

Deschutes County

Group No.: G0037173
Plan Name: Dental Plan
Effective: January 1, 2018

With Third Party Administrative Services Provided By:



This page left intentionally blank.

INTRODUCTION

Deschutes County has established the Deschutes County Group Dental Plan (referred to as the or this “Plan”) to provide dental care coverage for Eligible Employees and their Dependents. This Plan is established effective January 1, 2018 (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, or which are in *italics*, 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 within the meaning of 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 Covered Individual through this Plan, are not taxable income to the Covered Individual. The specific tax treatment of any Covered Individual will depend on the individual's personal circumstances; the Plan does not guarantee any particular tax treatment. Covered Individuals 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.

PacificSource Health Plans (“PacificSource”) is the Third Party Administrator and will process Claims, manage the network of Health Care Providers, answer dental benefit and Claim questions, and to generally provide administrative services to the Plan. If anything is unclear to you, please contact your Plan Sponsor or the Third Party Administrator at the number or address available in this Introduction section.

Written Plan Document and SPD

This Plan Document contains both the written Plan Document and the Summary Plan Description (“SPD”) required under ERISA. 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 Summary of Benefits provides 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 the Plan. Plan Sponsor is solely responsible for setting any and all criteria used to determine enrollment and eligibility.

Questions?

PacificSource's customer service representatives are 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 representatives are not authorized to interpret or change the terms of the Plan.

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

PacificSource Customer Service Team

Phone (888) 246-1370

Email dental@pacificsource.com

PacificSource Headquarters

110 International Way, Springfield, OR 97477

PO Box 7068, Springfield, OR 97475-0068

Phone (541) 686-1242 or (800) 624-6052

Website

PacificSource.com

As used in this Plan Document, the word 'year' refers to the contract year, which is the 12-month period beginning January 1st and ending December 31st. The word lifetime as used in this Plan Document refers to the period of time you or your eligible family members participate in this Plan or any other plan offered by the Plan Sponsor.

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 a provided to a member.

Governing Law

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

Para asistirle en español, por favor llame el número (866) 281-1464.

CONTENTS

- DENTAL BENEFIT SUMMARYA**
- ORTHODONTIC BENEFIT SUMMARYD**
- BECOMING ELIGIBLE 1**
 - ENROLLING DURING THE INITIAL ENROLLMENT PERIOD 2
 - ENROLLING NEW FAMILY MEMBERS 3
 - PLAN SELECTION PERIOD 7
 - WHEN COVERAGE ENDS..... 7
- CONTINUATION OF COVERAGE 8**
 - CONTINUATION DUE TO PLAN SPONSOR APPROVED PAID ADMINISTRATIVE LEAVE OF ABSENCE, DISABILITY, OR LEAVE OF ABSENCE 8
 - USERRA CONTINUATION..... 8
 - SURVIVING OR DIVORCED SPOUSES AND DOMESTIC PARTNERS..... 9
 - COBRA CONTINUATION..... 9
 - CONTINUATION WHEN YOU RETIRE 11
- HOW TO USE YOUR PLAN 13**
- USING THE DENTAL ADVANTAGE NETWORK 13**
- COVERED EXPENSES 15**
 - DENTAL PLAN BENEFITS..... 15
 - COVERED DENTAL SERVICES..... 15
 - CLASS I SERVICES 15
 - CLASS II SERVICES 16
 - CLASS III SERVICES 17
 - ORTHODONTIC SERVICES 17
- BENEFIT LIMITATIONS AND EXCLUSIONS 18**
 - EXCLUDED SERVICES 18
 - NECESSITY ACCORDING TO ACCEPTABLE DENTAL PRACTICE 21
 - INDIVIDUAL BENEFITS MANAGEMENT 21
- CLAIMS PAYMENT 21**
 - COORDINATION OF BENEFITS 23
 - THIRD PARTY LIABILITY..... 24
- COMPLAINTS, GRIEVANCES, AND APPEALS 26**
 - GRIEVANCE PROCEDURES 26
 - APPEAL PROCEDURES..... 26
 - HOW TO SUBMIT GRIEVANCES OR APPEALS..... 28
- RESOURCES FOR INFORMATION AND ASSISTANCE 29**
- PLAN ADMINISTRATION 32**
- DEFINITIONS 34**

This page left intentionally blank.

DENTAL BENEFIT SUMMARY

PLAN INFORMATION

Group Name:	Deschutes County
Group Number:	G0037173
Plan Name:	Dental
Provider Network:	Advantage Dental

EMPLOYEE ELIGIBILITY REQUIREMENTS

Minimum Hour Requirement:	20 hours per week
Waiting Period for New Employees:	First day of the month following 30 days.

This dental Plan covers the following services when performed by a licensed dentist, dental hygienist or denturist 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).

Advantage Network dentists contract with PacificSource to furnish dental services and supplies for a set fee. That fee is called the contracted allowable fee. Participating providers agree not to collect more than the contracted allowable fee. When you use an Advantage Network dentist, you will pay only the participating provider amounts below. If you choose not to use a participating dentist, or don't have access to them, reimbursement is based on the 90th percentile of the usual, customary and reasonable fee (UCR). If charges exceed the UCR fee, the excess charges are your responsibility.

Annual Benefit Maximum

\$2,000 per person per calendar year. Applies to all covered services.

For members age 18 and younger, Class I Services do not apply towards the Annual Benefit Maximum.

PAYMENT

All Services: Services during the first year of eligibility will have 20% co-insurance, in addition to the co-pay amounts listed below. In the second year of eligibility, the member will only pay the co-pay amounts listed below.

The member is responsible for any amounts shown above, in addition to the following amounts.

Service	Participating Providers	Non-participating Providers
Class I Services		
Examinations	\$15 co-pay	\$15 co-pay
Bitewing films, full mouth x-rays, cone beam x-rays, and/or panorex	\$15 co-pay	\$15 co-pay
Dental cleaning (prophylaxis)	\$15 co-pay	\$15 co-pay
Topical fluoride	\$15 co-pay	\$15 co-pay
Fluoride varnish	\$15 co-pay	\$15 co-pay
Sealants	\$15 co-pay	\$15 co-pay
Space maintainers	\$15 co-pay	\$15 co-pay
Athletic mouth guards	Not covered	Not covered
Brush biopsies	\$15 co-pay	\$15 co-pay
Initial Orthodontic Exam	\$15 co-pay	\$15 co-pay
Class II Services		
Fillings	\$25 co-pay	\$25 co-pay
Dental cleaning (periodontal maintenance)	\$25 co-pay	\$25 co-pay
Simple extractions	\$25 co-pay	\$25 co-pay
Periodontal scaling and root planing	\$25 co-pay	\$25 co-pay
Full mouth debridement	\$25 co-pay	\$25 co-pay
Complicated oral surgery	\$25 co-pay	\$25 co-pay
Pulp capping	\$25 co-pay	\$25 co-pay
Pulpotomy	\$25 co-pay	\$25 co-pay
Root canal therapy	\$25 co-pay	\$25 co-pay
Periodontal surgery	\$25 co-pay	\$25 co-pay
Tooth desensitization	\$25 co-pay	\$25 co-pay
Class III Services		
Crowns	\$25 co-pay	\$25 co-pay
Replacement of existing prosthetic device	\$25 co-pay	\$25 co-pay
Dentures	\$25 co-pay	\$25 co-pay

Bridges	\$25 co-pay	\$25 co-pay
Implants	\$25 co-pay	\$25 co-pay

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 annual benefit maximum?

