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Your plan: PacificSource

## OSU Graduate Assistant Health Insurance

Group No.: G0021007

Dental Choice Plus 0-20-20-50 50-2500 S3

Effective: October 01, 2016







Welcome to your PacificSource group dental plan. Your employer offers this coverage to help you and your family members stay well, and to protect you in case of illness, injury, or disease. Your plan includes a wide range of benefits and services, and we hope you will take the time to become familiar with them.

### ***Using this Handbook***

This handbook will help you understand how your plan works and how to use it. Please read it carefully and thoroughly. Within this handbook you'll find Dental Member Benefit Summaries for your dental plan and any other dental benefits provided under your employer's group dental policy. The summaries work with this handbook to explain your plan benefits. The handbook explains the services covered by your plan; the benefit summaries tell you how much your plan pays toward expenses and how much you're responsible for.

If anything is unclear to you, the PacificSource Customer Service staff is available to answer your questions. Please give us a call, visit us on the Internet, or stop by our office. We look forward to serving you and your family.

### ***Governing Law***

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

#### **PacificSource Customer Service Department**

Phone (541) 225-1981 or (866) 373-7053

Email [dental@pacificsource.com](mailto:dental@pacificsource.com)

#### **PacificSource Headquarters**

PO Box 7068, Springfield, OR 97475-0068

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

#### **Website**

[PacificSource.com](http://PacificSource.com)

*Para asistirle en español, por favor llame el número (800) 624-6052, extensión 5456.*

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**POLICY INFORMATION**

Group Name: OSU Graduate Assistant Health Insurance  
Group Number: G0021007

**EMPLOYEE ELIGIBILITY REQUIREMENTS**

Minimum Hour Requirement: Per Employer Guidelines  
Waiting Period for New Employees: Per Employer Guidelines

This dental care policy 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.

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.

Annual Deductible	Per Person, Per Contract Year	Per Family, Per Contract Year
All Providers	\$50	\$150
Annual Benefit Maximum		
\$2,500 per person per contract year. Applies to all covered services.		

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

Service	All Providers
Class I Services	
Examinations	No charge*
Bitewing films, full mouth x-rays, cone beam x-rays, and/or panorex	No charge*
Dental cleaning (prophylaxis and periodontal maintenance)	No charge*
Topical fluoride	No charge*
Fluoride varnish	No charge*
Sealants	No charge*
Space maintainers	No charge*
Athletic mouth guards	No charge*
Brush biopsies	No charge*
Class II Services - Restorative Treatment	
Fillings	Deductible then 20% co-insurance

Simple extractions	Deductible then 20% co-insurance
Periodontal scaling and root planing	Deductible then 20% co-insurance
Full mouth debridement	Deductible then 20% co-insurance
<b>Class II Services - Complicated Treatment</b>	
Complicated oral surgery	Deductible then 20% co-insurance
Pulp capping	Deductible then 20% co-insurance
Pulpotomy	Deductible then 20% co-insurance
Root canal therapy	Deductible then 20% co-insurance
Periodontal surgery	Deductible then 20% co-insurance
Tooth desensitization	Deductible then 20% co-insurance
<b>Class III Services</b>	
Crowns	Deductible then 50% co-insurance
Replacement of existing prosthetic device	Deductible then 50% co-insurance
Dentures	Deductible then 50% co-insurance
Bridges	Deductible then 50% co-insurance

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

\* Not subject to annual deductible.

## Additional Information

### What is the annual deductible?

Your plan's deductible is the amount of money that you pay first, before your plan starts to pay. You'll see that some services are covered by the plan without you needing to meet the deductible. The individual deductible applies if you enroll without dependents. If you and one or more dependents enroll, the individual deductible applies for each member only until the family deductible has been met.

Deductible does not apply to Class I Services.

### What is the annual benefit maximum?

The annual benefit maximum is the maximum amount payable by this policy for covered services received each contract 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 our website, [PacificSource.com](http://PacificSource.com).



# BECOMING COVERED

## ELIGIBILITY

### *Employees*

Your employer decides the minimum number of hours employees must work each week to be eligible for dental insurance benefits. Your employer may also require new employees to satisfy a waiting period called the 'probationary waiting period' before they and/or their family members are eligible for benefits.

You are eligible if you are employed by the Oregon State University and meet certain requirements. Please see your plan administrator for the specific requirements to determine eligibility.

### *Family Members*

While you are insured under this plan, the following family members are also eligible for coverage:

- Your legal spouse or your qualified domestic partner.
- Your, your spouse's, or your qualified 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 qualified 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. PacificSource 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 qualified domestic partner. 'Placement for adoption' means the assumption and retention by you, your spouse, or qualified 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 qualified domestic partner. Placement 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 qualified domestic partner's guardianship. To be eligible for coverage, the child must be unmarried; not in a qualified 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 and for whom the subscriber or subscriber's spouse or qualified domestic partner provides at least 50 percent support. It may also include any grandchildren under age 19 you are financially responsible for, who are unmarried and expected to live in your household for at least a year.

