

COSMETIC ORTHODONTIC BENEFIT SUMMARY

Benefit Year: Calendar Year

This Plan covers cosmetic orthodontia for all Members. Enrollment in cosmetic orthodontia coverage must be the same as enrollment in the dental Plan.

The dollar amount listed below is the maximum benefit allowed for all cosmetic orthodontic services covered under this benefit, when prescribed by a licensed dentist or licensed orthodontist.

Lifetime Benefit Maximum	All Providers Member Pays
$2,000 per Member	50%

Benefit Limitations

Benefits for cosmetic orthodontic Covered Services will be paid monthly on a pro-rated basis over the length of the treatment. If the cosmetic orthodontic treatment began before you were eligible for this Plan, this Plan will continue to make payments toward the remaining balance due, as of your initial eligibility date. The benefit maximum listed above will apply fully to this amount. This Plan's obligation to make payment for cosmetic orthodontic treatment ends when your eligibility ends, or when treatment is terminated before the case is completed.

Diagnostic casts are covered under the Cosmetic Orthodontic Benefit.

Exclusions

- This Plan does not cover repair or replacement of orthodontic appliances.
- Mail order or Internet/Web based Providers are not eligible Providers.

UNDERSTANDING HOW YOUR BENEFITS ARE PAID

This section of the Plan Document contains information to help you understand the benefits of this Plan and how certain aspects of this Plan work, including Deductibles, Copayments, Coinsurance, and benefit maximums. For more information, see the Benefit Summaries for Plan details. Many terms used in this Plan Document are defined in the Definitions section. You can identify such terms by their being capitalized.

BENEFIT YEAR

Calendar Year

Many benefits and provisions in this Plan are calculated on a calendar year basis. Each January 1, these provisions renew and may change, and you must satisfy the new or revised amounts for that year. Any benefit with a separate maximum benefit (for example, not on a calendar year basis) is identified in the Covered Services section of this Plan Document. Frequency limitations are calculated from the previous date of service or initial placement, unless otherwise specified.

If this Plan renews or is modified mid-calendar year, the previously satisfied Deductibles and benefit maximums will be credited toward the renewed or modified Plan.

DEDUCTIBLE

This Plan may require you to satisfy a Deductible before this Plan will pay benefits. Except for certain services that do not require satisfaction of the Deductible, this Plan will only begin to pay benefits for Covered Services once a Member satisfies the Deductible by incurring a specific amount of expenses during the Benefit Year. The amount that accrues to the Deductible is the Allowable Fee.

Your expenses for the following do not count toward the Deductible and will be your responsibility:

- Charges over the Allowable Fee;
- Charges for non-Covered Services; and
- Charges for any Coinsurance or Copayments.

If this Plan includes Cosmetic Orthodontia, those charges do not apply toward the Deductible. Covered Services used to satisfy the Deductible also accrue to the annual or Lifetime Maximums, if any apply.

COPAYMENT

This Plan may include a Copayment on certain services or supplies each time you receive a specified service or supply. Copayments are fixed dollar amounts. Any Copayment required will be the lesser of the fixed dollar amount or the Allowable Fee for the service or supply. The Provider will collect any Copayment.

COINSURANCE

After a Member has satisfied the individual Deductible or the family Deductible, if any applies, this Plan may include a Coinsurance payment on certain services or supplies each time you receive a specified service or supply. Coinsurance is a percentage of the Allowable Fee. Any Coinsurance

required will be based on the lesser of the billed charges or the Allowable Fee. The Provider will bill you and collect any Coinsurance payment.

BENEFIT MAXIMUM

This Plan may have a benefit maximum. The benefit maximum is the total amount that this Plan will pay for your dental care within the Benefit Year. After you have reached the benefit maximum, you will be responsible for all subsequent charges for the duration of the Benefit Year.

UNDERSTANDING DENTAL NECESSITY

In order for a service or supply to be covered, it must be both a Covered Service *and* Dentally Necessary.

Be careful – just because a treatment is prescribed or recommended by a Provider does not mean it is Dentally Necessary under the terms of this Plan. This Plan provides coverage only when such care is necessary to treat an Illness or Injury or the service qualifies as preventive care. All treatment is subject to review for Dental Necessity. Review of treatment may involve prior authorization, concurrent review of the continuation of treatment, post-treatment review, or any combination of these. A second opinion (at no cost to you when requested by PacificSource or the Plan Sponsor) may be required for a Dental Necessity determination.

Some Dentally Necessary services are not Covered Services. Dentally Necessary services and supplies that are specifically excluded from coverage under this Plan can be found in the Benefit Exclusions section.

If you ever have a question about your benefits, contact the PacificSource Customer Service team.

UNDERSTANDING EXPERIMENTAL, INVESTIGATIONAL, OR UNPROVEN SERVICES

This Plan does not cover services or treatments that are Experimental, Investigational, or Unproven.

To ensure you receive the highest quality care at the lowest possible cost, PacificSource, on behalf of the Plan Sponsor, reviews new and emerging technologies and medications on a regular basis. PacificSource's internal committees make decisions about coverage of these methods and medications based on literature reviews, standards of care and coverage, consultations, and review of evidence-based criteria. You and your Provider may request information regarding the criteria for determining these services or treatments. The Plan Sponsor has sole and complete authority to determine what is and is not covered under the terms of the Plan.

ELIGIBLE PROVIDERS

This Plan provides benefits only for Covered Services and supplies rendered by an eligible Provider. The services or supplies provided by individuals or companies that are not specified as eligible Providers are not eligible for reimbursement under the benefits of this Plan. To be eligible, the Providers must be practicing within the scope of their licenses.

COVERED SERVICES

This section of the Plan Document contains information about the benefits provided under this Plan. The following list of benefits is exhaustive. You are responsible for all charges for services that are

not a Covered Service. Covered Services are organized into different classes, starting with preventive care and advancing into specialized dental treatments.

Benefits are eligible for payment only to the extent a charge is, or would be, made for the least costly service or supply appropriate to your dental treatment. Charges in excess of the least costly service or supply appropriate for treatment, or the Allowable Fee, are not covered under this Plan and become your responsibility.

If you select a more expensive treatment than is customarily provided, this Plan will pay the applicable percentage of the lesser fee. You will be responsible for the balance of the Provider's charges.

As described in the prior section, these services and supplies may require you to satisfy a Deductible, make a Copayment, and/or pay Coinsurance. They may be subject to additional limitations or maximum dollar amounts. For an expense to be eligible for payment, you must be a Member of this Plan on the date the expense is incurred and eligible Providers practicing within the scope of their licenses must render the services. A treatment or service may be a Dental Necessity, yet not be a Covered Service. For information about exclusions, see the Benefit Exclusions section.

Subject to all the terms of this Plan, the following services and supplies are covered according to the Benefit Summaries.

COVERED DENTAL SERVICES

CLASS I SERVICES

For Members age 18 and younger, expenses for Class I Services do not apply towards your benefit maximum.

- **Examinations (routine or other diagnostic exams)** are covered. Separate charges for review of a proposed treatment plan or for diagnostic aids are not covered. Problem focused examinations are covered. Emergency examinations are covered.
- **Full mouth series of X-rays, cone beam X-rays, panorex, bitewing films, and periapical X-rays** are covered.
- **Dental cleanings (Prophylaxis)** are covered.
- **Fluoride (topical or varnish applications)** is covered.
- **Application of sealants** are covered.
- **Space maintainers** are covered.
- **Brush biopsies** are covered.
- **Initial orthodontic exam** is covered.

CLASS II SERVICES

- **Dental cleanings (Periodontal Maintenance)** are covered.
- **Composite Resin and Amalgam Restorations (fillings)** are covered. The amount paid for a gold Restoration will be limited to the Allowed Amount for a corresponding Amalgam Restoration.

A separate charge for anesthesia when used during restorative procedures is not a Covered Service.

- **Simple extractions of teeth** and other minor oral surgery procedures are covered. A separate charge for Alveolectomy performed in conjunction with removal of teeth is not a Covered Service.
- **Periodontal Scaling and Root Planing and/or Curettage** is covered.
- **Full mouth debridement** is covered.
- **Complicated oral surgery procedures,** such as the removal of impacted teeth are covered. A separate charge for Alveolectomy performed in conjunction with removal of teeth is not a Covered Service.
- **Pulp capping** is only covered when there is an exposure to the pulp. These are direct pulp caps. Coverage for indirect pulp caps are covered as part of the Restoration fee and are not covered as a separate charge.
- **Pulpotomy** is only covered for primary teeth.
- **Root canal therapy** on the same tooth is only covered for one charge in a 36 month period.
- **Periodontal surgery** is limited to procedures accompanied by a periodontal diagnosis and history of conservative (non-surgical) periodontal treatment.
- **Tooth desensitization** is covered as a separate procedure from other dental treatment.
- **Core build-ups** are covered.
- **General anesthesia (including nitrous oxide and oral conscious sedation)** and its administration in connection with complex oral surgery, major periodontics procedures, fractures or dislocations, or due to a concurrent medical condition.

CLASS III SERVICES

- **Crowns** and other cast or laboratory-processed Restorations are covered.
- **Initial cast partial denture, full denture, immediate denture, or overdenture** are limited to the cost of a standard full or cast partial denture. A separate charge for denture adjustments and relines performed within six months of the initial placement is not a Covered Service. Benefits for subsequent rebases and relines are provided only once in a 12 month period. Cast Restorations for partial denture Abutment teeth or for splinting purposes are not covered unless the tooth in and of itself requires a Cast Restoration.
- **Initial fixed bridges or removable cast partials** are covered.
- **Replacement of an existing prosthetic device** is only covered when the device being replaced is unserviceable, cannot be made serviceable, and has been in place for at least 60 months.
- **Crowns, onlays, bridges.** The completion date is the cementation date (seat date) regardless of the type of cement utilized.
- **Implants.** Surgical placement and removal of implants are limited to a Lifetime Maximum of one per tooth space. Benefits include final crown and implant Abutment over a single implant, final implant-supported bridge Abutment, and implant Abutment or pontic. An alternative benefit per

arch of a conventional full or partial denture for the final implant-supported full or partial denture prosthetic device is available.

- **Splints, night guards, or appliances** used to increase vertical dimensions, restore the occlusion, or correct habits such as tongue thrust and grinding teeth are covered. **Periodontal splinting** including crowns and bridgework used in conjunction with periodontal splinting is covered.

COSMETIC ORTHODONTIC SERVICES

This Plan covers **Cosmetic Orthodontic services** for all Members. See the Cosmetic Orthodontic Benefit Summary for benefit and cost sharing information.

Diagnostic casts are covered under the cosmetic orthodontic benefits.