The Annual Benefit Maximum is the maximum amount payable by this Plan for covered services received each calendar year.

Preauthorization

Coverage of certain dental services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called 'preauthorization'. Preauthorization is necessary to determine if certain services and supplies are covered under this Plan, and if you meet the Plan's eligibility requirements. You'll find the most current preauthorization list on their website, PacificSource.com.

ORTHODONTIC BENEFIT SUMMARY

This Plan covers orthodontia for all eligible members.

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

Lifetime Maximum	All Providers
\$2,000 per person	50% co-insurance

Limitations

Benefits for orthodontic covered services will be paid monthly on a pro-rated basis over the length of the treatment. If the orthodontic treatment began before the patient was eligible for this Plan, this Plan will continue to make payments toward the remaining balance due, as of the patient's initial eligibility date. The above mentioned maximum will apply fully to this amount. PacificSource's obligation, on behalf of the Plan Sponsor, to make payment for orthodontic treatment ends when the patient's eligibility ends, or when treatment is terminated before the case is completed.

Diagnostic casts are covered under the Orthodontic benefit.

Exclusions

- This Plan does not cover repair or replacement of orthodontic appliances furnished under this program.

BECOMING ELIGIBLE

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 filed 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 deductible and co-payments 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.

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. The Plan Sponsor decides the minimum number of hours employees must work each week to be eligible for dental benefits. The Plan Sponsor may also require new employees to satisfy a waiting period called the 'probationary waiting period' before they are eligible for benefits. The Plan Sponsor's eligibility requirements, including the length of the probationary waiting period are shown in your Dental Benefit Summary. All employees who meet those requirements are eligible for coverage.

Family members

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

- Your legal spouse or your domestic partner.
- Your, your spouse's, or your domestic partner's natural or step 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 over 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 child's physician, and will review the case before determining eligibility for coverage.
- A child placed for adoption with you, your spouse, or your domestic partner. 'Placed for adoption' means the assumption and retention by you, your spouse, or domestic partner of a legal obligation for full or partial support and care of the child in anticipation of adoption of the child. Coverage will continue assuming continued eligibility under this Plan unless placement is disrupted prior to legal adoption and the child is removed from placement.
- A foster child placed with you, your spouse, or your domestic partner. Placed means an individual who is placed by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. Coverage will continue

assuming continued eligibility under this Plan unless placement is disrupted and the child is removed from placement.

- A child placed in your, your spouse's, or your domestic partner's guardianship. To be eligible for coverage, the child must be unmarried; not in a domestic partnership; under age 19; and for whom you are the court appointed legal custodian or guardian with the expectation the child will live in your household for at least a year.

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.

Special Rules for Eligibility

At any time the Plan Administrator may require proof that a person 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 probationary waiting period, and meet the hours required for eligibility, you and/or your eligible family members become eligible for this Plan. Starting on the date you become eligible, you and your family members have 31 days to enroll. The Plan Sponsor calls this 31 day window the initial enrollment period. To enroll you must submit the completed enrollment application to the Plan Sponsor. The Plan Sponsor will send the application to PacificSource.

If you miss your initial enrollment period, you will not be able to enroll in the Plan later in the year, unless you have a special circumstance, called a 'qualifying event'. (For more information, see 'Special Enrollment Periods' and 'Late Enrollment' under the Enrolling After the Initial Enrollment Period section.)

Coverage for you and your enrolling family members begins after you satisfy the Plan Sponsor's probationary waiting period. The length of the probationary waiting period is stated in your Dental Benefit Summary. Coverage will only begin if the Plan Sponsor receives your enrollment information, and forwards it to PacificSource.

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 FAMILY MEMBERS

Newborns

Your newborn child is eligible 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 eligible for coverage only during the 31 days following the birth. In order to enroll the child, guardianship must be given to the employee on the Plan.

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 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 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 family members 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 family members will then 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 60 days from the court appointment to enroll them on 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 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

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 probationary waiting period.

Your dental 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 family members were covered before your layoff or termination, they can resume coverage at that time as well. You must re-enroll your family members by submitting your enrollment change within the 31 day enrollment.

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 probationary waiting period.

Your dental coverage will resume the day you return to work and again meet the Plan Sponsor's minimum hour requirement. If your family members were covered before your leave of absence, they can resume coverage at that time as well. You must re-enroll your family members by submitting an enrollment change to the Plan Sponsor 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, contact your Human Resources Department or dental Plan Administrator. Under FMLA, if you return to work after a qualifying FMLA medical leave, you will not have to satisfy another probationary waiting period under this Plan. Your dental coverage will resume the day you return to work and meet your employer's minimum hour requirement. If your family members were covered before your leave, they can also resume coverage at that time as well. You must re-enroll your family

members by submitting an enrollment change to the Plan Sponsor 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 probationary waiting period.

Special Enrollment Periods

You and your family members may decline coverage during your initial enrollment period. To find out if this Plan allows employees to decline coverage, ask your Plan Sponsor. If you wish to do so, you must submit a completed Waiver of Coverage form to the Plan Sponsor. You

and your family members may enroll in this Plan later if you qualify under the Special Enrollment Rules below.

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.

If you enroll during your initial enrollment period, your family members may decline coverage, and they may enroll in the Plan later if they 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 probationary periods required and each individual is eligible as stated in this Plan Document.

- **Special Enrollment Rule #1**

If you declined enrollment for yourself or your family members because of other health coverage or there was a change in contribution, you or your family members 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 health coverage ends (or within 60 days after the other health coverage ends if the other coverage is through Medicaid or a State Children's Health Insurance Program). 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 family members because of marriage, domestic partnership, birth, placement of foster child, or placement or finalization for adoption, you may be able to enroll yourself and/or your eligible family members at that time. To do so, you must submit a completed enrollment application to the Plan Sponsor within 31 days after the marriage, qualification of the domestic partnership, birth, placement of foster child, or placement for adoption. In the case of marriage or domestic partnership, coverage begins on the first day of the month after the marriage or qualification of the domestic partnership. In the case of birth, placement of foster child, placement or finalization for adoption, coverage begins on the date of birth or placement. In the case of marriage, if the enrollment application/change is received prior to the date of marriage, coverage will begin on the marriage date.