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

## ENROLLING DURING THE INITIAL ENROLLMENT PERIOD

Once you satisfy your employer's probationary waiting period, and meet the hours required for eligibility, you and your eligible family members become eligible for this plan. Starting on the date you become eligible, you and your family members have 45 days to enroll. We call this 45 day window the initial enrollment period. To enroll you must submit the enrollment application provided by your employer.

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 your employer's probationary waiting period. The length of the probationary waiting period is stated in your Dental Benefit Summary. Coverage will only begin if PacificSource receives your enrollment application and your employer's premium payment for that month.

The 'initial enrollment period' is the 45 day period beginning on the date a person is first eligible for enrollment in this plan. Everyone who becomes eligible for coverage has an initial enrollment period.

Coverage begins on the first day of the term for which the student receives at least a 0.20 FTE appointment provided a completed enrollment form is received by the OSU Insurance Liaison Office, 328 Student Health Services, Plagemand Building, within 45 days of the appointment. For purpose of the group health policy, the first day of each term is defined as follows:

- Fall: October 1
- Winter: January 1
- Spring: April 1
- Summer: July 1

In the event of a late assistantship, the effective date will instead be determined by the date the offer was made. A graduate assistantship with an effective date prior to the 16<sup>th</sup> of a month will be effective the first of the month within the same term. Eligibility for a graduate assistantship with an effective date on or after the 16<sup>th</sup> of the month will begin on the first day of the following month.

## **ENROLLING NEW FAMILY MEMBERS**

### ***Newborns***

Your newborn child is eligible for coverage from the moment of birth for 31 days. To enroll your child, PacificSource must receive your enrollment change and any additional premium from your employer within 60 days of birth. If additional premium is required, it is charged from the date of birth and prorated for the first month. A claim for maternity care is not considered notification for the purpose of enrolling a newborn child. Anytime there is a delay in providing enrollment information, PacificSource may ask for legal documentation to confirm validity.

### ***Adopted Children***

When a child is placed in your home for adoption, you have 60 days from the date of placement to enroll them in your plan. To enroll the child, PacificSource must receive your enrollment change and any additional premium from your employer within 60 days of the placement. If additional premium is required, it is charged from the date of birth or placement and prorated for the first month. Coverage for your new family members will begin on the date of placement. You may be required to submit a copy of the certificate of adoption or other legal documentation from a court or a child placement agency to complete enrollment.

### ***Foster Children***

When a foster child is placed in your home, you have 60 days from the date of placement to enroll them in your plan. To enroll the child, PacificSource must receive your enrollment change and any additional premium from your employer within 60 days of the placement. If additional premium is required, it is charged from the date of birth or placement and prorated for the first month. Coverage for your new family members will begin on the date of placement. You may be required to submit a copy of the legal documentation from a court or a child placement agency to complete enrollment.

### ***Family Members Acquired by Marriage***

If you marry, you have 60 days from the date of the marriage to enroll your new spouse and any newly eligible dependent children in your plan. PacificSource must receive your enrollment change and any additional premium from your employer within 60 days of the marriage. Coverage for your new family members will then begin on the first day of the month after the marriage. You may be required to submit a copy of your marriage certificate to complete enrollment.

### ***Family Members Acquired by Qualified 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 60 day initial enrollment period after the registration of the domestic partnership. PacificSource must receive your enrollment change and additional premium during the initial enrollment period. Coverage for your new family members will then begin on the first day of the month after the registration of the domestic partnership. You may be required to submit a copy of your Certificate of Registered Domestic Partnership to complete enrollment.

Unregistered domestic partners and their children may also become eligible for enrollment. If you and your unregistered domestic partner meet the criteria on the Affidavit of Domestic Partnership supplied by your employer, your domestic partner and your partner's dependent children are eligible for coverage during the 60 day initial enrollment period after the requirements of the Affidavit of Domestic Partnership are satisfied. PacificSource must receive your enrollment change, a copy of your Affidavit of Domestic Partnership, and additional premium during the initial enrollment period. Coverage for your new family members will then begin on the first day of the month after the Affidavit of Domestic Partnership is received by PacificSource.

### ***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 in your plan. PacificSource must receive your enrollment change and any additional premium from your employer within 60 days of the court appointment. Coverage will then begin on the first day of the month after the date of the court order. You may be required to submit a copy of the court order to complete enrollment. When the court order terminates or expires, the child is no longer an eligible child.

### ***Qualified Medical Child Support Orders***

This dental 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 dental benefit coverage for the child of a plan member.

If a court or state agency orders coverage for your spouse, qualified domestic partner, or child, you have 60 days from the date of the court order to enroll them in this plan. PacificSource must receive your enrollment change and any additional premium from your employer within 60 days of the court order. Coverage will become effective on the first day of the month after the court order. You may be required to submit a copy of the QMCSO to complete enrollment.

## **ENROLLING AFTER THE INITIAL ENROLLMENT PERIOD**

### ***Returning to Work after a Layoff***

If you are laid off and then rehired by your employer within three months, you will not have to satisfy another probationary waiting period.

Your dental coverage will resume the day you return to work and again meet your employer's minimum hour requirement. If your family members were covered before your layoff, they can

resume coverage at that time as well. You must re-enroll your family members by submitting your enrollment change within the 45 day initial enrollment period following your return to work.