BENEFIT EXCLUSIONS

EXCLUDED SERVICES

This Plan does not cover the following:

- Aesthetic (cosmetic) dental procedures – Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.
- Alveoloplasty.
- Antimicrobial agents – Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.
- Athletic injuries sustained while competing or practicing for a professional or semiprofessional athletic contest.
- Athletic mouth guards.
- Biopsies or histopathologic exams except when related to tooth structure.
- Charges for phone consultations, missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims.
- Collection of cultures and specimens.
- Comprehensive periodontal exams.
- Connector bar or stress breaker.
- Cosmetic reconstructive services and supplies – Procedures, appliances, Restorations, or other services that are primarily for cosmetic purposes (does not apply to emergency services).
- Diagnostic casts (study models) and occlusal appliances, gnathological recordings, occlusal equilibration procedures, or similar procedures are only covered in conjunction with the cosmetic orthodontia benefit.
- Drugs and medications that are prescribed drugs and take-home medicine or supplies distributed by a Provider for any Member, as well as premedication drugs, analgesics, and any other euphoric drugs for Members age 19 and over, unless otherwise noted in Covered Services.

- Educational programs – Instructions and/or training in plaque control and oral hygiene.
- Experimental, Investigational, or Unproven – This Plan does not cover services, supplies, protocols, procedures, devices, chemotherapy, drugs or medicines, or the use thereof that are Experimental, Investigational, or Unproven for the diagnosis and treatment of the Member. This limitation also excludes treatment that, when and for the purpose rendered: has not yet received recognized compendia support (for example, UpToDate, Lexicomp, FDA) for other than Experimental, Investigational, or Unproven, or clinical testing; is not of generally accepted medical practice in your plan's state of issuance or as determined by medical advisors, medical associations, and/or technology resources; is not approved for reimbursement by the Centers for Medicare and Medicaid Services; is furnished in connection with medical or other research; or is considered by any governmental agency or subdivision to be Experimental, Investigational, or Unproven, not reasonable and necessary, or any similar finding.

  If you or your Provider have any concerns about whether a course of treatment will be covered, we encourage you to contact the PacificSource Customer Service team. They will arrange for medical review of your case against our criteria, and notify you of whether or not the proposed treatment will be covered.
- Fractures of the maxilla and mandible – Surgery, services, and supplies provided in connection with the treatment of simple or compound fractures of the maxilla or mandible.
- General anesthesia except when administered by a Provider in connection with oral surgery in their office, unless otherwise noted in Covered Services.
- Gingivectomy, gingivoplasty, or crown lengthening in conjunction with crown preparation or fixed bridge services done on the same date of service.
- Hospital charges or additional fees charged by the Provider for hospital treatment.
- Hypnotherapy.
- Indirect pulp caps are to be included in the Restoration process, and are not a separate covered benefit.
- Infection control – A separate charge for infection control or sterilization.
- Intra and extra coronal splinting – Devices and procedures for intra and extra coronal splinting to stabilize mobile teeth.
- Mail order or Internet/web based Providers are not eligible Providers.
- Occlusal adjustments.
- Orthodontic services – Repair or replacement of orthodontic appliances.
- Orthognathic surgery – Surgery to manipulate facial bones, including the jaw, in Members with facial bone abnormalities performed to restore the proper anatomic and functional relationship to the facial bones.
- Periodontal probing, charting, and re-evaluations.
- Photographic images.
- Pin retention in addition to Restoration.

- Precision attachments.
- Pulpotomies on permanent teeth.
- Removal of clinically serviceable Amalgam Restorations to be replaced by other materials free of mercury, except with proof of allergy to mercury.
- Scheduled and/or non-emergent care outside of the United States.
- Services covered by the Member's medical plan.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth.
- Services for which no charge is normally made in the absence of insurance.
- Services or supplies covered under any plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law.
- Services or supplies with no charge, or for which the Plan Sponsor has paid, or for which the Member is not legally required to pay, or for which a Provider or facility is not licensed to provide even though the service or supply may otherwise be eligible. This exclusion includes any services provided by the Member, or any licensed professional that is directly related to the Member by blood or marriage.
- Services otherwise available – These include, but not limited to:
  - Services or supplies for which payment could be obtained in whole or in part if the Member applied for payment under any city, county, state, or federal law (except Medicaid);
  - Services or supplies the Member could have received in a hospital or program operated by a federal government agency or authority. Covered Services for services or supplies furnished to a Member by the Veterans' Administration of the United States that are not service-related are eligible for payment according to the terms of this Plan; and
  - Services or supplies for which payment would be made by Medicare.
- Sinus lift grafts to prepare sinus site for implants.
- Stress-breaking or habit-breaking appliances.
- Temporomandibular joint (TMJ) – Services or supplies for treatment of any disturbance of the temporomandibular joint.
- Third party liability, motor vehicle liability, motor vehicle insurance coverage, workers' compensation – Any services or supplies for Illness or Injury for which a third party is responsible or which are payable by such third party or which are payable pursuant to applicable workers' compensation laws, motor vehicle liability, uninsured motorist, underinsured motorist, and Personal Injury Protection (PIP) insurance and any other liability and voluntary medical payment insurance to the extent of any recovery received from or on behalf of such sources.
- Tooth transplantation – Services and supplies provided in connection with tooth transplantation, including re-implantation from one site to another, splinting, and/or stabilization. This exclusion does not relate to the re-implantation of a tooth into its original socket after it has been avulsed.

- Treatment after coverage ends – Services or supplies a Member receives after the Member's coverage under this Plan ends. The only exception is for Class III Services ordered and fitted before coverage ends and are placed within 31 days after coverage ends.
- Treatment not Dentally Necessary, according to acceptable dental practice, or treatment not likely to have a reasonably favorable prognosis.
- Treatment of any Illness or Injury resulting from an illegal occupation or attempted felony, or treatment received while in the custody of any law enforcement other than with the local supervisory authority while pending disposition of charges**.**
- Treatment prior to enrollment – or satisfaction of an Exclusion Period, if applicable.
- Unwilling to release information – Charges for services or supplies for which a Member is unwilling to release dental or eligibility information necessary to determine the benefits covered under this Plan.
- Vizilite.
- War-related conditions – The treatment of any condition caused by or arising out of an act of war, armed invasion, or while in the service of the armed forces, unless not covered by the Member's military or veterans coverage.

UTILIZATION REVIEW

PacificSource has a utilization review program based on criteria adopted by the Plan Sponsor to determine coverage. This program is administered by the PacificSource Health Services team. Questions regarding Dental Necessity, possible Experimental, Investigational, or Unproven services, appropriate setting, and appropriate treatment are forwarded to the PacificSource Dental Director for review and Benefit Determination based on the criteria established by the Plan Sponsor.

If you would like information on how PacificSource reached a particular utilization review Benefit Determination, please contact the PacificSource Health Services team by phone at 888-691-8209, or by email at healthservices@pacificsource.com.

PRIOR AUTHORIZATION

Coverage of certain services requires a Benefit Determination by PacificSource, on behalf of the Plan Sponsor, before the services are performed. This process is called prior authorization. PacificSource will utilize the criteria adopted by the Plan Sponsor and, where necessary, will coordinate review with the Plan Sponsor, to render a determination based on the Plan.

Prior authorization is necessary to determine if certain services and supplies are covered under this Plan, and if you meet the Plan's eligibility requirements.

Your Provider can request prior authorization from the PacificSource Health Services team. If your Provider will not request prior authorization for you, you may contact PacificSource yourself. In some cases, they may ask for more information or require a second opinion (at no cost to you when requested by PacificSource or the Plan Sponsor) before authorizing coverage.

Because of the changing nature of care, PacificSource, on behalf of the Plan Sponsor, continually reviews new technologies and standards. Therefore, procedures and services requiring prior authorization is subject to change. You can search for procedures and services that require prior

authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business). The prior authorization search tool is not intended to suggest that all items listed are covered by the benefits in this Plan.

When services are received from an In-network Provider, the Provider is responsible for contacting PacificSource to obtain prior authorization.

If your treatment does not receive prior authorization, you can still seek treatment, but your claim will be subjected to retrospective authorization. If a treatment requires prior authorization but was not received, the claim must be submitted within 60 days. If the claim is not submitted within 60 days or if the review determines the expenses were either not covered by this Plan or were not Dentally Necessary, you will be held responsible for the expense. Remember, any time you are unsure if an expense will be covered, contact the PacificSource Customer Service team.

Notification of the Benefit Determination will be communicated by letter, fax, or electronic transmission to the Provider, and you. If time is a factor, notification will be made by telephone and followed up in writing. For more information regarding the timelines for review of Pre-service Claims and Post-service Claims, see Claim Handling Procedures in the Claims Payment section.

Services and supplies necessary to determine the nature and extent of an Emergency Dental Condition are covered without prior authorization requirements.

PREDETERMINATION

PacificSource, on behalf of the Plan Sponsor, provides a Predetermination service for expensive treatment plans. Prior to receiving treatment, you or the Provider may request an estimate of what this Plan would pay and what you would pay, by contacting the PacificSource Customer Service team. This. This estimate is based on your benefits at the time the request is made and is not a guarantee of payment.

INDIVIDUAL/SUPPLEMENTAL BENEFITS

An individual/supplemental benefit may be available if the Plan approves coverage for services or supplies that are not a Covered Service. The decision to allow supplemental benefits will be made by the Plan on a case-by-case basis. The Plan and your attending Provider must concur in the request for supplemental benefits in lieu of specified Covered Services before supplemental benefits will be covered. The Plan's determination to cover and pay for supplemental benefits does not set a precedent for coverage of continued or additional supplemental benefits. No substitution will be made without your consent.

USING THE DENTAL NETWORK

This section explains how this Plan's benefits differ when you use In-network and Out-of-network Providers. This information is not meant to prevent you from seeking treatment from any Provider if you are willing to take increased financial responsibility for the charges incurred.

All Providers are independent contractors. Neither the Plan Sponsor nor PacificSource can be held liable for any claim for damages or injuries you experience while receiving care.

Under this Plan, you are free to seek care from any Provider without a referral. You may, however, be

required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan.

IN-NETWORK PROVIDERS

In-network Providers contract with PacificSource to provide services and supplies for an Allowable Fee. In-network Providers bill PacificSource directly, and are paid directly by this Plan. When you receive Covered Services or supplies from an In-network Provider, you are only responsible for any applicable Deductibles, Copayments, and/or Coinsurance amounts.

FINDING AN IN-NETWORK PROVIDER

You can find up-to-date In-network Provider information:

- On the PacificSource website, PacificSource.com, go to Find a Doctor to easily look up In-network Providers. You can also print your own customized directory.
- Contact the PacificSource Customer Service team. Their team can answer your questions about specific Providers.

OUT-OF-NETWORK PROVIDERS

When you receive services or supplies from an Out-of-network Provider, your out-of-pocket expense is likely to be higher than if you had used an In-network Provider. If the same services or supplies are available from an In-network Provider, you may be responsible for more than the applicable Deductibles, Copayments, and/or Coinsurance amounts.

Allowable Fee for Out-of-network Providers

This Plan's payment to Out-of-network Providers may be derived from several sources, depending on the service or supply and the service area where it is provided. To calculate this Plan's payment to Out-of-network Providers, the Plan determines the Allowable Fee, then subtracts the Out-of-network Provider benefits.