- **Special Enrollment Rule #3**

If you or your family members 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 family members at that time. To do so, you must submit a completed enrollment application to the Plan Sponsor within 60 days of the date you and/or your family members 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 and you do not qualify for a special enrollment period, your enrollment will be delayed until the Plan's next designated open enrollment period.

A 'late enrollee' is an otherwise eligible employee or family member who does not qualify for a special enrollment period explained above, and who:

- Did not enroll during the initial enrollment period; or

- Enrolled during the initial enrollment period but discontinued coverage later.

A late enrollee may enroll by submitting a completed enrollment application to the Plan Sponsor during the open enrollment period. When you or your family members enroll during the open enrollment period, coverage becomes effective the first day of the contract year.

The annual open enrollment period is every November, during a two week period to be determined annually. Employees and their dependents who are late enrollees or who are otherwise eligible for coverage under the Plan will be able to enroll in the Plan. Benefit choices for late enrollees made during the open enrollment period will become effective January 1st. Plan participants will receive detailed information regarding open enrollment from their employer.

PLAN SELECTION PERIOD

If the Plan Sponsor offers more than one benefit plan, you may choose another plan option only upon this Plan's anniversary date. You may select a different plan option by completing a selection form or application form and submitting it to the Plan Sponsor. 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 enrolled individuals will end. Coverage ends on the last day of the last month in which you worked full time. You may, however, be eligible to continue coverage for a limited time. (See Continuation of Coverage section).

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, contact the Plan Sponsor. (See the Continuation of Insurance section).

Dependent Children

When your enrolled child no longer qualifies as a dependent, their coverage will end on the last day of the month they become ineligible. Please see Eligibility in the Becoming Covered section for information on when your dependent child is eligible. The Continuation of Coverage section includes information on other coverage options for those children who no longer qualify for coverage.

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 their 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 your employer 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.

CONTINUATION OF COVERAGE

Under federal and/or state laws, you and your covered family members may have the right to continue this Plan's coverage for a specified time. You and your family members may be eligible if:

- Your employment ends or you have a reduction in hours.
- You take a leave of absence for military service.
- You divorce.
- You die.
- Your children no longer qualify as dependents.

The following sections describe your rights to continuation under applicable state and/or federal laws, 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 person may remain eligible 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, this continuance will remain in effect until the end of the three calendar month period that next follows the month in which the person last worked as an active employee.

For paid administrative leave, continuance will remain in effect until the date the employer, in its sole discretion, ends the continuance.

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 person.

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

Enrolled individuals 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 family members who were enrolled in the Plan can take continuation. The only exceptions are newborn babies and newly acquired eligible family members not covered by another group dental Plan.
- To apply for continuation, you must submit a completed Continuation Election Form to your employer 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.

SURVIVING OR DIVORCED SPOUSES AND DOMESTIC PARTNERS

If your group has 20 or more employees, or your group dental 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 eligible for Medicare or other coverage. Dependent children are subject to the Plan’s age and other eligibility requirements. Some restrictions and guidelines apply; please see your employer for specific details.

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 your Human Resources Department or dental Plan Administrator.

COBRA Eligibility

If, as an active employee, you were required to enroll in a medical plan as well as this dental Plan, you may continue coverage under this dental Plan if you also continue coverage under the medical plan. If, as an active employee, you enrolled in only the dental Plan, you may continue coverage under this dental Plan according to the following:

A ‘qualifying event’ is the event that causes your regular group coverage to end and makes you eligible for continuation coverage. When the following qualifying events happen, you may continue coverage for the lengths of time shown:

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	Spouse and children may continue for up to 36 months ²
Employee’s eligibility for Medicare benefits if it causes a loss of coverage	Spouse and children may continue for up to 36 months
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 covered family member is determined disabled by the Social Security Administration 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 family members 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, including the late enrollment waiting period.

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

Domestic partners and their covered children may not continue this Plan's coverage under COBRA independent of the employee.

When Continuation Coverage Ends

Your continuation coverage will end before the end of the continuation period above if any of the following occur:

- Your continuation premium is not paid on time.
- You become entitled to Medicare benefits.
- The Plan Sponsor discontinues this Plan and no longer offers a group dental Plan to any of its employees.
- Your continuation period was extended from 18 to 29 months due to disability, and you are no longer considered disabled.

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. If the Plan Sponsor offers more than one benefit plan to eligible employees, a member electing COBRA may select enrollment for another plan at the time the member elects COBRA coverage. Members electing COBRA may not add family members at this time unless they otherwise qualify under the 'Special Enrollment' provisions of the Plan.

COBRA continuation benefits are always the same as your employer's current benefits. The Plan Sponsor has the right to change the benefits of this dental Plan or eliminate the Plan entirely. If that happens, any changes to the group dental 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 family members of your continuation rights.

When the Plan Sponsor learns of your eligibility for continuation, it 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 family member 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 or coverage.

Continuation Premium

Enrolled individuals 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.

Keep Your Plan Sponsor Informed of Any Address Changes

It is your responsibility to ensure that you keep the Plan Sponsor informed of any changes in your mailing address, and the mailing address of any dependents covered by your dental coverage. You should also keep a copy of any notices you send to the Plan Sponsor along with proof of transmission or mailing.

CONTINUATION WHEN YOU RETIRE

Continuation upon retirement is based on meeting all the retirement requirements set forth in your employment agreement 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.

If you become eligible for PERS while enrolled in COBRA due not being at 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 eligible for 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 family member's continuation 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.

HOW TO USE YOUR PLAN

When you first visit your dentist after becoming covered under this Plan, let the office staff know that PacificSource provides administrative services to this Plan. You will need to show your member ID card, which contains your group number and benefit information. Most dental offices will send the bills directly to PacificSource. Your dentist may submit claims and treatment programs on a standard American Dental Association form. If your dentist has any questions regarding billing procedures, they can call PacificSource toll-free at (866) 373-7053.

For extensive dental work, we recommend that your dentist submit a preauthorization request to PacificSource. We then determine how much the Plan will pay toward the proposed treatment and review the estimate with your dentist prior to treatment. If your covered family members require extensive dental work, be sure your member ID number and group number are included on their pre-treatment form for identification purposes.