### ***Returning to Work after a Leave of Absence***

If you return to work after an employer approved leave of absence of three 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 your employer'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 your enrollment change within the 45 day initial enrollment period following your return to work.

### ***Returning to Work after Family Medical Leave***

If you work for a company that employs 50 or more people, your employer is probably subject to the Family Medical Leave Act (FMLA). To find out if you have rights under FMLA, ask your 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 resume coverage at that time as well. You must re-enroll your family members by submitting an enrollment change within the 45 day initial enrollment period following your return to work.

### ***Special Enrollment Periods***

In accordance with your employer's guidelines, both you and your family members may decline coverage when you are first eligible. If you choose to decline coverage, you must complete an OSU Student Insurance Waiver within 45 days of your graduate teaching appointment.

Employees are allowed to waive medical coverage and enroll in dental only if the employee has an eligible waiver.

OSU allows you to waive coverage only under the following situations (see OSU for more detailed requirements):

- If you are sponsored by your embassy
- If you are covered as a U.S. based employee, or as a dependent of a U.S. based employee
- To waive this coverage, an employee must complete a waiver form and have adequate equivalent or better coverage that covers both emergent and non-emergent care. This coverage must include medical, vision, dental, and pharmacy coverage. This coverage may not be waived to coverage obtained outside the United States. The employee's other coverage must be reviewed and approved by the OSU Student Health Insurance office.
- Special Enrollment Rule #1

If you declined enrollment for yourself or your family members because of other dental insurance coverage, you or your family members may enroll in the plan later if the other coverage ends. To do so, you must request enrollment within 60 days after the other dental insurance coverage ends (or within 60 days after the other health insurance coverage ends if the other coverage is through Medicaid or a State Children's Health Insurance Program). Coverage will begin the day after the other coverage ends.

- Special Enrollment Rule #2

If you acquire new family members because of marriage, newly qualified domestic partnership, birth, placement of foster child, or placement for adoption, you may be able to enroll yourself and/or your newly acquired family members at that time. To do so, you must request enrollment within 60 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 the marriage or qualification of the domestic partnership. In the case of birth, placement of foster child, or placement for adoption, coverage begins on the date of birth or placement.

- **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 request enrollment 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.

**Child turning two years of age.** If you declined enrollment in this plan’s coverage for your newborn or child under 24 months of age, you may enroll that child upon turning two years of age. To enroll your child, you must request enrollment and pay any required premium by the last day of the month in which they turn two years old. Coverage becomes effective for your child the first day of the month following receipt of the application.

***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.

You may enroll yourself or your family member as a ‘late enrollee’ by submitting an enrollment application to your employer during one of the following open enrollment periods designated by your employer:

For applications received between September 16-30, enrollment becomes effective October 1

For applications received between December 16-31, enrollment becomes effective January 1

For applications received between March 16-31, enrollment becomes effective April 1

For applications received between June 16-30, enrollment becomes effective July 1

**PLAN SELECTION PERIOD**

If your employer offers more than one benefit plan option, you may choose another plan option only upon your plan’s anniversary date. You may select a different plan option by completing a selection form or application form. Coverage under the new plan option becomes effective on your plan’s anniversary date.

## WHEN COVERAGE ENDS

If you leave your job for any reason or your work hours are reduced below your employer's minimum requirement, coverage for you and your enrolled family members will end. Coverage ends on the last day of the last month in which you worked full time and for which a premium was paid. You may, however, be eligible to continue coverage for a limited time; please see the Continuation section of this handbook for more information.

### *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 your employer of the divorce or separation, and continuation coverage may be available for your spouse. If there are special child custody circumstances, please contact the PacificSource Membership Services Department. Please see the Continuation section for more information.

### *Dependent Children*

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

### *Dissolution of Qualified Domestic Partnership*

If you dissolve your qualified domestic partnership, coverage for your qualified 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 qualified domestic partnership is final. You must notify your employer of the dissolution of the qualified domestic partnership. Under Oregon state continuation laws, a registered domestic partner and their covered children may continue this plan's coverage under the same circumstances and to the same extent afforded an enrolled spouse and their enrolled children. (See Oregon Continuation in the Continuation of Insurance section.) Qualified domestic partners and their covered children are not recognized as qualified beneficiaries under federal COBRA continuation laws. Qualified domestic partners and their covered children may not continue this plan's coverage under COBRA independent of the employee. (See COBRA Continuation in the Continuation of Insurance section.)

## CONTINUATION OF INSURANCE

Under federal and/or state law, you and your 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 or dissolve your qualified domestic partnership.
- You die.
- You become eligible for Medicare benefits if it causes a loss of coverage for your family members.
- Your children no longer qualify as dependents.

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

## 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:

- Family members who were not enrolled in the group plan cannot 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 45 days after the last day of coverage under the group plan.
- You must pay continuation premium to your employer by the first of each month. Your employer will include your continuation premium in the group's regular monthly payment. PacificSource cannot accept the premium directly from you.
- Your employer must still be insured by PacificSource. If your employer discontinues this plan, you will no longer qualify for continuation.