Balance Billing

The Allowable Fee is often less than the Out-of-network Provider's charge. In that case, the difference between the Allowable Fee and the Provider's billed charge is also your responsibility; this difference is called Balance Billing. It also does not apply toward any cost sharing required by this Plan.

TERMINATION OF PROVIDER CONTRACTS

PacificSource will attempt to notify you within 30 days of learning about the termination of a Provider contractual relationship if you have received services in the previous six months from such a Provider when:

- A Provider terminates a contractual relationship with PacificSource in accordance with the terms and conditions of the agreement;
- A Provider terminates a contractual relationship with an organization under contract with

PacificSource; or

- PacificSource terminates a contractual relationship with an individual Provider or the organization with which the Provider is contracted in accordance with the terms and conditions of the agreement.

The Provider becomes an Out-of-network Provider on the date the contract with PacificSource terminates. Any services you receive from them will be paid at the percentage shown in the out-of-network column of the Benefit Summaries. To avoid unexpected costs, be sure to verify each time you see your Provider that they are still in-network.

CLAIMS PAYMENT

How to File a Claim

When an In-network Provider treats you, your claims are automatically sent to PacificSource and processed. All you need to do is show your PacificSource Member ID card to the Provider.

If you receive care from an Out-of-network Provider, the Provider may submit the claim to PacificSource for you. If not, you are responsible for sending the claim to PacificSource for processing. Your claim must include a copy of your Provider's itemized bill, including the Provider name and address, the Provider tax identification number and National Provider Identifier (NPI), procedure codes, and diagnosis codes. It must also include your name, PacificSource Member ID number, group name, group number, and the Member's name. If you were treated for an Accidental Injury, please include the date, time, place, and circumstances of the Accident.

All claims for benefits must be turned in to PacificSource within 90 days of the date of service. If you are unable to submit a claim within 90 days, present the claim with an explanation for consideration for coverage. In some cases PacificSource may accept the late claim. The Plan will never pay a claim that was submitted more than a year after the date of service.

Claims Payment Practices

Unless additional information is needed to process your claim, PacificSource will make every effort to pay or deny your claim within 30 days of receipt. If a claim cannot be paid within 30 days of receipt because additional information is needed, PacificSource will acknowledge receipt of the claim and explain why payment is delayed.

Claim Handling Procedures

Claim Determination – PacificSource, on behalf of the Plan Sponsor, will make a claim determination within the time period noted in the chart below for the specific type of claim, unless additional information is necessary to process the claim. In that event, PacificSource will send you notice that the claim was received and explain what additional information is necessary to process the claim. If PacificSource does not receive the necessary information within 15 days of the delay notice, they will either deny the claim or notify you every 45 days while the claim remains under investigation. No extension is permitted for Urgent Care Claims.

Type of Notice	Concurrent Care Claim	Urgent Care Claim	Pre-service Claim	Post-service Claim
Initial determination by PacificSource	24 hours	48 hours	2 business days	30 calendar days
If PacificSource requires additional information, PacificSource will make request within	24 hours	48 hours	2 business days	30 calendar days
Provider or Member must provide requested additional information within	24 hours	48 hours	5 business days	15 calendar days
Once PacificSource receives the information, decision will be made and written notice sent within	24 hours	48 hours	2 business days	30 calendar days

Adverse Benefit Determinations – PacificSource, on behalf of the Plan Sponsor, will notify you in writing of a decision to deny, modify, reduce, or terminate payment, coverage authorization or provision of services or benefits.

Review of Adverse Benefit Determinations – An Adverse Benefit Determination applied for on a pre-service, post-service, or concurrent care basis may be Appealed in accordance with this Plan's Appeals procedures. For more information, see the Complaints, Grievances, and Appeals section.

Payment of Claims

PacificSource may pay benefits to the Member, the Provider, or both jointly. Neither the benefits of this Plan nor a claim for payment of benefits under the Plan are assignable in whole or in part to any person or entity.

Questions about Claims

If you have questions about the status of a claim, you are welcome to contact the PacificSource Customer Service team or go online to view your claims information via the PacificSource website. You may also contact the PacificSource Customer Service team if you believe a claim was denied in error. They will review your claim and your Plan benefits to determine if the claim is eligible to be

reprocessed accordingly. Then they will either reprocess the claim or contact you with an explanation.

Benefits Paid in Error

If the Plan makes a payment to you that you are not entitled to, or pays a person who is not eligible for payment, it may recover the payment. It may also deduct the amount paid in error from your future benefits.

In the same manner, if the Plan applies expenses to the Deductible that would not otherwise be reimbursable under the terms of this Plan, it may deduct a like amount from the accumulated Deductible amounts and/or recover payment of expenses that would have otherwise been applied to the Deductible.

Legal Procedures

You may not take legal action against the Plan Sponsor or PacificSource to enforce any provision of this Plan until 60 days after your claim is submitted. Also, you must exhaust this Plan's claims procedures before filing benefits litigation. No such action shall be brought against the Plan Sponsor or PacificSource after the expiration of any applicable statutes of limitations.

COORDINATION OF BENEFITS

This is a summary of only a few of the provisions of this Plan to help you understand coordination of benefits which can be very complicated. This is not a complete description of all of the coordination rules.

Double Coverage

It is common for family members to be covered by more than one dental plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one dental plan, the law permits your plans to follow a procedure called coordination of benefits to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered dental expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, contact the PacificSource Customer Service team or contact the Division of Financial Regulation.

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. PacificSource will need this information to determine whether this Plan is the primary or secondary benefit payer. The primary plan always pays first when you have a claim.

Any plan that does not contain your state's COB rules will always be primary.

When This Plan is Primary

If you or a Dependent are covered under another plan in addition to this one, this Plan will be primary when:

Your Own Expenses

- The claim is for your own dental expenses.

Your Spouse's or Domestic Partner's Expenses

- The claim is for your Spouse or your Domestic Partner, who is covered by this Plan.

Your Child's Expenses

- The claim is for the dental expenses of your child who is covered by this Plan; and
- You are married and your birthday is earlier in the year than your Spouse's or your Domestic Partner's, or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the birthday rule; or
- You are separated or divorced and you have informed us of a court decree that makes you responsible for the child's dental expenses; or
- There is no court decree, but you have custody of the child.

Other Situations

This Plan will be primary when any other provisions of state or federal law require us to be.

How This Plan Pays Claims When It Is Primary

When this Plan is the primary plan, PacificSource, on behalf of the Plan Sponsor, will pay the benefits in accordance with the terms of the Plan, just as if you had no other dental coverage under any other plan.

How This Plan Pays Claims When It Is Secondary

This Plan will be secondary whenever the rules do not require it to be primary.

When this Plan is the secondary plan, it does not pay until after the primary plan has paid its benefits. This Plan will then pay part or all of the allowable expenses left unpaid, as explained below. An allowable expense is a dental expense covered by one of the plans, including Copayments, Coinsurance, and Deductibles.

- If there is a difference between the amounts the plans allow, this Plan will base its payment on the higher amount. However, if the primary plan has a contract with the Provider, the combined payments will not be more than the amount called for in the contract or the amount called for in the contract of the primary plan, whichever is higher.
- This Plan will determine its payment by calculating the amount it would have paid if it had been primary, and apply that calculated amount to any allowable expense that is left unpaid by the primary plan. The Plan may limit its payment by any amount so that, when combined with the amount paid by the primary plan, the total benefits paid do not exceed the total allowable expense for your claim. This Plan will credit any amount it would have paid in the absence of your other dental coverage toward this Plan's Deductibles.
- If the primary plan covers similar kinds of dental expenses, but allows expenses that we do not

cover, this Plan may pay for those expenses.

- This Plan will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your primary plan has reduced its benefit because you did not obtain prior authorization, as required by that plan, this Plan will not pay the amount of the reduction, because it is not an allowable expense.

Questions about Coordination of Benefits?
Contact the Plan Sponsor, PacificSource's Customer Service team, or the Division of Financial Regulation.

THIRD PARTY LIABILITY

If you use this Plan's benefit for an Illness or Injury you think may involve another party, you must contact PacificSource right away.

Third party liability means claims that are the responsibility of someone other than the Plan Sponsor. The liable party may be a person, firm, or corporation. Auto Accidents, slip-and-fall property Accidents, and medical malpractice claims are examples of common third party liability cases.

A third party includes liability and casualty insurance, and any other form of insurance that may pay money to, or on behalf of, a Member, including, but not limited to, uninsured motorist coverage, under-insured motorist coverage, premises med-pay coverage, Personal Injury Protection (PIP) coverage, homeowner's insurance, and workers' compensation insurance.

When PacificSource receives a claim that might involve a third party, they may send you a questionnaire to help determine responsibility.

In all third party liability situations, this Plan's coverage is secondary. By enrolling in this Plan, you automatically agree to the following terms regarding third party liability situations:

- If this Plan pays any claim that you claim is, or that is alleged to be, the responsibility of another party, you will hold the right of recovery against the other party in trust for the Plan Sponsor.

- The Plan Sponsor is entitled to reimbursement for any paid claims out of the recovery from a third party if there is a settlement, judgment, or recovery from any source. This is regardless of whether the other party or insurer admits liability or fault, or otherwise disputes the relatedness of the claims paid by this Plan to the Injury caused by the third party. The Plan Sponsor shall have the first right of reimbursement in advance of all other parties, including the participant, and a priority to any money recovered from third parties.

- The Plan Sponsor may subtract a proportionate share of the reasonable attorney's fees you incurred from the money you are to pay back to the Plan Sponsor.

- The Plan Sponsor may ask you to take action to recover expenses they have paid from the responsible party. The Plan Sponsor may also assign a representative to do so on your behalf. If there is a recovery, the Plan Sponsor will be reimbursed for any expenses or attorney's fees out of recovery, as allowed by state law.

- If you receive a third party settlement, that money must be used to pay your related expenses incurred both before and after the settlement. If you have ongoing expenses after the settlement, PacificSource, on behalf of the Plan Sponsor, may deny your related claims until the full settlement (less reasonable attorney's fees) has been used to pay those expenses.

- You and/or your agent or attorney must agree to keep segregated in its own account any recovery or payment of any kind to you or on your behalf that relates directly or indirectly to an Injury or Illness giving rise to the Plan Sponsor's right of reimbursement or subrogation, until that right is satisfied or released.

- If any of these conditions are not met, then PacificSource, on behalf of the Plan Sponsor, may recover any such benefits paid or advanced for any Illness or Injury through legal action, as well as reasonable attorney fees incurred by the Plan Sponsor.

- Unless Federal Law is found to apply.

- The Plan Sponsor's right to reimbursement overrides the made whole doctrine and this Plan disclaims the application of the made whole doctrine to the fullest extent permitted by law.