USING THE DENTAL ADVANTAGE NETWORK

This section explains how this Plan's benefits differ when you use Dental Advantage Network providers and non-participating 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 dental care 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 dental care.

PARTICIPATING PROVIDERS

Participating providers contract with PacificSource, directly or indirectly, to furnish dental services and supplies to members enrolled in this Plan for a set fee. That fee is called the contracted allowable fee. Participating providers agree not to collect more than the contracted allowable fee. When you receive covered dental services or supplies from a participating provider, you are only responsible for the amounts stated in the Dental Benefit Summary. Depending on your Plan, those amounts can include a deductible, co-payment, and/or co-insurance payment.

NON-PARTICIPATING PROVIDERS

When you receive dental services or supplies from a non-participating provider, payment and application of benefits are as follows:

- Eligible charges considered for payment to non-participating providers are based on the allowable usual, customary, and reasonable (UCR) fee.
- PacificSource makes payment for non-participating providers at the percentage stated in the Dental Benefit Summary. The non-participating provider's usual charge may exceed the allowable UCR fee. The dollar amount PacificSource pays may be a lower percentage of the provider's total charge than the non-participating provider co-insurance stated in the Dental Benefit Summary.

Example of Provider Payment

The following example shows how payment could be made to providers for a covered service billed at \$110 for a Class II procedure. This is only an example; this Plan's benefits may be different:

	In-network Provider	Out-of-network Provider
Provider's usual charge	\$110	\$110
Provider discount	\$10	\$0
PacificSource allowable fee	\$100	\$100
Member's co-insurance	20%	20%
PacificSource's payment	\$80	\$80
Member's amount of allowable fee	\$20	\$20
Charges above allowable fee	\$0	\$10
Member's total payment due to provider	\$20	\$30
Percent of charge paid by PacificSource	80%	73%
Percent of charge paid by member	20%	27%

FINDING DENTAL ADVANTAGE NETWORK PROVIDER INFORMATION

You can find up-to-date Dental Advantage Network provider information:

- Asking your dental care provider if they are a Dental Advantage Network provider for PacificSource-backed dental plans.
- On the PacificSource website, PacificSource.com. go to 'Find a Doctor or Dentist' to easily look up Dental Advantage providers. You can also print your own customized directory.
- By contacting the PacificSource Customer Service team. Their staff can answer your questions about specific providers.

TERMINATION OF PROVIDER CONTRACTS

PacificSource will use best efforts to notify you within 30 days of learning about the termination of a provider contractual relationship if you have received services in the previous three 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.

Note: On the date a provider's contract with PacificSource terminates, they become a non-participating provider and any services you receive from them will be paid at the percentage shown in the "Non-participating Provider" column of your Dental Benefit Summary. To avoid

unexpected costs, be sure to verify each time you see your provider that they are still participating in the network.

Contact our Customer Service team for additional information.

COVERED EXPENSES

DENTAL PLAN BENEFITS

When this Plan pays for dental services, it actually pays the percentage of charges based on reasonable and customary charges. A charge is reasonable and customary when it falls within a general range of charges being made by most dental providers in your service area for similar treatment of similar dental conditions. If the charge for a treatment or service is more than the reasonable and customary charge in your service area, you may be required to pay the difference. The reasonable and customary charge for dental expense is the 'covered charge' referred to in this Plan Document.

If you or your covered family member selects 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. With the Advantage Network, participating dentists agree to write off any charges over and above the negotiated, contracted fees for most services. When you use a participating dentist in the Advantage Network, you will not be responsible for any excess charges and will pay only the Plan's deductible and/or co-insurance amount. If you choose not to use a participating Advantage Network dentist, or don't have access to them, reimbursement will continue to be based on the contracted allowable fee. If that non-participating dentist's fees exceed the contracted allowable fee, the excess charges are also your responsibility.

Subject to all the terms of this Plan, incurred dental expense for the following services and supplies are covered according to the Dental Benefit Summary. 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 contracted allowable fee are not covered under this Plan and become your responsibility.

COVERED DENTAL SERVICES

This Plan covers the following services when performed by an eligible provider and when determined to be necessary by the generally accepted standards of dental practice for the prevention or treatment of oral disease or for accidental injury, including masticatory function (chewing of food). Covered services may also be provided by a dental hygienist or denturist to the extent that they are operating within the scope of their license as required under state law.

Covered dental services are organized into different classes, starting with preventive care and advancing into specialized dental treatments.

CLASS I SERVICES

- Benefits for **examinations** (routine or other diagnostic exams) are covered. Separate charges for review of a proposed treatment plan or for diagnostic aids, such as study models and diagnostic lab tests (other than brush biopsies), are not covered. Problem focused examinations are covered.

- Benefits for a **full mouth series x-rays, a cone beam x-ray, panorex, bite-wing films, and periapical x-rays** are covered.
- Benefits for **dental cleaning (prophylaxis)** are covered.
- Benefits for the **topical application of fluoride** are limited to two applications per calendar year.
- Benefits for **fluoride varnish applications** are covered.
- Benefits for **the application of sealants** are covered.
- Benefits for **space maintainers** are covered.
- Benefits for **brush biopsies** are covered.
- Benefits for the initial **Orthodontic exam** is covered as Class I.

CLASS II SERVICES

- Benefits for **dental cleaning (periodontal maintenance)** are covered.
- Benefits for a **composite, resin, or similar restoration** in a posterior (back) tooth are covered. A separate charge for anesthesia when used during restorative procedures is not a covered benefit.
- **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 benefit.
- Benefits for **periodontal scaling and root planing and/or curettage** are covered.
- Benefits for **full mouth debridement** are covered.
- **Complicated oral surgery procedures** such as the removal of impacted teeth are limited to procedures that have been preauthorized by PacificSource. A separate charge for alveolectomy performed in conjunction with removal of teeth is not a covered benefit.
- Benefits for **pulp capping** are payable only when there is an exposure to the pulp. These are direct pulp caps. Indirect pulp caps are not covered.
- Benefits for a **pulpotomy** are payable only for deciduous teeth.
- Benefits for **root canal therapy** on the same tooth are payable only for one charge in a 36 month period.
- Benefits for **periodontal surgery** are limited to procedures that have been preauthorized by PacificSource and accompanied by a periodontal diagnosis and history of conservative (non-surgical) periodontal treatment.
- Benefits for **tooth desensitization** are covered as a separate procedure from other dental treatment.
- **Core build-ups** are only covered when used to restore a tooth that has been treated endodontically (root canal).