## COBRA CONTINUATION

If you work for an employer that has 20 or more employees, your employer is probably 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 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 the 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:

<b>Qualifying Event</b>	<b>Continuation Period</b>
Employee's termination of employment or reduction in hours	Employee, spouse, and children may continue for up to 18 months <sup>1</sup>
Employee's divorce	Spouse and children may continue for up to 36 months <sup>2</sup>
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 <sup>2</sup>
Child no longer qualifies as a dependent	Child may continue for up to 36 months <sup>2</sup>

<sup>1</sup> 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.

<sup>2</sup> 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.

Qualified domestic partners and their covered children may not continue this policy'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.
- Your employer discontinues its dental policy and no longer offers a group dental policy 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 your employer provides both medical and dental coverage and you were enrolled in both, you may continue both medical and dental. If your employer provides only one type of coverage, or if you were enrolled in only one type of coverage, you may continue only that coverage.

COBRA continuation benefits are always the same as your employer's current benefits. Your employer has the right to change the benefits of its dental policy or eliminate the policy entirely. If that happens, any changes to the group dental policy will also apply to everyone enrolled in continuation coverage.

## ***Your Responsibilities and Deadlines***

*You must notify your employer within 60 days if you divorce, dissolve your qualified domestic partnership, or if your child no longer qualifies as a dependent. That will allow your employer to notify you or your family members of your continuation rights.*

When your employer learns of your eligibility for continuation, your employer 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 your employer. 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 or your employer do not provide these notifications within the time frames required by COBRA, PacificSource's responsibility to provide coverage under the group policy will end.

## ***Continuation Premium***

Enrolled individuals are responsible for the full cost of continuation coverage. Your employer uses the services of a third-party COBRA administrator to collect premium for continuation coverage. Please see your employer for more information about your plan's COBRA administrator. The monthly premium must be paid to your plan's COBRA administrator. PacificSource cannot accept continuation premium directly from you. You may make your first premium payment any time within 45 days after you return your Continuation Election Form to your plan's COBRA administrator. After the first premium payment, each monthly payment must reach your plan's COBRA administrator within 30 days of your plan's COBRA administrator premium due date. If your plan's 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. Premium rates are established annually and may be adjusted if the plan's benefits or costs change.

## **WORK STOPPAGE**

### ***Labor Unions***

If you are a union member, you have certain continuation rights in the event of a labor strike. Your union is responsible for collecting your premium and can answer questions about coverage during the strike.

## **HOW TO USE YOUR PLAN**

When you need dental care, you may visit any dentist. When you first visit your dentist after becoming covered under this plan, let the office staff know you have dental benefits through PacificSource. You will need to show your PacificSource ID card, which contains your group number and benefit information. Most dental offices will bill PacificSource directly. Your dentist may submit claims and treatment programs on a standard American Dental Association form. If your dentist has any questions regarding billing procedures, he or she can call PacificSource toll-free at (888) 977-9299.

For extensive dental work, we recommend that your dentist submit a pre-treatment estimate to PacificSource. We then determine how much your 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.

## **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 handbook.

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 your 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 policy, 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 policy and become your responsibility.

## **COVERED DENTAL SERVICES**

This dental plan covers the following services when performed by an eligible provider and when determined to be necessary by the standards generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury, including masticatory function. 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**

#### **Diagnostic:**

- Benefits for **examinations** (routine or other diagnostic exams) are limited to two examinations per person per contract year. 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 limited to two per contract year.
- Benefits for **full mouth x-rays, cone beam x-rays, or panorex** are limited to one complete mouth series, cone beam x-rays, or panorex in any 36 month period and further limited to four bite-wing films in a six month period. When an accumulative charge for additional periapical x-rays in a one year period matches that of a complete mouth series, no further benefits for periapical x-rays or panorex are available for the remainder of the year.

#### **Preventive:**

- Benefits for **dental cleaning (prophylaxis and periodontal maintenance)** are limited to a combined total of three procedures per person per contract year. The limitation for dental cleaning applies to any combination of prophylaxis and/or periodontal maintenance in the contract year. A separate charge for periodontal charting is not a covered benefit. Periodontal maintenance is not

covered when performed within three months of periodontal scaling and root planing and/or curettage.

- Benefits for the **topical application of fluoride** are limited to two applications per contract year.
- Benefits for **fluoride varnish applications** are limited to four applications per contract year for enrolled individuals age 18 and younger.
- Benefits for **the application of sealants** are limited to one application in a 36 month period to permanent molars and bicuspids and only enrolled individuals age 18 and younger.
- Benefits for **space maintainers** are covered for enrolled individuals age 18 and younger.
- Benefits for **athletic mouth guards** are limited to one per lifetime age 18 and younger if the enrolled individual is still enrolled in secondary school.
- Benefits for **brush biopsies** used to aid in the diagnosis of oral cancer are covered.

## **CLASS II RESTORATIVE SERVICES**

### **Restorative:**

- Benefits for a **composite, resin, or similar restoration** in a posterior (back) tooth are limited to the amount that would be paid for a corresponding amalgam restoration. A separate charge for anesthesia when used during restorative procedures is not a covered benefit. PacificSource will pay for a filling on a tooth surface only once per contract year. Three or more surface fillings are limited to one per surface per contract year.

### **Oral Surgery:**

- **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.