Right of Recovery – Time Limit for Reimbursements

PacificSource regularly engages in activities to identify and recover claims payments which should not have been paid or applied to Deductible amounts (for example, claims which are duplicate claims, errors, or fraudulent claims). If PacificSource, on behalf of the Plan Sponsor, makes a payment to you that you are not entitled to, or pays a person who is not eligible for payment, they may recover the payment. They must request reimbursement within 12 months of the claim payment except under the following circumstance:

- In the case where PacificSource and/or the Plan Sponsor becomes aware of an incorrect payment that was made due to an error, misstatement, misrepresentation, omission, or concealment other than insurance fraud by the Provider or another person, the 12 month time limit begins on the date PacificSource and/or the Plan Sponsor has actual knowledge of the invalid claim, claim overpayment, or other incorrect payment. Regardless of the date upon which PacificSource and/or the Plan Sponsor obtains actual knowledge of an invalid claim, claim overpayment, or other incorrect payment, PacificSource, on behalf of the Plan Sponsor, may not request reimbursement more than 24 months after the payment.

Motor Vehicle and Other Accidents

If you are involved in a motor vehicle Accident or other Accident, your related dental expenses are not covered by this Plan if they are covered by any other type of insurance plan.

The Plan may pay your dental claims from the Accident if an insurance claim has been filed with the other insurance company and that insurance has not yet paid.

By enrolling in this Plan, you agree to the terms in the previous section regarding third party liability.

On-the-Job Illness or Injury and Workers' Compensation

This Plan does not cover any work-related Illness or Injury that is caused by any for-profit activity, whether through employment or self-employment. The only exceptions would be if:

- You are the owner, partner, or principal of the Plan Sponsor, are injured in the course of employment, and are otherwise exempt from the applicable state or federal workers' compensation insurance program;

- The appropriate state or federal workers' compensation insurance program has determined that coverage is not available for your Injury; or

- You are employed by an Oregon based group, and have timely filed an application for coverage with the State Accident Insurance Fund or other Workers' Compensation carrier and are waiting for determination of coverage from that entity.

Claims submitted for coverage under this section are processed in accordance with the terms of this Plan.

If you are not the owner, partner, or principal of the Plan Sponsor, then this Plan may pay your dental claims if a workers' compensation claim has been denied on the basis that the Illness or Injury is not work related, and the denial is under Appeal.

Continuation of Benefits After Injury or Illness Covered by Workers' Compensation Insurance

Coverage under this Plan shall be available to eligible Employees who are not actively working and are receiving workers' compensation insurance payments. Contribution amounts/levels will be the same as if the Eligible Employee was actively at work. This continuation of benefits is administered in accordance with the coverage extension provision and with any state or federal continuation requirements. If an Employee incurs an Injury or Illness for which a workers' compensation claim is filed, the Eligible Employee may maintain such coverage until the earlier or:

- The Employee takes full-time employment with another Employer; or
- Twelve months from the date the Employee first makes payment of contribution under this provision. This twelve months of continued coverage is in lieu of, not in addition to, any other continuation of insurance provision described in other sections.

The contractual rules for third party liability, motor vehicle and other accidents, and on-the-job illness or injury are complicated and specific. Please refer to your Plan Sponsor for complete details, or contact the PacificSource Third Party Claims team.

COMPLAINTS, GRIEVANCES, AND APPEALS

QUESTIONS, CONCERNS, OR COMPLAINTS

If you have a question, concern, or Complaint about your coverage, please contact the PacificSource Customer Service team. Many times, their Customer Service team can answer your question or resolve an issue to your satisfaction right away. If you feel your issues have not been addressed, you have the right to submit a Grievance and/or Appeal in accordance with this section.

Members who do not speak English, have literacy difficulties, or have physical or mental disabilities that impede their ability to file an Appeal may contact the PacificSource Customer Service team for assistance. They can usually arrange for a multilingual staff member or interpreter to speak with them in their native language.

GRIEVANCE PROCEDURES

If you or your Authorized Representative are dissatisfied with the availability, delivery, or the quality of dental services; or claims payment, handling, or reimbursement for dental services; you may file a Grievance in writing. Grievances are not Adverse Benefit Determinations and do not establish a right to internal or External Review for a resolution to a Grievance.

PacificSource, on behalf of the Plan Sponsor, will attempt to address your Grievance, generally within

30 days of receipt. For more information, see the How to Submit Grievances or Appeals section.

APPEAL PROCEDURES

First Internal Appeal: If you believe this Plan has improperly reduced or terminated a dental item or service, or failed or refused to provide or make a payment in whole or in part for a dental item or service that is based on any of the reasons listed below, you or your Authorized Representative may Appeal the decision. The request for Appeal must be made in writing and within 180 days of your receipt of the Adverse Benefit Determination. For more information, see the How to Submit Grievances or Appeals section. You may Appeal if there is an Adverse Benefit Determination based on a:

- Denial of eligibility for or termination of enrollment in a plan;
- Rescission or cancellation of your coverage, whether or not the Rescission has an adverse effect on any particular benefit at the time;
- Imposition of a third party liability, network exclusion, annual benefit limit, or other limitation on otherwise Covered Services or items;
- Determination that a dental item or service is Experimental, Investigational, or Unproven, not a Dental Necessity, effective, or appropriate; or
- Determination that a course or plan or treatment you are undergoing is an active course of treatment for the purpose of continuity of care.

Any staff involved in the initial Adverse Benefit Determination will not be involved in the Internal Appeal.

You or your Authorized Representative may submit additional comments, documents, records, and other materials relating to the Adverse Benefit Determination that is the subject of the Appeal. If an Authorized Representative is filing on your behalf, PacificSource will not consider your Appeal to be filed until such time as they have received the Authorization to Use or Disclose PHI and the Designation of Authorized Representative forms.

If you request review of an Adverse Benefit Determination, this Plan will continue to provide coverage for the disputed benefit, pending outcome of the review, if you are currently receiving services or supplies under the disputed benefit. If this Plan prevails in the Appeal, you may be responsible for the cost of coverage received during the review period. The decision at the External Review level is binding unless other remedies are available under state or federal law.

Second Internal Appeal: If you are not satisfied with the first Internal Appeal decision, you may request an additional review. Your Appeal and any additional information not presented with your first Internal Appeal must be forwarded to PacificSource within 60 days of the first Appeal response.

Any staff involved in the first Internal Appeal will not be involved in the second Internal Appeal.

Request for Expedited Response: If there is a clinical urgency to do so, you or your Authorized Representative may request in writing or orally, an expedited response to an internal or External Review of an Adverse Benefit Determination. To qualify for an expedited response, your attending Provider must attest to the fact that the time period for making a non-urgent Benefit Determination could seriously jeopardize your life, health, your ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the dental care service or treatment that is the subject of the request. If your Appeal qualifies for an expedited review and would also

qualify for External Review (see External Independent Review), you may request that the internal and External Reviews be performed at the same time.

External Independent Review: If your dispute with the Plan relates to an Adverse Benefit Determination that a course or plan of treatment is not a Dental Necessity; is Experimental, Investigational, or Unproven; is not an active course of treatment for purposes of continuity of care; or is not delivered in an appropriate dental care setting and with the appropriate level of care, you or your Authorized Representative may request an External Review by an independent review organization. PacificSource must receive a signed Authorization To Use/Disclose Protected Health Information form within five business days of your external independent review request. This form must be signed to grant the review organization access to health records relevant to the decision. This form is located on the website, PacificSource.com/resources/documents-and-forms. For more information, see the How to Submit Grievances or Appeals section.

Your request for an independent review must be made within 180 days of the date of the second Internal Appeal response. External independent review is available at no cost to you, but is generally only available when coverage has been denied for the reasons stated above and only after all Internal Appeal levels are exhausted. You are provided five days to submit additional written information to the independent review organization for consideration during the review.

PacificSource, on behalf of the Plan Sponsor may, at its discretion and with your consent, waive the requirements of compliance with the Internal Appeals process and have a dispute referred directly to External Review. You shall be deemed to have exhausted the Internal Appeals if the Plan Sponsor fails to strictly comply with its Appeals process and with state and federal requirements for Internal Appeals.

If the independent review organization reverses the decision, this Plan will apply their decision quickly. However, if the independent review organization stands by the decision, there is no further Appeal available to you.

If the Plan Sponsor fails to comply with the decision of the independent review organization assigned under Oregon law, you have a private right of action against the Plan Sponsor for damages arising from an Adverse Benefit Determination subject to the External Review.

If you have questions regarding Oregon's External Review process, you may contact:

Division of Financial Regulation
Call 503-947-7984 or 888-877-4894

Timelines for Responding to Appeals

You will be afforded two levels of Internal Appeal and, if applicable to your case, an External Review. PacificSource will acknowledge receipt of an Appeal no later than seven days after receipt. A written decision in response to the Appeal will be made within 30 days after receiving your request to Appeal.

The above time frames do not apply if the period is too long to accommodate the clinical urgency of a situation, or if you do not reasonably cooperate, or if circumstances beyond your or our control prevent either party from complying with the time frame. In the case of a delay, the party unable to comply must give notice of delay, including the specific circumstances, to the other party.

Information Available with Regard to an Adverse Benefit Determination

The final Adverse Benefit Determination will include:

- A reference to the specific internal rule or guideline used in the Adverse Benefit Determination; and
- An explanation of the scientific or clinical judgment for the Adverse Benefit Determination, if the Adverse Benefit Determination is based on Dental Necessity, Experimental, Investigational, or Unproven treatment, or a similar exclusion.

Upon request, this Plan will provide you with any additional documents, records, or information that is relevant to the Adverse Benefit Determination.

HOW TO SUBMIT GRIEVANCES OR APPEALS

Grievances and Appeals can be submitted in writing by you or your Authorized Representative. Before submitting a Grievance or Appeal, we suggest you contact the PacificSource Customer Service team with your concerns. Issues can often be resolved at this level. Otherwise, you may file a Grievance or Appeal by contacting:

PacificSource Health Plans
Attn: Grievance and Appeals
PO Box 7068
Springfield, OR 97475-0068

Email dental@pacificsource.com, with Grievance or Appeal as the subject

Fax 541-225-3628

Assistance Outside PacificSource

You have the right to file a Complaint or seek other assistance from the Division of Financial Regulation. Assistance is available by contacting:

Division of Financial Regulation
Consumer Advocacy Unit
PO Box 14480
Salem, OR 97309-0405

Call 503-947-7984 or 888-877-4894

Email dfr.insurancehelp@dcbs.oregon.gov

Website dfr.oregon.gov

BECOMING COVERED

Who Pays for Your Benefits

Deschutes County shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. This authorization must be filled out, signed and returned with the enrollment application.

The level of any Employee contributions is set by the Plan Sponsor. The Plan Sponsor reserves the right to change the level of Employee contribution.

In addition, the Deductibles, Copayment amounts, and/or Coinsurance may also change periodically. You will be notified by your Plan Sponsor of any changes in the cost this Plan's coverage before they take effect.

ELIGIBILITY

Employees

Your status as an Employee is determined by the employment records maintained by the Plan Sponsor. Workers classified by the Plan Sponsor as independent contractors are not eligible for coverage under this Plan under any circumstances. You become eligible to enroll in coverage on this Plan when you have met the Plan Sponsor's eligibility requirements, which may include a Waiting Period or require you to work a certain minimum number of hours.