- Benefits for **anesthesia services** are limited to children age six or younger and patients with mental disabilities that render them incapable of treatment in the dental office under local anesthesia. This is limited to conscious sedation and single oral sedatives.
- Benefits for **general anesthesia (including nitrous oxide)** 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

- Benefits for **crowns** and other cast or laboratory-processed restorations are limited to the restoration of any one tooth in a 60 month period. If a tooth can be restored with a material such as amalgam or composite resin, covered charges are limited to the cost of amalgam or non-laboratory composite resin restoration even if another type of restoration is selected by the patient and/or dentist.
- Benefits for an 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 benefit. Benefits for subsequent 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.
- Benefits for initial **fixed bridges or removable cast partials** are covered. Benefits for temporary full or partial dentures must be preauthorized by PacificSource.
- Benefits for the **replacement of an existing prosthetic device** are provided only when the device being replaced is unserviceable, cannot be made serviceable, and has been in place for at least 60 months.
- Benefits for the surgical placement and removal of **implants** are limited to once per lifetime per tooth space. Services must be preauthorized by PacificSource to be covered. 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.
- Benefits for splints, night guards, or appliances used to increase vertical dimensions, restore the occlusion, or correct habits such as tongue thrust and grinding teeth. Periodontal splinting including crowns and bridgework used in conjunction with periodontal splinting.

ORTHODONTIC SERVICES

This Plan covers charges for orthodontia for all eligible individuals

The amount this Plan pays is outlined in the Orthodontic Benefit Summary.

Benefits for orthodontic covered services will be paid monthly on a pro-rated basis over the length of the treatment. If the orthodontic treatment began before the patient was eligible for this Plan, this Plan will continue to make payment toward the remaining balance due as of the patient's initial eligibility date. The lifetime maximum amount stated in the Orthodontic Benefit Summary will apply fully to this amount.

Diagnostic casts are covered under the orthodontic benefit.

This Plan does not cover repair or replacement of orthodontic appliances furnished under this program.

PacificSource's obligation, on behalf of the Plan Sponsor, to make payment for orthodontic treatment ends when the patient's eligibility ends, or when treatment is terminated before the case is completed.

BENEFIT LIMITATIONS AND EXCLUSIONS

EXCLUDED SERVICES

This Plan does not provide benefits in any of the following circumstances or for any of the following conditions:

- Aesthetic 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 activities – Any injuries sustained while competing or practicing for a professional or semiprofessional athletic contest.
- Athletic mouth guards.
- Benefits not stated – Any services and supplies not specifically described as covered benefits under the dental Plan.
- Biopsies or histopathologic exams – (except when related to tooth structure and preauthorized).
- Bone replacement grafts for purposes other than to prepare sockets for implants after tooth extraction.
- Charges for missed appointments.
- Collection of cultures and specimens.
- Comprehensive periodontal exams.
- Connector bar or stress breaker.
- Core build-ups are not covered unless used to restore a tooth that has been treated endodontically (root canal).
- Cosmetic/reconstructive services and supplies – Procedures, appliances, restorations, or other services that are primarily for cosmetic purposes (does not apply to emergency services). This includes services or supplies rendered primarily to correct congenital or developmental malformations, including but not limited to, peg laterals, cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia, veneers, and fluorosis (discoloration of teeth). However, the replacement of congenitally missing teeth is covered.
- Denture replacement made necessary by loss, theft, or breakage.

- Diagnostic casts – Diagnostic casts (study models), occlusal appliance, gnathological recordings, occlusal equilibration procedures, or similar procedures are only covered in conjunction with the 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 (for example, nitrous oxide or non-intravenous sedation), and any other euphoric drugs, or any take-home medicine or supplies distributed by a provider.
- Educational programs – Instructions and/or training in plaque control and oral hygiene.
- Experimental or investigational procedures – Services, supplies, protocols, procedures, devices, drugs or medicines, or the use thereof that are experimental or investigational for the diagnosis and treatment of the patient. An experimental or investigational service is not made eligible for benefits by the fact that other treatment is considered by the member's dental care provider to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.
- 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 dentist in connection with oral surgery in his/her office.
- 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 dentist for hospital treatment.
- Hypnosis.
- 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 furnished under this Plan.
- Orthognathic surgery – Surgery to manipulate facial bones, including the jaw, in patients 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.
- 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 or supplies with no charge, or for the Plan Sponsor has paid, or for which you are not legally required to pay, or 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 to you by any licensed professional that is directly related to you by blood or marriage.
- Services otherwise available – These include but are 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 expenses 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.
- Services or supplies provided outside of the United States, except in cases of emergency.
- 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 insurance and any other liability and voluntary dental 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 and 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 provided after enrollment in this Plan ends.
- Treatment not dentally necessary according to acceptable dental practice or treatment not likely to have a reasonably favorable prognosis.

- Treatment of any illness, injury, or disease 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 – Dental services began before you or your family member became eligible for those services under this Plan.
- Unwilling to release information – Charges for services or supplies for which you are unwilling to release dental or eligibility information necessary to determine the benefits payable 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 aggression, or while in the service of the armed forces that occurred while on this.

NECESSITY ACCORDING TO ACCEPTABLE DENTAL PRACTICE

The benefits of this Plan are paid only toward the covered expense of necessary diagnosis or treatment according to acceptable dental practice. This is true even though the service or supply is not specifically excluded. All treatment is subject to review for necessity according to acceptable dental practice. Review of treatment may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. **Just because a dentist may prescribe, order, recommend, or approve a service or supply does not, of itself, make the charge a covered expense.**

The Plan has the right to arrange, at its expense, a second opinion by a provider of its choice, and is not required to pay benefits unless that opinion has been rendered.

INDIVIDUAL BENEFITS MANAGEMENT

Individual benefits management addresses, as an alternative to providing covered services, the Plan's consideration of economically justified alternative benefits. The decision to allow alternative benefits will be made by the Plan on a case-by-case basis. The Plan's determination to cover and pay for alternative benefits for a member shall not be deemed to waive, alter or affect the Plan's right to reject any other or subsequent request or recommendation. The Plan may elect to provide alternative benefits if the Plan and the member's attending provider concur in the request for and in the advisability of alternative benefits in lieu of specified covered services, and, in addition, the Plan concludes that substantial future expenditures for covered services for the member could be significantly diminished by providing such alternative benefits under the individual benefit management program.

CLAIMS PAYMENT

How to File a Claim

When a participating provider treats you, your claims are automatically sent to PacificSource and processed. All you need to do is show your member ID card to the provider.

If you receive care from a non-participating provider, the provider may submit the claim to PacificSource for you. If not, you are responsible for sending the claim to them for processing.

Your claim must include a copy of your provider's itemized bill. It must also include your name, member ID number or social security number, group name, group number, and the patient'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 it is not possible to submit a claim within 90 days, turn in the claim with an explanation as soon as possible. In some cases PacificSource may accept the late claim if the Plan allows. This Plan will never pay a claim that was submitted more than a year after the date of service.