### **Periodontic:**

- Benefits for **periodontal scaling and root planing and/or curettage** are limited to only one procedure per quadrant in any 36 month period. For the purpose of this limitation, eight or fewer teeth existing in one arch will be considered one quadrant.

### **Preventive:**

- Benefits for **full mouth debridement** are limited to once every 24 months. This procedure is only covered if the teeth have not received a prophylaxis in the prior 24 months and if an evaluation cannot be performed due to the obstruction by plaque and calculus on the teeth. This procedure is not covered if performed on the same date as the prophylaxis.

## **CLASS II COMPLICATED SERVICES**

### **Oral Surgery:**

- **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.

### **Endodontic:**

- 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.

#### **Periodontic:**

- 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.

#### **Adjunctive General Services:**

- Benefits for **tooth desensitization** are covered as a separate procedure from other dental treatment.
- 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** administered by a dentist in a dental office in conjunction with approved oral surgery procedures are covered.

## **CLASS III SERVICES**

#### **Restorative:**

- 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.

#### **Prosthodontic:**

- 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 any **cast partial denture, full denture, immediate denture, or overdenture** are limited to once every 60 months, up 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 **fixed bridges or removable cast partials** are covered once every 60 months. Benefits for temporary full or partial dentures must be preauthorized by PacificSource.
- Benefits for the **initial placement of full or partial dentures, fixed bridges** (including acid-etch metal bridges), **and implants** are provided only if the denture, bridgework, or implant includes replacement of a natural tooth which has been extracted or lost while the member's coverage is in effect. However, this limitation does not apply after the member has been covered under the policyholder's group dental plan for a period of at least 36 consecutive months.

## **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.

- 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 for enrolled individuals age 19 and older.
- Benefits not stated - Any services and supplies not specifically described as covered benefits under the group dental plan and/or any endorsement attached hereto.
- Biopsies or histopathologic exams - (except when related to tooth structure and preauthorized).
- Bone replacement grafts to prepare sockets for implants after tooth extraction.
- Charges for broken 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. 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) and occlusal appliances.
- 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 (e.g., nitrous oxide or non-intravenous sedation), and any other euphoric drugs or any take-home medicine or supplies distributed by a provider for enrolled individuals age 19 and older.
- 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.
- 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.
- Implants - Surgical preparation, surgical placement, or removal of implants.

- 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.
- Orthodontic services - Repair or replacement of orthodontic appliances furnished under this plan.
- Orthodontic services - Treatment of misalignment of teeth and/or jaws, or any ancillary services expressly performed because of orthodontic treatment.
- 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 which your employer 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 - 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 medical payment insurance to the extent of any recovery received from or on behalf of such sources.

- Tooth transplantation - Services and supplies provided in connection with tooth transplantation, including re-implantation from one site to another 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 insurance ends - Services or supplies member receives after the member's coverage under this plan ends. The only exception is for Class III Services ordered and fitted before enrollment ends and are placed within 31 days after enrollment 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 eligibility for payment under this plan.
- 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 any PacificSource policy sponsored by the member's employer.

## **NECESSITY ACCORDING TO ACCEPTABLE DENTAL PRACTICE**

The benefits of this group dental policy 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.**

PacificSource 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, PacificSource's consideration of economically justified alternative benefits. The decision to allow alternative benefits will be made by PacificSource on a case-by-case basis. PacificSource's determination to cover and pay for alternative benefits for a member shall not be deemed to waive, alter or affect PacificSource's right to reject any other or subsequent request or recommendation. PacificSource may elect to provide alternative benefits if PacificSource 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, PacificSource 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 PacificSource participating provider treats you, your claims are automatically sent to PacificSource and processed. All you need to do is show your PacificSource ID card to the provider.

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.

## ***Proofs of Loss***

PacificSource, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss. Upon receipt of the forms for proof of loss, the claimant then must submit the proofs of loss within 90 days of the date of the loss or as soon as reasonably possible. 'Proofs of loss' include written proof covering the occurrence, the character and the extent of the loss for which claim is made.

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, we 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, we will acknowledge receipt of the claim and explain why payment is delayed. If we do not receive the necessary information within 15 days of the delay notice, we will either deny the claim or notify you every 45 days while the claim remains under investigation.

PacificSource may pay benefits to the member, the provider, or both jointly. Neither the benefits of this policy nor a claim for payment of benefits under the policy 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 Department. You may also contact Customer Service if you believe a claim was denied in error. We will review your claim and your group policy benefits to determine if the claim is eligible for payment. Then we will either reprocess the claim for payment, or contact you with an explanation.

## ***Benefits Paid in Error***

If PacificSource makes a payment to you that you are not entitled to, or pays a person who is not eligible for payment, we may recover the payment. We may also deduct the amount paid in error from your future benefits if PacificSource receives an agreement from you in writing.

In the same manner, if PacificSource applies dental expense to the plan deductible that would not otherwise be reimbursable under the terms of this policy; we may deduct a like amount from the accumulated deductible amount and/or recover payment of dental expense that would have otherwise been applied to the deductible. Examples of amounts recoverable under this provision include, but are not limited to, benefits provided for incurred expense for the treatment of an excluded dental condition. The fact that a dental expense was applied to the plan's deductible or a drug was

provided under the plan's prescription drug program 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 your 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, state law permits your insurers 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 our Customer Service Department or contact your state insurance department.