Elected Officials

The Plan Sponsor provides coverage for elected officials and their families. Please see the Dental Benefit Summary for the Plan Sponsor's eligibility requirements, including the length of the Waiting Period. The following elected officials are eligible for coverage:

- Three County Commissioners,
- County Sheriff,
- District Attorney,
- County Assessor,
- County Clerk,
- Justice of the Peace,
- County Treasurer.

Dependents

While you are covered under this Plan, the following Dependents are also eligible for coverage:

- Your legal Spouse or your Domestic Partner.
- Your, your Spouse's, or your Domestic Partner's Dependent Children under age 26 regardless of the child's place of residence, marital status, or financial dependence on you.
- Your, your Spouse's, or your Domestic Partner's unmarried Dependent Children age 26 or older who are mentally or physically disabled. To qualify as Dependents, they must have been continuously unable to support themselves since turning age 26 because of a mental or physical disability. The Plan Sponsor requires documentation of the disability from the Dependent Child's Provider, and will review the case before determining eligibility for coverage.

No family or household members other than those listed above are eligible to enroll under your coverage.

No person can be covered both as an Employee and as a Dependent, or as a Dependent of more than one Employee. Separate enrollments for Employees that are married or are in a domestic

partnership will not be allowed. The Employee who is employed the longest with Deschutes County must enroll his or her Spouse, Domestic Partner and any other eligible Dependents.

However, if both the mother and father are Employees of COIC, their children will be covered as Dependents of the mother and father.

In cases where the mother or father is an Employee of Deschutes County and the mother or father is an Employee of COIC, their children will be covered as Dependents of the mother and father.

To be eligible, the family or household member must permanently reside within the United States.

Special Rules for Eligibility

At any time the Plan Administrator may require proof that a Member qualifies, or continues to qualify, as a Dependent as defined by this Plan.

ENROLLING DURING THE INITIAL ENROLLMENT PERIOD

Once you satisfy the Plan Sponsor's Waiting Period, and meet the hours required for eligibility, you and your eligible Dependents become eligible for this Plan. Starting on the date you become eligible, you and your Dependents have 31 days to enroll, called the Initial Enrollment Period. To enroll, you must submit the enrollment information to the Plan Sponsor. The Plan Sponsor will send the information to PacificSource.

If you miss your Initial Enrollment Period, you will not be able to enroll in this Plan later in the year, unless you qualify for a special enrollment period. For more information, see the Enrolling After the Initial Enrollment Period section.

Employees who were determined eligible for coverage during the applicable measurement period (and their eligible Dependents) may enroll in the Plan the first day of the first full calendar month of the following stability period, as defined by the ACA. Employees will be credited for time previously satisfied toward the employment Waiting Period.

ENROLLING NEW DEPENDENTS

Newborns

Your newborn Dependent Child will be automatically enrolled from the date of birth for 31 days. To enroll your child beyond 31 days, the Plan Sponsor must receive your enrollment change within 31 days of the child's birth. A claim for maternity care is not considered notification for the purpose of enrolling a newborn child. The Plan Sponsor may ask for legal documentation to confirm validity.

In the case of a newborn of a Dependent Child, they will be automatically enrolled from the date of birth for 31 days. In order to enroll the child beyond 31 days, guardianship must be given to the Employee on the Plan, and the Plan Sponsor must receive your enrollment change within 31 days of the child's birth.

In the case of a newborn of a male Dependent Child, the Employee must supply proof of paternity (at the Plan's expense).

Adopted Children

Your adopted Dependent Child is eligible from the date of birth, placement, or finalization for 31 days. To enroll your child, the Plan Sponsor must receive your enrollment change within 31 days of the

birth, placement, or finalization. Coverage for your new family members will begin on the date of birth, placement, or finalization. The Plan Sponsor may ask for legal documentation to confirm validity. If your adopted child is older than age 18 at the time of placement or finalization, they may not be enrolled in this Plan.

Foster Children

When a foster Dependent child is placed in your home, you have 31 days from the date of placement to enroll them on the Plan. To enroll the child, the Plan Sponsor must receive your enrollment change within 31 days of the placement. Coverage for your new family members will begin on the date of placement. The Plan Sponsor may ask for legal documentation to confirm validity.

Family Members Acquired by Marriage

If you marry, you have 31 days from the date of the marriage to add your new Spouse and any newly eligible Dependent Children on this Plan. The Plan Sponsor must receive your enrollment change from you within 31 days of the marriage. If the enrollment change is received prior to the date of marriage, coverage for your new Dependents will begin on the date of marriage. If the enrollment form is received after the date of marriage but within the 31 day enrollment period, coverage will begin on the first day of the month after the date of the marriage. The Plan Sponsor may ask for legal documentation to confirm validity.

Family Members Acquired by Domestic Partnership

If you and your Domestic Partner have been issued a Certificate of Registered Domestic Partnership, your Domestic Partner and your partner's Dependent Children are eligible for coverage during the 31 day enrollment period after the registration of the Domestic Partnership. The Plan Sponsor must receive your enrollment change during the enrollment period. Coverage for your new Dependents will begin on the first day of the month after the date of the registration of the Domestic Partnership. The Plan Sponsor may ask for legal documentation to confirm validity.

Family Members Placed in Your Guardianship

If a court appoints you custodian or guardian of an eligible Dependent Child, you have 31 days from the court appointment to enroll them in this Plan. The Plan Sponsor must receive your enrollment change and any additional contribution from you within 31 days of the court appointment. Coverage will then begin on the first day of the month after the date of the court appointment. The Plan Sponsor may ask for legal documentation to confirm validity. When the court order terminates or expires, the child is no longer eligible for coverage under this Plan.

Qualified Medical Child Support Orders

This Plan complies with qualified medical child support orders (QMCSO) issued by a state court or state child support agency. A QMCSO is a judgment, decree, or order, including approval of a settlement agreement, which provides for health benefit coverage for the child of a member of this Plan.

If a court or state agency orders coverage for your Spouse, Domestic Partner, or Dependent Child, you have 31 days from the date of the court order to enroll them in this Plan. The Plan Sponsor must receive your enrollment change and any additional contribution from you within 31 days of the court order. Coverage will become effective on the first day of the month after the date of the court order. The Plan Sponsor may ask for legal documentation to confirm validity.

ENROLLING AFTER THE INITIAL ENROLLMENT PERIOD

Open Enrollment Periods

- If Eligible Employees and/or eligible Dependents are not enrolled during the Initial Enrollment Period, they must wait until the next open enrollment period to enroll unless they qualify for a special enrollment period as described below.

Special Enrollment Periods

You and/or your Dependents may decline coverage during your Initial Enrollment Period. To find out if this Plan allows Employees to decline coverage, ask the Plan Sponsor. If you wish to do so, you must submit a waiver of coverage to the Plan Sponsor.

Retirees and COBRA members may waive coverage for any reason. However, if they waive coverage, they will not be able to re-enroll at a future date.

You and/or your Dependents may enroll in this Plan later if you qualify under the Special Enrollment Rules below. Employees are allowed to waive medical coverage and enroll in dental only if the employee has an eligible waiver.

All special enrollment provisions assume that the Employee has satisfied any Waiting Periods required and each individual is eligible as stated in the Plan.

- Special Enrollment Rule #1

  If you declined enrollment for yourself or your Dependents because of other coverage or there was a change in contribution, you or your Dependents may enroll in the Plan later if the other coverage ends. To do so, you must submit a completed enrollment application to the Plan Sponsor within 31 days after the other coverage ends. If the other coverage was through Medicaid or a State Children's' Health Insurance Program, you and/or your Dependents will have 60 days to submit an enrollment change. Coverage will begin on the first day of the month following the receipt of the completed enrollment application.

- Special Enrollment Rule #2

- If you acquire new Dependents due to a qualifying event, you may be able to enroll yourself and/or your eligible Dependents at that time. Special Enrollment Rule #3

- If you or your Dependents become eligible for a premium assistance subsidy under Medicaid or a state Children's Health Insurance Program (CHIP), you may be able to enroll yourself and/or your Dependents at that time. To do so, you must request enrollment within 60 days of the date you and/or your Dependents become eligible for such assistance. Coverage will begin on the first day of the month after becoming eligible for such assistance.

Late Enrollment

If you did not enroll during your Initial Enrollment Period or enrolled and later discontinued coverage, and you do not qualify for a special enrollment period, your enrollment will be delayed until the Plan's next designated open enrollment period.

The annual open enrollment period is every November, during a two week period to be determined annually. Employees and their Dependents who are otherwise eligible for coverage under the Plan will be able to enroll in the Plan. Benefit choices made during the open enrollment period will become

effective January 1st. Plan participants will receive detailed information regarding open enrollment from their employer.

Returning to Work after a Layoff or Termination

If you are laid off or terminated, and then rehired by the Plan Sponsor within six months, you will not have to satisfy another Waiting Period.

Your coverage will resume the first day of the month after you return to work and again meet the Plan Sponsor's minimum hour requirement. If your Dependents were covered before your layoff, they can resume coverage at that time as well. You must re-enroll yourself and/or your Dependents by submitting an enrollment change within the 31 day enrollment period following your return to work.

Returning to Work after a Leave of Absence

If you return to work after a Plan Sponsor-approved Leave of Absence of six months or less, you will not have to satisfy another Waiting Period.

Your coverage will resume the first day of the month after you return to work and again meet the Plan Sponsor's minimum hour requirement. If your Dependents were covered before your leave, they can resume coverage at that time as well. You must re-enroll yourself and/or your Dependents by submitting an enrollment change within the 31 day enrollment period following your return to work.

Returning to Work after Family Medical Leave

If the Plan Sponsor employs 50 or more people, it is probably subject to the Family Medical Leave Act (FMLA). To find out if you have rights under FMLA, ask the Plan Sponsor. Under FMLA, if you return to work after a qualifying FMLA medical leave, you will not have to satisfy another Waiting Period.

Your coverage will resume the day you return to work and again meet the Plan Sponsor's minimum hour requirement. You must re-enroll yourself and/or your Dependents by submitting an enrollment change within the 31 day enrollment period following your return to work.

Status Change

Part-time to full-time conversion

Part-time Employees who have waived coverage and then become a full-time Employee or have a significant increase in work hours (minimum of 25%) may elect to enroll in the Standard Plan at that time. You may enroll by submitting an enrollment change to the Plan Sponsor within the 31 days following the change in your employment status. Coverage is effective the first of the month following the receipt of the application.

Part-time Employees who are enrolled in the High Deductible Plan option who then become full-time Employees may either waive continuation of coverage or enroll in the Standard Plan option at that time. You may enroll by submitting an enrollment change to the Plan Sponsor within the 31 days following the change in your employment status. Coverage will become effective the first day of the calendar month following or coinciding with the date the Employee is considered a full-time Employee.

If a part-time Employee's hours are reduced by a Deschutes County approved temporary reduction in hours, coverage will continue without termination.