All claims should be sent to:

*PacificSource Health Plans
Attn: Dental Claims
PO Box 7068
Springfield, OR 97475-0068*

Claim 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. 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.

The Plan 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. You may also contact Customer Service if you believe a claim was denied in error. PacificSource will review your claim and the Plan benefits to determine if the claim is eligible for payment. Then PacificSource will either reprocess the claim for payment, 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 if the Plan receives an agreement from you in writing.

In the same manner, if the Plan applies dental expense to the Plan deductible that would not otherwise be reimbursable under the terms of this Plan; it may deduct a like amount from the accumulated deductible amount and/or recover payment of the dental expense that would have otherwise been applied to the deductible. Examples of amounts recoverable under this provision include, but are not limited to, services for an excluded dental condition. The fact that a dental expense was applied to the Plan's deductible does not in itself create an eligible expense or infer that benefits will continue to be provided for an otherwise excluded condition.

COORDINATION OF BENEFITS

This is a summary of only a few of the provisions of this dental 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 care 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 the 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 COB rules will always be primary.

When This Plan is Primary

If you or a family member 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 domestic partner, who is covered by this Plan.

Your Child's Expenses

- The claim is for the dental care 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 care expenses; or
- There is no court decree, but you have custody of the child.

Other Situations

The Plan will be primary when any other provisions of federal law require it to be.

How this Plan Pays Claims When it is Primary

When this Plan is the primary plan, we will pay the benefits in accordance with the terms of the Plan, just as if you had no other dental care 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 care 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, our 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. This Plan may reduce 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 care coverage toward our own plan deductible.
- If the primary plan covers similar kinds of dental care expenses, but allows expenses that this Plan does not cover, it 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 plan has reduced its benefit because you did not obtain preauthorization, as required by that plan, this Plan will not pay the amount of the reduction, because it is not an allowable expense.

THIRD PARTY LIABILITY

Third party liability means claims that are the responsibility of someone other than this Plan. The liable party may be a person, firm, or corporation. Auto accidents and 'slip-and-fall' property accidents 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.

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

When PacificSource receives a claim that might involve a third party, they will 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 determined to be the responsibility of another party, you will hold the right of recovery against the other party in trust for the Plan.

- The Plan is entitled to full reimbursement for any paid claims if there is a settlement or judgment from the other party. This is so regardless of whether the other party or insurer admits liability or fault.
- The Plan may subtract a proportionate share of the reasonable attorney's fees you incurred from the money you are to pay back to the Plan.
- The Plan may ask you to take action to recover dental expenses we have paid from the responsible party. The Plan may also assign a representative to do so on your behalf. If there is a recovery, the Plan will be reimbursed for any expenses or attorney's fees out of that recovery.
- If you receive a third party settlement, that money must be used to pay in full your related dental expenses incurred both before and after the settlement. If you have ongoing dental expenses after the settlement, the Plan may deny your related claims until the full settlement (less reasonable attorney's fees) has been used to pay those expenses.

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 policy.

The Plan may pay your dental claims from the accident if a dental 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, injury, or disease that is caused by any for-profit activity, whether through employment or from 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 have timely filed an application for coverage with the appropriate state or federal workers' compensation insurance program, such as Oregon's State Accident Fund or other Worker's Compensation carrier, and are awaiting a 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 this group then the 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.

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 Department.

This Plan will remain in effect upon timely payment of the full contribution until whichever of the following events first occurs:

- The employee takes full-time employment with another employer; or
- Six months from the date the employee first makes payment under this provision.

COMPLAINTS, GRIEVANCES, AND APPEALS

Questions, Concerns, or Complaints

The Plan Sponsor understands that you may have questions or concerns about your benefits, eligibility, the quality of care you receive, or how we reached a claim determination or handled a claim. PacificSource will try to answer your questions promptly and give you clear, accurate answers based on the criteria established by the Plan Sponsor.

If you have a question, concern, or complaint about your coverage, please contact PacificSource's Customer Service Department. 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.

GRIEVANCE PROCEDURES

If you are dissatisfied with the availability, delivery, or the quality of dental care services; or claims payment, handling or reimbursement for dental care services; you may file a grievance in writing. PacificSource will attempt to address your grievance, generally within 30 days of receipt. (See How to Submit Grievances or Appeals below.)

APPEAL PROCEDURES

First Internal Appeal: If you believe the Plan Sponsor, or PacificSource acting on behalf of the Plan Sponsor, has improperly reduced or terminated a dental care item or service, or failed or refused to provide or make a payment in whole or in part for a dental care item or service, that is based on any of the reasons listed below, you or your authorized representative (See Definition section) may appeal (request a review) that decision. The request for appeal must be made in writing and within 180 days of the adverse benefit determination (See How to Submit Grievances or Appeals below). You may appeal if there is an adverse benefit determination based on a:

- Denial of eligibility for or termination of enrollment in a dental care plan;
- Rescission or cancellation of your coverage;
- Imposition of a source-of-injury exclusion*, network exclusion, annual benefit limit or other limitation on otherwise covered services or items;
- Determination that a dental care item or service is experimental, investigational or not a dental necessity, effective or appropriate; or
- Determination that a course or plan of treatment you are undergoing is an active course of treatment for the purpose of continuity of care.

* Source-of-injury exclusions cannot exclude injuries resulting from a medical or dental condition or domestic violence.

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, your appeal is not considered to be filed until such time as PacificSource has received the 'Authorization to Use or Disclose PHI' and the 'Designation of Authorized Representative' forms.

You may receive continued coverage under the Plan for otherwise covered services pending the conclusion of the internal appeals process. If the Plan makes payment for any service or item on your behalf that is later determined not to be a covered service or item, you will be required to reimburse the Plan for the non-covered service or item.

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 should be forwarded to your Plan Sponsor within 60 days of the first appeal response. You may send your request for appeal and any documentation to the Plan Sponsor's address that appears in the section entitled "How to Submit Grievances or Appeals."

Any staff involved in the first internal appeal determination 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 physician 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 below) 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 medically necessary; is experimental or investigational; is not an active course of treatment for purposes of continuity of care; or is not delivered in an appropriate healthcare setting and with the appropriate level of care, you or your authorized representative may request an external review by an independent review organization (See How to Submit Grievances or Appeals below).

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 grievance levels are exhausted. The Plan will pay for any cost associated with the external independent review. You must submit your request for an external review directly to your Plan Sponsor.

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 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 Plan Sponsor fails to comply with the decision of the independent review organization assigned under Oregon law, you have a private right of action (sue) 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 the Division of Financial Regulation at (503) 947-7984 or the toll-free message line at (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 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 treatment, or a similar exclusion.