### **Primary or Secondary?**

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

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

### **When This Plan is Primary**

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

#### **Your Own Expenses**

- The claim is for your own dental expenses.

#### **Your Spouse's Expenses**

- The claim is for your spouse or your qualified 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 qualified 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**

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

## How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits in accordance with the terms of your contract, just as if you had no other dental care coverage under any other plan.

## How We Pay Claims When We Are Secondary

We will be secondary whenever the rules do not require us to be primary.

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We 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, we will base our 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 our contract or the amount called for in the contract of the primary plan, whichever is higher.
- We will determine our payment by calculating the amount we would have paid if we had been primary, and apply that calculated amount to any allowable expense that is left unpaid by the primary plan. We may reduce our 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. We will credit any amount we 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 we do not cover, we may pay for those expenses.
- We 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 pre-certification, as required by that plan, we 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 PacificSource. 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 benefits for an illness or injury you think may involve another party, contact PacificSource right away.*

When we receive a claim that might involve a third party, we will send you a questionnaire to help us 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 PacificSource 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 PacificSource.
- PacificSource is entitled to 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.

- PacificSource may subtract a proportionate share of the reasonable attorney's fees you incurred from the money you are to pay back to PacificSource.
- PacificSource may ask you to take action to recover dental expenses we have paid from the responsible party. PacificSource may also assign a representative to do so on your behalf. If there is a recovery, PacificSource 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 your related dental expenses incurred both before and after the settlement. If you have ongoing dental expenses after the settlement, PacificSource 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.

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

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

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

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

- You are the owner, partner, or principal of the employer group insured by PacificSource, are injured in the course of employment with the employer group that is insured by PacificSource, 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
- If you are employed by an Oregon Based Group and have timely filed an application for coverage with the State Accident Insurance Fund or other Workers' Compensation Carrier and are waiting for determination of coverage from that entity. Claims submitted for coverage under this section are processed in accordance with the terms of this policy.

If you are not the owner, partner, or principal of this group then PacificSource 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 contact the PacificSource Third Party Claims Department for complete details.

Your plan will remain in effect upon timely payment of the full premium 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*

PacificSource 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. We try to answer your questions promptly and give you clear, accurate answers.

*If you have a question, concern, or complaint about your PacificSource coverage, please contact our Customer Service Department. Many times our Customer Service staff 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; or matters pertaining to the contractual relationship between you and PacificSource, 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 PacificSource 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 of) our 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 plan;
- 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.

PacificSource staff involved in the initial adverse benefit determination will not be involved in the internal appeal.

You or your authorized representative may submit additional comments, documents, records and other materials relating to the adverse benefit determination that is the subject of the appeal. If an authorized representative is filing on your behalf, PacificSource will not consider your appeal to be filed until such time as it has received the 'Authorization to Use or Disclose PHI' and the 'Designation of Authorized Representative' forms.

You may receive continued coverage under the dental benefit plan for otherwise covered services pending the conclusion of the internal appeals process. If PacificSource 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 expected to reimburse PacificSource 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 PacificSource within 60 days of the first appeal response.

**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 or health or 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 PacificSource relates to an adverse benefit determination that a course or plan of treatment is not a dental necessity; is experimental or investigational; is not an active course of treatment for purposes of continuity of care; or is not delivered in an appropriate dental care setting and with the appropriate level of care, you or your authorized representative may request an external review by an independent review organization. (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.

PacificSource 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 PacificSource fails to strictly comply with its appeals process and with state and federal requirements for internal appeals. If PacificSource fails to comply with the decision of the independent review organization assigned under Oregon law, you have a private right of action (sue) against PacificSource 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 Oregon Insurance Division 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 notice of the 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 PacificSource 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 is relevant to the adverse benefit determination.

## **HOW TO SUBMIT GRIEVANCES OR APPEALS**

Before submitting a grievance or appeal, we suggest you contact our Customer Service Department with your concerns. You can reach us by phone or email at the contact information found on the first page of your Member Handbook. Issues can often be resolved at this level. Otherwise, you may file a grievance or appeal by:

### **Writing to:**

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

Emailing [cs@pacificsource.com](mailto:cs@pacificsource.com), with 'Grievance' as the subject

Faxing (541) 225-3628

If you are unsure of what to say or how to prepare a grievance, please call our Customer Service Department. We 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 Oregon Insurance Division. Assistance is available:

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

By writing to:

The Oregon Insurance Division  
Consumer Advocacy Unit  
PO Box 14480  
Salem, OR 97309-0405

Through the Internet at <http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx>

Or by email at [cp.ins@state.or.us](mailto:cp.ins@state.or.us)

## **RESOURCES FOR INFORMATION AND ASSISTANCE**

### ***Assistance in Other Languages***

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

### ***Information Available from PacificSource***

PacificSource makes the following written information available to you free of charge. You may contact our Customer Service Department by phone, mail, or email to request any of the following:

- A directory of dental providers under your plan;
- Information about our drug list (also known as a formulary);

- A copy of our annual report on complaints and appeals;
- 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 we have with providers;
- A description of our efforts to monitor and improve the quality of dental services;
- Information about how we check the credentials of our network providers and how you can obtain the names and qualifications of your dental providers;
- Information about our preauthorization and utilization review procedures; or
- Information about any dental plan offered by PacificSource.