Full-time to part-time conversion

Full-time Employees who have been covered under the Standard Plan and then become part-time Employees or have a significant decrease in work hours (minimum of 25%) may elect to waive continuation of coverage or enroll in the High Deductible Plan option at that time. You may enroll by submitting an enrollment change to the Plan Sponsor within the 31 days following the change in your employment status. Coverage will become effective the first day of the calendar month following or coinciding with the date the Employee is considered a part-time Employee.

Full-time hourly Employees who were covered under the Standard Plan and who experience a change in job status to a part-time position of less than 20 hours per week while in a stability period may continue coverage in the Standard Plan for 3 calendar months following the job status change, if the Employee continues to work in the part-time position and is on the Employer's payroll for that work. The Employee may also choose to enroll in the High Deductible Plan option at the time of the job status change. You may enroll by submitting an enrollment change to the Plan Sponsor within the 31 days following the change in your employment status. Coverage will become effective the first day of the calendar month following or coinciding with the date the Employee is considered a part-time Employee. Starting with the fourth calendar month, the Employee's eligibility will be determined on a month-to-month basis for the remainder of the stability period.

Employment transfer between COIC and Deschutes County

Employees who were employed by COIC and transfer their employment to Deschutes County or vice versa, will not have to re-serve the waiting period.

PLAN SELECTION PERIOD

If the Plan Sponsor offers more than one Plan option, you may only change to a different Plan option upon this Plan's anniversary date. You may select a different Plan option, if available, by submitting an enrollment change. Coverage under the new Plan option becomes effective on this Plan's anniversary date.

WHEN COVERAGE ENDS

If you leave your job for any reason or your work hours are reduced below the Plan Sponsor's minimum requirement, coverage for Members will end. Coverage ends on the last day of the month in which you worked the required minimum hours for coverage. Coverage for elected officials ends on the last day of the month in which you are no longer serving as an elected official of the County. You may be eligible to continue coverage for a limited time. For more information, see the Continuation of Coverage section.

Dependent Children

When your enrolled child no longer qualifies as a Dependent, their coverage will end on the last day of that month.

If two Employees are covered under the Plan and the Employee who is covering the Dependent Children terminates coverage, the Dependent Child may be continued by the other covered Employee with no waiting period as long as coverage has been continuous.

Dissolution of Domestic Partnership

If you dissolve your domestic partnership, coverage for your Domestic Partner and the Domestic Partner's children not related to you by birth or adoption will end on the last day of the month in which the dissolution of the domestic partnership is final. You must notify the Plan Sponsor of the

dissolution of the domestic partnership. Domestic Partners and their covered children are not recognized as qualified beneficiaries under federal COBRA continuation laws. Domestic Partners and their covered children may not continue this Plan's coverage under COBRA independent of the Employee.

Divorced Spouses

If you divorce, coverage for your Spouse will end on the last day of the month in which the divorce decree or legal separation is final. You must notify the Plan Sponsor of the divorce or separation, and continuation coverage may be available for your Spouse. If there are special child custody circumstances, please contact the Plan Sponsor.

CONTINUATION OF COVERAGE

The following sections describe your rights to continuation under federal and/or state law, and the requirements you must meet to enroll in continuation coverage.

Continuation Due to Plan Sponsor Approved Paid Administrative Leave of Absence, Disability, or Leave of Absence

A Member may remain eligible for coverage for a limited time if active, full-time work ceases due to disability, Employer-certified leave of absence, or paid administrative leave.

For disability or Employer-certified leave of absence, coverage eligibility will remain in effect until the end of the three calendar month period that next follows the month in which the Member last worked as an active Employee.

For paid administrative leave, coverage eligibility will remain in effect until the date the Employer, in its sole discretion, ends such eligibility.

While continued, coverage will be that which was in force on the last day worked as an active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued Members.

If you return to work after a Plan Sponsor-approved paid administrative leave of absence, you will not have to satisfy another Waiting Period.

USERRA CONTINUATION

If you take a Leave of Absence from your job due to military service, you have continuation rights under the Uniformed Services Employment and Re-employment Rights Act (USERRA).

Members may continue this Plan's coverage if you, the Employee, no longer qualify for coverage under the Plan because of military service. Continuation coverage under USERRA is available for up to 24 months while you are on military leave. If your military service ends and you do not return to work, your eligibility for USERRA continuation coverage will end. Premium for continuation coverage is your responsibility.

The following requirements apply to USERRA continuation:

- Only Dependents who were enrolled in the Plan can take continuation. The only exceptions are newborn babies and newly acquired eligible Dependents not covered by another group dental plan.

- To apply for continuation, you must submit a completed Continuation Election form to the Plan Sponsor within 60 days after the last day of coverage under the Plan.
- You must pay continuation premium to the Plan Sponsor by the first of each month. PacificSource cannot accept the premium directly from you.
- The Plan Sponsor must still be self-insured. If the Plan Sponsor discontinues this Plan, you will no longer qualify for continuation.

COBRA CONTINUATION

This Plan is subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended. To find out if you have continuation rights under COBRA, ask the Plan Sponsor.

If COBRA is available to you and certain circumstances (a qualifying event) occur that cause you to lose coverage, you may have the right to continue coverage for a period of time.

COBRA Eligibility and Length of Continuation

When the following qualifying events cause you to lose coverage, you may continue coverage for the lengths of time shown in the table:

Qualifying Event	**Continuation Period**
Employee's termination of employment or reduction in hours	Employee, Spouse, and children may continue for up to 18 months[1]
Employee's divorce or legal separation	Spouse and children may continue for up to 36 months[2]
Employee's entitlement to Medicare benefits if it causes a loss of coverage	Spouse and children may continue for up to 36 months[2]
Employee's death	Spouse and children may continue for up to 36 months[2]
Child no longer qualifies as a Dependent	Child may continue for up to 36 months[2]

[1] If the Employee or Dependent is determined disabled by the Social Security Administration prior to or within the first 60 days of COBRA coverage, all qualified beneficiaries may continue coverage for up to 29 months.

[2] The total maximum continuation period is 36 months, even if there is a second qualifying event. A second qualifying event might be a divorce, death, or child no longer qualifying as a Dependent after the Employee's termination or reduction in hours.

If your Dependents were not covered prior to your qualifying event, they may enroll in the continuation coverage while you are on continuation. They will be subject to the same rules that apply to active Employees.

If your employment is terminated for gross misconduct, you and your Dependents are not eligible for COBRA continuation.

Domestic Partners and their Dependent Children may not continue this Plan's coverage under COBRA independent of the Employee.

When Continuation Coverage Ends

COBRA coverage will end earlier than the maximum period outlined in the table above if:

- Premiums are not paid timely;
- Member becomes covered under another group plan or Medicare after electing COBRA. Coverage already in effect under another plan at the time of COBRA election will not make COBRA unavailable and COBRA coverage may continue for up to 36 months from the date the Member became entitled to Medicare;
- The Plan Sponsor discontinues this Plan and no longer offers a group dental plan to any of its Employees;
- Member who qualified for a disability extension is determined by the Social Security Administration to no longer be disabled;
- Member is terminated for cause (for example, submission of fraudulent claims).

Type of Coverage

Under COBRA, you may continue any coverage you had before the qualifying event. If the Plan Sponsor provides both medical and dental coverage and you were enrolled in both, you may continue both medical and dental. If the Plan Sponsor provides only one type of coverage, or if you were enrolled in only one type of coverage, you may continue only that coverage.

COBRA continuation benefits are always the same as the Plan Sponsor's current benefits. The Plan Sponsor has the right to change the benefits of this Plan or eliminate this Plan entirely. If that happens, any changes to this Plan will also apply to everyone enrolled in continuation coverage.

Your Responsibilities and Deadlines

You must notify the Plan Sponsor within 60 days if you divorce, or if your child no longer qualifies as a Dependent. That will allow the Plan Sponsor to notify you or your Dependents of your continuation rights.

When the Plan Sponsor learns of your eligibility for continuation, the Plan Sponsor will notify you of your continuation rights and provide a Continuation Election form. You then have 60 days from that date or 60 days from the date coverage would otherwise end, whichever is later, to enroll in continuation coverage by submitting a completed Continuation Election form to the Plan Sponsor. If continuation coverage is not elected during that 60 day period, coverage will end on the last day of the last month you were an active Employee, or when your Dependent lost eligibility.

If you fail to provide the Plan Sponsor with the Continuation Election form in the required timeframe, then the Plan Sponsor's obligation to provide you with COBRA coverage will end. PacificSource does not accept any liability for any failure, on your part or the part of the Plan Sponsor, to provide required notices for coverage.

Continuation Premium

Members are responsible for the full cost of continuation coverage. The Plan Sponsor uses the services of a third-party COBRA administrator to collect premium for continuation coverage. Please see the Plan Sponsor for more information about the Plan's COBRA administrator. The monthly premium must be paid to the Plan Sponsor's COBRA administrator. You may make your first premium payment any time within 45 days after you return your Continuation Election form to the Plan Sponsor's COBRA administrator. After the first premium payment, each monthly payment must

reach the Plan Sponsor's COBRA administrator within 30 days of your premium due date. If the COBRA administrator does not receive your continuation premium on time, continuation coverage will end. If your coverage is canceled due to a missed payment, it will not be reinstated for any reason. It is solely your responsibility to ensure that the COBRA administrator receives the premium on time. Premium rates are established annually and may be adjusted if the Plan's benefits or costs change.

SURVIVING OR DIVORCED SPOUSES AND DOMESTIC PARTNERS

If your group has 20 or more Employees, or this Plan has 20 or more Subscribers, and you die, divorce, or dissolve your domestic partnership, and your Spouse or Domestic Partner is 55 years or older, your Spouse or Domestic Partner may be able to continue coverage until entitled to Medicare or other coverage. Dependent Children are subject to this Plan's age and other eligibility requirements. Some restrictions and guidelines apply; contact the Plan Sponsor for specific details.

CONTINUATION WHEN YOU RETIRE

Continuation upon retirement is based on meeting all the retirement requirements set forth in the terms and conditions of your employment agreed to with your Plan Sponsor

- You must be receiving benefits from PERS (Public Employee Retirement System) or from a similar retirement Plan offered by your Plan Sponsor;
- You must have been continuously covered under the group's Plan for at least 24 consecutive months prior to the retirement, unless otherwise indicated by a management/labor agreement.

Retired Employees must elect Retiree coverage within 30 days of the date of their retirement or loss of other Deschutes County coverage to be eligible for this coverage.

Only those Dependents who are enrolled under this Plan at the time the Employee retired are eligible to continue coverage under this Plan as the retiree's Dependents. A covered retiree may only add a newborn child, adopted child or child placed for adoption, or a foster child after his/her retirement date.

If you become eligible for PERS while enrolled in COBRA due to a medical determination that you are not able to work because of disability, you can elect to re-enroll as a retired Employee only under this Plan. You must request re-enrollment within 6 months of PERS eligibility.