Upon request, PacificSource will provide you with any additional documents, records or information that are relevant to the adverse benefit determination.

HOW TO SUBMIT GRIEVANCES OR APPEALS

Before submitting a grievance or appeal, we suggest you contact PacificSource's Customer Service team with your concerns. You can reach it by phone or email at the contact information found on the first page of this Plan Document. Issues can often be resolved at this level. Otherwise, you may file a grievance or appeal by:

First Level Appeal Writing to:

PacificSource
Attn: Grievance Review
PO Box 7068
Springfield, OR 97475-0068

Emailing cs@PacificSource.com, with 'Grievance' as the subject

Faxing (541) 225-3628

Second Level Appeal Writing to:

Deschutes County
Attn: Trygve Bolken
PO Box 6005
Bend, OR 97708-6005

Emailing trygve.bolken@deschutes.org with “Grievance” or “Appeal” as the subject

Faxing (541) 330-4626

If you are unsure of what to say or how to prepare a grievance, please call PacificSource’s Customer Service team. They will help you through the grievance process and answer any questions you have.

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 calling (503) 947-7984 or the toll-free message line at (888) 877-4894

By writing to:

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

Through their website at <http://dfr.oregon.gov>

Or by email at cp.ins@state.or.us

RESOURCES FOR INFORMATION AND ASSISTANCE

Assistance in Other Languages

Plan members who do not speak English may contact PacificSource’s Customer Service team for assistance. PacificSource can usually arrange for a multilingual staff member or interpreter to speak with them in their native language.

Information Available from PacificSource

The Plan makes the following written information available to you free of charge. You may contact PacificSource’s Customer Service team to request any of the following:

- A directory of participating dental care providers under this Plan;
- A description (consistent with risk-sharing information required by the Centers for Medicare and Medicaid Services, formerly known as Health Care Financing Administration) of any risk-sharing arrangements the Plan or PacificSource has with providers;

- A description of the Plan and/or PacificSource's efforts to monitor and improve the quality of dental services;
- Information about how PacificSource checks the credentials of its network providers and how you can obtain the names and qualifications of your dental providers;
- Information about preauthorization and utilization review procedures; and
- Information about any dental plan offered by PacificSource.

Information and Assistance 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 our 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 our utilization review policies;
- An annual summary of our quality assessment activities; and
- An annual summary of the scope of our provider network and accessibility of dental services.

You can request this information by contacting the Division of Financial Regulation:

By calling (503) 947-7984 or the toll-free message line at (888) 877-4894

By writing to:

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

Through their website at <http://dfr.oregon.gov>

Or by email at cp.ins@state.or.us

RIGHTS AND RESPONSIBILITIES

The Plan 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 dental records and personal information.
- You have a right to voice complaints about the Plan, PacificSource or the care you receive, and to appeal decisions you believe are wrong.
- You have a right to participate with your dental care 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 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 and PacificSource, and for understanding this Plan's benefits. You are responsible for contacting the Plan and/or PacificSource Customer Service team if anything is unclear to you.
- You are responsible for making sure your provider obtains preauthorization for any services that require it before you are treated.
- You are responsible for providing the Plan and PacificSource with all the information required to provide benefits under this Plan.
- You are responsible for giving your dental care provider complete health information to help accurately diagnose and treat you.
- You are responsible for telling your providers you are covered by the Plan and showing your 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 or PacificSource if you believe you are not receiving adequate care.

- You are responsible for supplying information to the extent possible that the Plan or PacificSource needs in order to administer your benefits or your dental providers need in order to provide care.
- You are responsible for following plans and instructions for care that you have agreed to with your doctors.
- You are responsible for understanding your health problems and participating in developing mutually agreed upon goals, to the degree possible.

PRIVACY AND CONFIDENTIALITY

The Plan and PacificSource have strict policies in place to protect the confidentiality of your personal information, including your dental records. Your personal information is only available to the staff members who need that information to do their jobs.

Disclosure outside the Plan 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 your written authorization (or your representative) before disclosing your personal information outside the Plan 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 Health 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 Number

502

Plan Sponsor’s Employer Identification / Tax Identification Number:

93-6002292

Contract Year:

January 1 to December 31

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: Tom Anderson, 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 County Commissioners 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 group Plan, the Plan Sponsor is required by law to advise you in writing of the termination.

Legal Procedures

You may not take legal action against the Plan Sponsor or PacificSource to enforce any provision of the Plan until 60 days after your claim is properly submitted in accordance with established procedures. Also, you must exhaust this Plan's claims procedures, and grievance

and appeals procedures, before filing benefits litigation. No action shall be brought against the Plan Sponsor or PacificSource after the expiration of any applicable statutes of limitations.

DEFINITIONS

Wherever used in this Plan, the following definitions apply to the masculine and feminine and singular plural forms of terms. For the purpose of this Plan, 'employee' includes the employer when covered by this Plan. 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.

Adverse benefit determination means the Plan's denial, reduction, or termination of a dental care item or service, or the Plan's failure or refusal to provide or to make a payment in whole or in part for a dental care item or service, that is based on this Plan's:

- Denial of eligibility for or termination of enrollment in a dental benefit Plan;
- Rescission or cancellation of a Plan or coverage;
- Imposition of a source-of-injury exclusion*, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;
- Determination that a dental care item or service is experimental, investigational, or 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.

* Source-of-injury exclusions cannot exclude injuries resulting from a medical or dental condition or domestic violence.

Allowable fee is the dollar amount established for reimbursement of charges for specific services or supplies provided by non-participating providers. PacificSource uses several sources to determine the allowable fee. Depending on the service or supply and the geographical area in which it is provided, the allowable fee may be based on data collected from Centers for Medicare and Medicaid Services (CMS), contracted vendors, other nationally recognized databases, or PacificSource Health Plans, as documented in PacificSource's payment policy and adopted by the Plan Sponsor.

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 representative, to change a previous decision made by the Plan Sponsor concerning;

- Access to dental care benefits, including an adverse benefit determination made pursuant to utilization management;
- Claims payment, handling or reimbursement for dental care services;
- Rescissions of member's benefit coverage by the Plan Sponsor; and
- Other matters as specifically required by law.

Authorized representative is an individual who by law or by the consent of a person may act on behalf of the person. 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.

Benefit determination means the activity taken to determine or fulfill the Plan Sponsor's responsibility for provisions under this dental 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 dental benefit claims;
- Review of dental care services with respect to dental necessity (including underlying criteria), coverage under the dental Plan, appropriateness of care, experimental/investigational treatment, justification of charges; and
- Utilization review activities, including precertification and preauthorization of services and concurrent and retrospective review of services.