### ***Information and Assistance Available from the Oregon Insurance Division***

The following consumer information is available from the Oregon Insurance Division:

- 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 Oregon Insurance Division by writing to the Oregon Insurance Division, Consumer Advocacy Unit, PO Box 14480, Salem, OR 97309-0405 or by phone at (503) 947-7984, or the toll-free message line at (888) 877-4894, on the Internet at <http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx>, or by email at [cp.ins@state.or.us](mailto:cp.ins@state.or.us).

## **FEEDBACK AND SUGGESTIONS**

*As a PacificSource member you are encouraged to help shape our corporate policies and practices. We welcome any suggestions you have for improving your plan or our services.*

You may send comments or feedback using the 'Contact Us' form on our website, at PacificSource.com. You may also write to us at:

*PacificSource Health Plans  
Attn: Customer Experience Strategist  
PO Box 7068  
Springfield, OR 97475-0068*

## **RIGHTS AND RESPONSIBILITIES**

*PacificSource is 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 PacificSource, our services, our providers, and your rights and responsibilities.
- You have a right to expect clear explanations of your plan 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 medical records and personal information.
- You have a right to voice complaints about 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 medical 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.
- You have a right to make recommendations regarding PacificSource Health Plans' member rights and responsibilities policy.

### ***Your Responsibilities as a Member:***

- You are responsible for reading this benefit handbook and all other communications from PacificSource, and for understanding your plan's benefits. You are responsible for contacting PacificSource Customer Service 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 PacificSource with all the information required to provide benefits under your 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 PacificSource and showing your 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 PacificSource if you believe you are not receiving adequate care.
- You are responsible for supplying information to the extent possible that 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**

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

Disclosure outside PacificSource is allowed only when necessary to provide your coverage, or when otherwise allowed by law. Except when certain statutory exceptions apply, state law requires us to have written authorization from you (or your representative) before disclosing your personal information outside 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**

### ***Group Insurance Policy***

This plan is fully insured. Benefits are provided under a group insurance policy between your employer and PacificSource Health Plans. Your employer - the policyholder - has a copy of the group insurance policy, which contains specific information regarding eligibility and benefits. Under the group insurance policy, PacificSource - not the policyholder - is responsible for paying claims. However, the policyholder and PacificSource share responsibility for administering the plan's eligibility and enrollment requirements. The policyholder has given PacificSource authority to determine eligibility for benefits under the plan and to interpret the terms of the plan.

Our address is:

PacificSource Health Plans  
PO Box 7068  
Springfield, OR 97475-0068

### ***Plan Funding***

Insurance premiums for employees are paid in whole or in part by the plan administrator (your employer) out of its general assets. Any portion not paid by the plan administrator is paid by employee payroll deductions.

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

The plan administrator is authorized to apply for and accept policy changes on behalf of the policyholder.

*If changes occur, PacificSource will provide your plan administrator with information to notify you of changes to your plan. Your plan administrator will then communicate any benefit changes to you.*

If your group dental plan terminates and your employer does not replace the coverage with another group plan, your employer is required by law to advise you in writing of the termination. When this plan's group policy terminates, PacificSource will notify your employer about any available options for you to continue your coverage, such as COBRA continuation.

## ***Legal Procedures***

You may not take legal action against PacificSource to enforce any provision of the group policy until 60 days after your claim is submitted to us. Also, you must exhaust this plan's claims procedures before filing benefits litigation. You may not take legal action against PacificSource more than three years after the deadline for claim submission has expired.

## **EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)**

Generally, dental benefit plans subject to ERISA include employer-sponsored plans, but do not include governmental and church plans or any other statute-exempt plan. If the plan under which you are covered is an ERISA plan, you have the right to bring civil action under ERISA section 502 to enforce your current or future rights under the terms of the plan or to recover benefits due to you. Although PacificSource offers you the opportunity of a second level appeal and an independent review, ERISA permits civil action after the PacificSource appeals process has been exhausted. (See Complaints, Grievances, and Appeals - Appeal Procedures section.)

### ***Your rights under ERISA***

As a participant in an ERISA plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). The policyholder (your employer) is the 'plan administrator' as defined in ERISA. The plan administrator is an agent of those individually enrolled under the group policy, and is not the agent of PacificSource. ERISA states that all plan participants are entitled to:

#### **Receive information about your plan and benefits**

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report (Form 5500 Series). The plan administrator is required by law to provide each participant with a copy of this summary annual report only in a year in which the plan has to file an annual report.

#### **Continue group dental plan coverage**

Continue dental care coverage for eligible individuals if there is a loss of coverage under the plan as a result of a qualifying event. Eligible individuals may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your continuation coverage rights.

#### **Prudent actions by plan fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called 'fiduciaries' of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising any rights under ERISA.

## ***Enforce your rights***

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. (See Complaints, Grievances, and Appeals - Appeal Procedures section.)