Your continuation coverage will end when any one of the following occurs:

When a retired Employee's coverage terminates. Retired Employee coverage will terminate on the earliest of these dates:

- The date the Plan is terminated;
- The date the covered retired Employee's eligible class is eliminated;
- The first day of the calendar month the covered retired Employee becomes entitled to Medicare;
- The end of the period for which the required contribution has been paid if the charge for the next period is not paid when, due or
- As otherwise specified in the Eligibility section of the Plan.

Your Dependent's continuation of coverage will end when any one of the following occurs:

- When Dependent Coverage of a Retired Employee Terminates.
- When a retired Employee's coverage terminates under this Plan due to reaching age 65 or becoming entitled to Medicare, his/her Dependents may remain eligible for benefits until the Dependent's coverage terminates as outlined below. The Plan Sponsor must be notified that the Dependent coverage is to continue within 31 days of the retired Employee's termination. A retired Employee's Dependent's coverage will terminate on the earliest of these dates:
- The last day of the calendar month the Plan or Dependent coverage under the Plan is terminated;
- On the last day of the calendar month a covered Spouse or Domestic Partner of a retired Employee loses coverage due to loss of dependency status (See the Continuation of Coverage section.);
- The first day of the month the covered Dependent Spouse or Domestic Partner becomes entitled to Medicare;
- On the last day of the calendar month that a Dependent Child ceases to be a Dependent as defined by the Plan (See the Continuation of Coverage section.);
- The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due; or
- As otherwise specified in the Eligibility section of the Plan.

WORK STOPPAGE

Labor Unions

If an Employee is employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, coverage may be continued for up to six months. The Employee must pay the full contribution, including any part usually paid by the Employer, directly to the union or trust that represents him or her. The union or trust must continue to pay the contributions on the due date. Coverage cannot be continued if fewer than 75% of those normally enrolled continue coverage or if the Employee or Dependent(s) otherwise lose eligibility under the Plan. This six months of continued coverage is in lieu of and not in addition to any continuation of coverage provisions of the Plan.

RESOURCES FOR INFORMATION AND ASSISTANCE

Assistance

Members who do not speak English, have literacy difficulties, or have physical or mental disabilities may contact the PacificSource Customer Service team for assistance.

Information Available from PacificSource

PacificSource makes the following disclosure information available to you free of charge. You may contact the PacificSource Customer Service team to request a copy (by mail or electronically) or by visiting the website, PacificSource.com. Available disclosure information includes, but not limited to, the following:

- A directory of Providers under this Plan;

- A description (consistent with risk-sharing information required by the Centers for Medicare and Medicaid Services) of any risk-sharing arrangements the Plan or PacificSource has with Providers;
- A description of the Plan Sponsor's and/or PacificSource's efforts to monitor and improve the quality of dental services;
- Information about how PacificSource checks the credentials of network Providers and how you can obtain the names and qualifications of your Providers;
- Information about prior authorization, Predetermination and utilization review procedures; and
- Information about any plan offered by PacificSource.

Information Available from the Division of Financial Regulation about PacificSource

The following consumer information is available from the Division of Financial Regulation:

- The results of all publicly available accreditation surveys;
- A summary of PacificSource's health promotion and disease prevention activities;
- Samples of the written summaries delivered to PacificSource policyholders;
- An annual summary of Grievances and Appeals against PacificSource;
- An annual summary of PacificSource's utilization review policies;
- An annual summary of PacificSource's quality assessment activities; and
- An annual summary of the scope of PacificSource's Provider network and accessibility of services.

You can request this information by contacting:

Division of Financial Regulation
Consumer Advocacy Unit
PO Box 14480
Salem, OR 97309-0405

Call 503-947-7984 or 888-877-4894

Email dfr.insurancehelp@dcbs.oregon.gov

Website dfr.oregon.gov

RIGHTS AND RESPONSIBILITIES

The Plan Sponsor and PacificSource are committed to providing you with the highest level of service in the industry. By respecting your rights and clearly explaining your responsibilities under this Plan, we will promote effective dental care.

Your Rights as a Member

- You have a right to receive information about the Plan and PacificSource, our services, our Providers, and your rights and responsibilities.
- You have a right to expect clear explanations of this Plan's benefits and exclusions.
- You have a right to be treated with respect and dignity.
- You have a right to impartial access to dental care without regard to race, religion, gender, national origin, or disability.
- You have a right to honest discussion of appropriate or Dentally Necessary treatment options. You are entitled to discuss those options regardless of how much the treatment costs or if it is covered by this Plan.
- You have a right to the confidential protection of your records and personal information.
- You have a right to voice Complaints about this Plan, PacificSource, or the care you receive, and to Appeal decisions you believe are wrong.
- You have a right to participate with your Provider in decision-making regarding your care.
- You have a right to know why any tests, procedures, or treatments are performed and any risks involved.
- You have a right to refuse treatment and be informed of any possible medical or dental consequences.
- You have a right to refuse to sign any consent form you do not fully understand, or cross out any part you do not want applied to your care.
- You have a right to change your mind about treatment you previously agreed to.

Your Responsibilities as a Member

- You are responsible for reading this Plan Document and all other communications from the Plan Sponsor and PacificSource, and for understanding this Plan's benefits. You are responsible for contacting the Plan Sponsor or PacificSource's Customer Service team if anything is unclear to you.
- You are responsible for making sure your Provider obtains prior authorization for any services that require it before you are treated.
- You are responsible for providing the Plan Sponsor and PacificSource with all the information required to provide benefits under this Plan.
- You are responsible for giving your Provider complete information to help accurately diagnose and treat you.
- You are responsible for telling your Providers you are covered by this Plan and showing your PacificSource Member ID card when you receive care.
- You are responsible for being on time for appointments, and calling your Provider ahead of time if you need to cancel.
- You are responsible for any fees the Provider charges for late cancellations or no shows.

- You are responsible for contacting the Plan Sponsor or PacificSource if you believe you are not receiving adequate care.
- You are responsible for supplying information to the extent possible that the Plan Sponsor or PacificSource needs in order to administer your benefits or your Providers need in order to provide care.
- You are responsible for following plans and instructions for care that you have agreed to with your Providers.
- You are responsible for understanding your health and dental problems and participating in developing mutually agreed upon goals, to the degree possible.

PRIVACY AND CONFIDENTIALITY

The Plan Sponsor and PacificSource have strict policies in place to protect the confidentiality of your personal information, including dental records. Detailed information is available at PacificSource.com/privacy-policy.

Your personal information is only available to staff members who need that information to do their jobs. Disclosure outside the Plan Sponsor and PacificSource is allowed only when necessary to provide your coverage, or when otherwise allowed by law. Except when certain statutory exceptions apply, the law requires written authorization from you (or your Authorized Representative) before disclosing your personal information outside the Plan Sponsor or PacificSource. An example of one exception is that we do not need written authorization to disclose information to a designee performing utilization management, quality assurance, or peer review on our behalf.

PLAN ADMINISTRATION

Name of Plan:

The Deschutes County Group Dental Plan (the “Plan”).

Name and Address of the Plan Sponsor:

Deschutes County
PO Box 6005
Bend, OR 97708-6005
Phone: (541) 385-3215
Fax: (541) 330-4626

Plan Sponsor’s Employer Identification / Tax Identification Number:

93-6002292

Plan Identification Number:

502

Contract Year:

January 1st to December 31st

Type of Plan:

Group Dental Plan (self-insured)

Type of Administration:

The Plan is administered by Employees of the Plan Sponsor and under an administrative services agreement with a Third Party Administrator.

Name and Address of Third Party Administrator:

PacificSource Health Plans
P.O. Box 7068
Springfield, OR 97475-0068
Phone: (888) 977-9299
Fax: (541) 684-5264

Name and Address of Designated Agent for Service of Legal Process:

Deschutes County
Attn: Nick Lelack, County Administrator
PO Box 6005
Bend, OR 97708-6005
Phone: (541) 385-3215
Fax: (541) 330-4626

Funding Method and Contributions:

This Plan is self-insured, meaning that benefits are paid from the general assets and/or trust funds of the Plan Sponsor and are not guaranteed under an insurance policy or contract. The cost of the Plan is paid with contributions by the Plan Sponsor and participating Employees. The Plan Sponsor determines the amount of contributions to the Plan, based on estimates of claims and administration costs. The Plan Sponsor may purchase insurance coverage to guard against excess loss incurred by allowed claims under the Plan, but such coverage is not included as part of the Plan.

Plan Changes

The terms, conditions, and benefits of this Plan may be changed from time to time. The following people have the authority to accept or approve changes or terminate this Plan:

- The Plan Sponsor's board of directors or other governing body;
- The owner or partners of the Plan Sponsor; or
- Anyone authorized by the above people to take such action.

The Plan Administrator is authorized to make Plan changes on behalf of the Plan Sponsor.

If this Plan terminates and the Plan Sponsor does not replace the coverage with another Plan, the Plan Sponsor is required by law to advise you in writing of the termination.

DEFINITIONS

Wherever used in this Plan, the following definitions apply to the masculine and feminine, and singular and plural forms of the terms. Other terms are defined where they are first used in the text.

Abutment is a tooth used to support a prosthetic device (bridges, partials, or overdentures). With an implant, an Abutment is a device placed on the implant that supports the implant crown.

Accident means an unforeseen or unexpected event causing Injury that requires medical attention.

Adverse Benefit Determination means this Plan's denial, reduction, or termination of, or this Plan's failure to provide or make a payment in whole or in part, for a benefit that is based on this Plan's:

- Denial of eligibility for or termination of enrollment in this Plan;
- Rescission or cancellation of your coverage;
- Imposition of a third party liability, network exclusion, annual benefit limit, or other limitation on otherwise Covered Services or items;
- Determination that a dental item or service is Experimental, Investigational, or Unproven, not a Dental Necessity, effective, or appropriate; or
- Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care.

Allowable Fee is the maximum amount this Plan will reimburse Providers. In-network Providers are paid the Contracted Allowable Fee and Out-of-network Providers are paid the Out-of-Network Allowable Fee.

- **Contracted Allowable Fee** is an amount this Plan agrees to pay an In-network Provider for a given service or supply through direct or indirect contract.
- **Out-of-network Allowable Fee** is the dollar amount established by PacificSource for reimbursement of charges for specific services or supplies provided by Out-of-network Providers.

  The Out-of-Network Allowable Fee is based on the Usual, Customary, and Reasonable (UCR) fee. UCR is the fee based on charges being made by Providers in the same service area for similar treatment of similar dental conditions. A UCR fee is based on Provider billing data gathered by PacificSource and adjusted to the 90th percentile. UCR fees are reviewed by PacificSource annually.

  An Out-of-network Provider may charge more than the limits established by the Out-of-Network Allowable Fee. Charges that are eligible for reimbursement, but exceed the Out-of-Network Allowable Fee, are the Member's responsibility. For more information, see the Out-of-Network Providers section.

Alveolectomy is the removal of bone from the socket of a tooth.

Amalgam is a silver-colored material used in restoring teeth.