Calendar year means the 12 month period beginning January 1 of any year through December 31 of the same year.

Cast restoration includes crowns, inlays, onlays, and other restorations made to fit a patient's tooth that are made at a laboratory and cemented onto the tooth.

Co-insurance means a defined percentage of the allowable fee or usual, customary and reasonable fee for covered services and supplies the member receives. It is the percentage the member is responsible for, not including co-pays and deductible. The co-insurance the member is responsible for is listed in the Dental Benefit Summary.

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 an agent acting on behalf of the Plan Sponsor, including PacificSource, and that 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.

Contract year means a 12 month period beginning on the date the Plan is issued or the anniversary of the date the Plan was issued. The specific dates for the contract year applicable to this Plan are reflected in the introductory section at the beginning of this Plan Document. If changes are made to the Plan on a date other than the anniversary of issuance, a new contract year may start on the date the changes become effective if so agreed by the Plan Sponsor and PacificSource. A contract year may or may not coincide with a calendar year.

Contracted allowable fee is an amount the Plan Sponsor agrees to pay a participating provider for a given service or supply through direct or indirect contract.

Co-payment (also referred to as 'co-pay') is a fixed up-front dollar amount the member is required to pay for certain covered services. The co-pay applicable to a specific covered service is listed under that specific benefit in the Dental Benefit Summary.

Covered expense is an expense for which benefits are payable under by this Plan subject to applicable deductible, co-payment, co-insurance, or other specific limitations.

Creditable coverage means a member's prior dental coverage that meets the following criteria:

- There was no more than a 63 day break between the last day of coverage under the previous plan and the first day of coverage under this Plan. The 63 day limit excludes the employer's eligibility waiting period.
- The prior coverage was one of the following types of insurance: group coverage (including Federal Employee Health Benefit Plans and Peace Corps), individual coverage (including student health plans), Medicaid, Medicare, TRICARE, Indian Health Service or tribal organization coverage, state high-risk pool coverage, and public health plans.

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 dental expense that must be paid by the member before the benefits of this Plan are applied.

Dental emergency means the sudden and unexpected onset of a condition, or exacerbation of an existing condition, requiring necessary care to control pain, swelling or bleeding in or around the teeth and gums. Such emergency care must be provided within 48 hours following the onset of the emergency and includes treatment for acute infection, pain, swelling, bleeding, or injury to natural teeth and oral structures. The emergency care does not include follow-up care such as, but not limited to, crowns, root canal therapy, or prosthetic benefits.

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

- Consistent with the symptoms or diagnosis and treatment or prevention of the condition;
- Consistent with generally accepted standards of good dental practice, or expert consensus dentist 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 disease or injury involved and the patient's overall dental 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 dentist may recommend or approve a service or supply does not, of itself, make the charge a covered expense.

Dental Provider or Dentist means a licensed doctor of dental surgery (D.D.S.) or a licensed doctor of medical dentistry (D.M.D.)

Dependent children means any natural, step, adopted or eligible child you, your spouse, or your domestic partner are legally obligated to support or contribute support. This may include eligible dependent children for which you are the court appointed legal custodian or guardian. Eligible dependent children may be covered under the Plan only if they meet the eligibility requirements of the Plan. (See the Becoming Covered – Eligibility section.)

Domestic partner means:

- **Registered domestic partner** means an individual of the same gender, age 18 or older, who is joined in a domestic partnership, and whose domestic partnership is legally registered in any state.

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

Eligible employee means an employee who has met the Plan Sponsor's minimum eligibility requirements as defined in the Dental Benefit Summary, and who is otherwise eligible for coverage under the terms of this Plan.

Employee means any individual employed by the Employer.

Employer generally means the Plan Sponsor unless otherwise noted.

Enrollee means an employee, family member of the employee, or individual otherwise eligible and enrolled for coverage under this Plan. In this Plan, enrollee is referred to as subscriber, member, or you.

Exclusion period means a period during which specified conditions, treatments or services are excluded from coverage.

External appeal or review means the request by an appellant for an independent review organization to determine whether the Plan Sponsor's internal appeal decisions are correct.

Grievance means:

- A request submitted by a member or an authorized representative of a member;
 - In writing, for an internal appeal or an external review; or
 - In writing or orally, for an expedited internal review or an expedited external review.
- A written complaint submitted by a member or an authorized representative of a member regarding:
 - The availability, delivery, or quality of a dental care service;
 - Claims payment, handling, or reimbursement for dental care services and, unless the member has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination.

Incurred expense means charges of a dental provider for services or supplies for which the member becomes obligated to pay. The expense of a service is incurred on the day the service is rendered, and the expense of a supply is incurred on the day the supply is delivered.

Initial enrollment period means the period of days set by the Plan Sponsor that determines when an individual is first eligible to enroll.

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

Internal appeal means a review of an adverse benefit.

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.

Member means an individual covered under this Plan.

Non-participating provider is a provider of covered dental services or supplies that does not directly or indirectly hold a provider contract or agreement with PacificSource.

Participating provider means a dentist, oral surgeon, endodontist, orthodontist, periodontist, pedodontist, denturist, or dental hygienist that directly or indirectly holds a provider contract or agreement with PacificSource.

Periapical x-ray is an x-ray of the area encompassing or surrounding the tip of the root of a tooth.

Periodontal maintenance is a periodontal procedure for patients 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.

Prophylaxis is a cleaning and polishing of all teeth.

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.

Radiographic Image means any x-ray or computerized image of the teeth and jaws 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, and cephalometric x-rays.

Rescind or rescission means to retroactively cancel or discontinue coverage under a dental plan for reasons other than failure to timely pay required premiums or required contributions toward the cost of coverage.

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

Source-of-injury exclusions means this Plan may exclude benefits for the treatment of injuries based on the source of that injury, as long as the plan does not exclude benefits otherwise provided for treatment of injury if the injury results from an act of domestic violence, medical or dental condition. Source of injury means objects, equipment, and other factors that caused the injury or illness

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 family member 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.

Usual, customary, and reasonable fee (UCR) is the dollar amount based on charges being made by dental providers in the same service area for similar treatment of similar dental conditions. A usual, customary, and reasonable fee is based on provider billing data gathered by PacificSource and adjusted to the 90th percentile. Usual, customary and reasonable fees are reviewed by PacificSource annually.

A non-participating provider may charge more than the limits established by the definition of UCR. Charges that are eligible for reimbursement but exceed the UCR are the member's responsibility.

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

This page left intentionally blank.

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, 2018.

Dated this 27 day of December, 2017

By 

Title Board Chair

This page left intentionally blank.