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. (A claimant will need to exhaust the plan's claims procedure before filing benefits litigation; see the Complaints, Grievances, and Appeals Appeal Procedures section and the first paragraph of this section.) In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

## ***Assistance with your questions***

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of Employee Benefits Security Administration., U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration., U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## **DEFINITIONS**

*Wherever used in this policy, the following definitions apply to the terms listed below, and the masculine includes the feminine and the singular includes the plural. For the purpose of this policy, 'employee' includes the employer when covered by this policy. 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** PacificSource's denial, reduction, or termination of a dental care item or service, or PacificSource'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 PacificSource'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 by PacificSource 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, as documented in PacificSource's payment policy.

**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 PacificSource 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;
- Matters pertaining to the contractual relationship between a member and PacificSource;
- Rescissions of member's benefit coverage by PacificSource; 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 PacificSource'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 on each 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 Benefit Summary.

**Complaint** means an expression of dissatisfaction directly to PacificSource that is about a specific problem encountered by a member, or about a benefit determination by PacificSource or an agent acting on behalf of PacificSource, and that includes a request for action to resolve the problem or change the benefit determination. 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 insurance policy is issued or the anniversary of the date the insurance policy was issued. If changes are made to the insurance policy on a date other than the anniversary of issuance, a new policy year may start on the date the changes become effective if so agreed by PacificSource and the policyholder. A contract year may or may not coincide with a calendar year.

**Contracted allowable fee** is an amount PacificSource 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 Benefit Summary.

**Covered expense** is an expense for which benefits are payable under 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 policy and the first day of coverage under this policy. 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 policy 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 health condition;
- Not for the convenience of the member or a provider of services or supplies; and
- The least costly of the alternative services or supplies that can be safely provided.

The fact that a 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 qualified domestic partner are legally obligated to support or contribute support for. 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 Becoming Covered - Eligibility.) It may also include any grandchildren under age 19 you are financially responsible for, who are unmarried and expected to live in your household for at least a year.

**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 he/she operates within the scope of their license.

**Eligible employee** means an employee who is eligible for coverage under a group dental benefit plan. Employees who have been employed for fewer than the number of days required as indicated on the Dental Benefit Summary are not eligible employees unless the employer and PacificSource so agree. Eligible employees may be covered under the group dental plan only if they meet the eligibility requirements according to the terms of the plan.

**Employee** means any individual employed by an employer.

**Endorsement** is a written attachment that alters and supersedes any of the terms or conditions set forth in this plan.

**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.

**External appeal** or review means the request by an appellant for an independent review organization to determine whether PacificSource'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; or
  - Matters pertaining to the contractual relationship between a member and PacificSource.

**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 your employer 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 member's dental benefit plan.

**Internal appeal** means a review by PacificSource of an adverse benefit determination made by PacificSource.

**Large employer** means an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the contract year.

**Leave of absence** is a period of time off work granted to an employee by the employer 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 employer. A leave can be granted for any reason acceptable to the employer, including disability and pregnancy.

**Member** means an individual insured under a PacificSource dental plan.

**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.

**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.

**Qualified domestic partner** means:

- **Registered domestic partner** means an individual of same gender, age 18 or older, who is joined in a domestic partnership, and whose domestic partnership is legally registered in any state.
- **Unregistered domestic partner** means an individual of same or opposite gender who is joined in a domestic partnership with the subscriber and meets the following criteria:
  - Is age 18 or older;
  - Not related to the subscriber by blood closer than would bar marriage in the state where they have permanent residence and are domiciled;
  - Shares jointly the same permanent residence with the subscriber for at least six months immediately preceding the date of application to enroll and intent to continue to do so indefinitely;
  - Has an exclusive domestic partnership with the subscriber and has no other domestic partner;

- Does not have a legally binding marriage nor has had another domestic partner within the previous six months; and
- Was mentally competent to consent to contract when the domestic partnership began and remains mentally competent.

**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 benefit plan or group or individual dental insurance policy 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.

**Schedule** means the page entitled Dental Schedule attached to this group dental policy.

**Spouse** means any individuals who are lawfully married under any state law, including individuals married to a person of the same sex who were legally married in a state that recognizes such marriages, but who are domiciled in Oregon. Similarly, the term 'marriage' will be read to include a same-sex marriage that is legally recognized as a marriage under any state law. The terms 'spouse' and 'marriage,' however, do not include individuals in a qualified domestic partnership. (See 'Qualified domestic partner' in this definitions section.)

**Subscriber** means an employee or former employee insured under a PacificSource dental policy. When a family unit that does not include an employee or former employee is insured under a policy, the oldest family member is referred to as the subscriber.

**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 85<sup>th</sup> 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.





Customer Service

*Idaho*

**208.333.1596** Local (*Boise*)

**800.688.5008** Toll-free

*Montana*

**406.442.6589** Local (*Helena*)

**877.590.1596** Toll-free

*Oregon*

**541.684.5582** Local (*Eugene/Springfield*)

**888.977.9299** Toll-free

**541.225.3631** Fax

**cs@pacificsource.com** Email

Headquarters

**PO Box 7068**

**Springfield, OR 97475-0068**

**541.686.1242** Local (*Eugene/Springfield*)

**800.624.6052** Toll-free

Website

**PacificSource.com**