Appeal means a written or verbal request from a Member or, if authorized by the Member, the

Member's Authorized Representative, to change a previous decision made under this Plan concerning:

- Access to dental benefits, including an Adverse Benefit Determination made pursuant to utilization management;
- Claims payment, handling, or reimbursement for dental services;
- Rescission of the Member's benefit coverage; and
- Other matters as specifically required by law.

Authorized Representative is an individual who by law or by the consent of a Member may act on behalf of the Member. An Authorized Representative *must* have the Member complete and execute an Authorization to Use or Disclose PHI form and a Designation of Authorized Representative form, both of which are available at PacificSource.com**,** and which will be supplied to you upon request. These completed forms must be submitted to PacificSource before PacificSource can recognize the Authorized Representative as acting on behalf of the Member.

Balance Billing means the difference between the Allowable Fee and the Provider's billed charge. Out-of-network Providers may bill the Member this amount.

Benefit Determination means the activity taken to determine or fulfill the Plan Sponsor's responsibility for provisions under this Plan and provide reimbursement for dental care in accordance with those provisions. Such activity may include:

- Eligibility and coverage determinations (including coordination of benefits), and adjudication or subrogation of claims;
- Review of dental services with respect to Dental Necessity (including underlying criteria), coverage under this Plan, appropriateness of care, Experimental, Investigational, or Unproven treatment, justification of charges; and
- Utilization review activities, including Predetermination and prior authorization of services and concurrent and post-service review of services.

Benefit Year refers to the period of time during which benefits accumulate toward Plan maximums and is on a calendar year basis, beginning January 1 through December 31 of the same year.

Cast Restoration includes crowns, inlays, onlays, and other Restorations made to fit a Member's tooth that are made at a laboratory and cemented onto the tooth.

Coinsurance means a defined percentage of the Allowable Fee for certain Covered Services and supplies the Member receives. It is the percentage the Member is responsible for, not including Copayments and Deductibles.

Complaint means an expression of dissatisfaction directly to the Plan Sponsor or PacificSource that is about a specific problem encountered by a Member, or about a Benefit Determination by the Plan Sponsor, or about an agent acting on behalf of the Plan Sponsor, including PacificSource. It includes a request for action to resolve the problem or change the Benefit Determination. The Complaint does not include an Inquiry.

Composite Resin is a tooth-colored material used in restoring teeth.

Concurrent Care Claim means a request for an extension of healthcare services already approved. The review is conducted during a Member's stay or course of treatment in a facility, the office of a Provider, or other inpatient or outpatient healthcare setting.

Copayment (also referred to as Copay) is a fixed, up-front dollar amount the Member is required to pay for certain Covered Services.

Covered Service means a service or supply for which benefits are payable under this Plan subject to applicable Deductibles, Copayments, Coinsurance, or other specific limitations.

Curettage is the scraping and cleaning of the walls of a real or potential space, such as a gingival pocket or bone, to remove pathological material.

Deductible means the portion of the expense for a Covered Service that must be paid by the Member before the benefits of this Plan are applied. A Plan may include more than one Deductible.

Dentally Necessary or Dental Necessity 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 or prevention of the condition;
- Consistent with generally accepted standards of good dental practice, or expert consensus Provider opinion published in peer-reviewed dental literature, or the results of clinical outcome trials published in peer-reviewed dental literature;
- As likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any other service or supply, both as to the Illness or Injury involved and the Member's overall health condition;
- Not for the convenience of the Member or a Provider of services or supplies; and
- The least costly of the alternative services or supplies that can be safely provided.

The fact that a Provider may recommend or approve a service or supply does not, of itself, make the charge a Covered Service.

Dependent means the Employee's legal Spouse, Domestic Partner, and Dependent Children who qualify for coverage under the Employee's plan. For more information, see the Eligibility section.

Dependent Children means the following:

- Biological children;
- Step children;
- Adopted children; a child will be considered a Dependent upon assumption of a legal obligation for total or partial support in anticipation of adoption; and
- Foster children or children for whom you or your Spouse/Domestic Partner are under a current court order to act as legal custodian or guardian.

Domestic Partner means an individual that meets the following definition:

- **Registered Domestic Partner** means an individual, age 18 or older, who is joined in a domestic partnership, and whose domestic partnership is legally registered in any state.

Eligible Employee means an Employee or former Employee who is eligible for coverage under this Plan. Eligible Employees may be covered under this Plan only if they meet the eligibility requirements according to the terms of this Plan.

Emergency Dental Condition means a dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain or infection such that a prudent layperson, who possesses an average knowledge of health and dentistry, could reasonably expect the absence of immediate dental attention to result in:

- Placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Employee means any individual employed by the Plan Sponsor.

Employer generally means the Plan Sponsor unless otherwise noted.

Experimental, Investigational, or Unproven means services, supplies, protocols, procedures, devices, chemotherapy, drugs or medicines, or the use thereof, that are Experimental, Investigational, or Unproven for the diagnosis and treatment of Illness or Injury.

- Experimental, Investigational, or Unproven services and supplies include, but not limited to, services, supplies, procedures, devices, chemotherapy, drugs or medicines, or the use thereof, which at the time they are rendered and for the purpose and in the manner they are being used:
  - Have not yet received full U.S. government agency required approval (for example, FDA) for other than Experimental, Investigational, or Unproven, or clinical testing;
  - Are not of generally accepted dental practice in this Plan's state of issue or as determined by dental advisors, dental associations, and/or technology resources;
  - Are not approved for reimbursement by the Centers for Medicare and Medicaid Services;
  - Are furnished in connection with dental or other research; or
  - Are considered by any governmental agency or subdivision to be Experimental, Investigational, or Unproven, not considered reasonable and necessary, or any similar finding.
- When making decisions about whether treatments are Experimental, Investigational, or Unproven, this Plan relies on the above resources as well as:
  - Expert opinions of specialists and other dental authorities;
  - Published articles in peer-reviewed dental literature;
  - External agencies whose role is the evaluation of new technologies and drugs; and
  - External Review by an independent review organization.
- The following will be considered in making the determination whether the service is in an Experimental, Investigational, or Unproven status:
  - Whether there is sufficient evidence to permit conclusions concerning the effect of the services

on health outcomes;

- Whether the scientific evidence demonstrates that the services improve health outcomes as much or more than established alternatives;
- Whether the scientific evidence demonstrates that the services' beneficial effects outweigh any harmful effects; and
- Whether any improved health outcomes from the services are attainable outside an investigational setting.

External Review means the request by an appellant for a determination by an independent review organization at the conclusion of an Internal Appeal.

Grievance means a written Complaint submitted by or on behalf of a Member regarding service delivery issues other than denial of payment for services or non-provision of services, including dissatisfaction with care, waiting time for services, Provider or staff attitude or demeanor, or dissatisfaction with service provided by the carrier.

Illness means a sickness, disease, ailment, bodily disorder, and pregnancy.

In-network Provider means a Provider that directly or indirectly holds a Provider contract or agreement with PacificSource.

Initial Enrollment Period means a period of days set by the Plan Sponsor that determines when an Employee is first eligible to enroll.

Injury means bodily trauma or damage that is independent of disease or infirmity. The damage must be caused through external and Accidental means.

Inquiry means a written request for information or clarification about any subject matter related to this Plan.

Internal Appeal means a review of an Adverse Benefit Determination.

Leave of Absence is a period of time off work granted to an Employee by the Plan Sponsor at the Employee's request and during which the Employee is still considered to be employed and is carried on the employment records of the Plan Sponsor. A leave can be granted for any reason acceptable to the Plan Sponsor, including disability and pregnancy.

Lifetime Maximum means the maximum benefit that will be provided toward the expenses incurred by any one Member during the Member's lifetime and while the Member is covered by this Plan or any other Plan offered by the Plan Sponsor.

Member means a person covered by this Plan.

Out-of-network Provider means a Provider that does not directly or indirectly hold a Provider contract or agreement with PacificSource.

Periodontal Maintenance is a periodontal procedure for Members who have previously been treated for periodontal disease. In addition to cleaning the visible surfaces of the teeth (as in Prophylaxis) surfaces below the gum-line are also cleaned. This is a more comprehensive service than a regular cleaning (Prophylaxis).

Periodontal Scaling and Root Planing means the removal of plaque and calculus deposits from the root surface under the gum line.

Plan Amendment is a written attachment that amends, alters, or supersedes any of the terms or conditions set forth in this Plan Document.

Post-service Claim means a request for benefits that involves services you have already received.

Pre-service Claim means a request for benefits that requires approval by PacificSource, on behalf of the Plan Sponsor, in advance (prior authorization) in order for a benefit to be paid.

Predetermination means an estimate provided before dental treatment starts that tells you if treatment is covered, the amount this Plan will pay, the amount for which you will be responsible, and any alternate treatment options covered by this Plan. A Predetermination is not a guarantee of payment and is based on benefits available at the time requested.

Prophylaxis is a cleaning and polishing of all teeth.

Provider means a dentist, oral surgeon, endodontist, orthodontist, periodontist, or pedodontist. Provider may also include a denturist, dental therapist, or dental hygienist to the extent that they operate within the scope of their license.

Pulpotomy is the removal of a portion of the pulp, including the diseased aspect, with the intent of maintaining the vitality of the remaining pulpal tissue by means of a therapeutic dressing.

Rescission means to retroactively cancel or discontinue coverage under this Plan for reasons other than failure to timely pay required premiums or required contributions. This Plan may not rescind coverage unless the Member or person seeking coverage on behalf of the Member, performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of a material fact, as prohibited by the terms of the Plan or coverage and a 30 day prior written notice is provided.

Restoration is the treatment that repairs a broken or decayed tooth. Restorations include, but not limited to, fillings and crowns.

Spouse means any individual who is legally married under current state law.

Subscriber means an Employee or former Employee covered under this Plan. When a family that does not include an Employee or former Employee is covered under this Plan, the oldest Dependent is referred to as the Subscriber.

Third Party Administrator means an organization that processes claims and performs administrative functions on behalf of the Plan Sponsor pursuant to the terms of a contract or agreement. In the case of this Plan, the term Third Party Administrator refers solely to PacificSource.

Urgent Care Claim means a request for medical care or treatment with respect to which the time periods for making a non-urgent determination could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Waiting Period means the period that must pass with respect to the Employee before the Employee is eligible to be covered for benefits under the terms of this Plan.

X-ray (radiographic image) is a computerized image that provides information for detecting, diagnosing, and treating conditions that can threaten oral and general health. It includes cone beam X-rays, bitewing X-rays, single film X-rays, intraoral X-rays, extraoral X-rays, panoramic X-rays, periapical X-rays, and cephalometric X-rays.

SIGNATURE PAGE

It is agreed by Deschutes County that the provisions of this document are correct and will be the basis for the administration of the Dental Plan. The effective date of the Deschutes County Dental Plan is January 1, 2023.

Dated this 25 (Date) day of October (Month), 2022 (Year)

By Nick Lelack

Title County Administrator