

Member

## Benefit Handbook



### OSU Graduate Assistant Health Insurance

Group No.: G0021007

Dental Choice Plus 0-20-20-50 50-2500 PY VAR

Effective: October 01, 2014



**We're in it for the people.**





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) 684-5582 or (888) 977-9299

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**POLICY INFORMATION**

Group Name: OSU Graduate Assistant Health Insurance  
 Group Number: G0021007  
 Plan Name: Dental Choice Plus 0-20-20-50 50-2500 PY VAR

**EMPLOYEE ELIGIBILITY REQUIREMENTS**

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

The following 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 law in the state of issuance. Eligible charges are limited to the usual, customary, and reasonable charges of dental providers in the same service area for similar treatment of similar dental conditions.

Advantage Network dentists agree to write off any charges over and above negotiated, contracted fees for most services. When you use an Advantage Network dentist, you will not be responsible for any excess charges and will pay only your plan's coinsurance amount. If you choose not to use a participating dentist, or don't have access to them, reimbursement is based on the 85<sup>th</sup> percentile of the Advantage Network fee schedule. If those charges exceed the fee schedule, the excess charges are your responsibility.

**This plan covers dental services for members through age 18 as required under the Affordable Care Act.**

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

**The member is responsible for the above deductible and the following co-insurance.**

Service	All Providers
<b>Class I Services</b>	
Examinations	No charge*
Bitewing films, full mouth 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*
<b>Class II Services - Restorative Treatment</b>	
Fillings	20% co-insurance
Simple surgical extractions	20% co-insurance
Periodontal scaling	20% co-insurance

Root planing and/or curettage	20% co-insurance
Full mouth debridement	20% co-insurance
<b>Class II Services - Complicated Treatment</b>	
Complicated oral surgery	20% co-insurance
Pulp capping	20% co-insurance
Pulpotomy	20% co-insurance
Root canal therapy	20% co-insurance
Periodontal surgery	20% co-insurance
Tooth desensitization	20% co-insurance
<b>Class III Services</b>	
Crowns	50% co-insurance
Replacement of existing prosthetic device	50% co-insurance
Dentures	50% co-insurance
Bridges	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 on the Dental Benefit Summary that some services are covered by the plan without you needing to meet the deductible. In addition to the individual deductible, your plan also has a family deductible and we will credit you with whichever deductible you meet first. For the family deductible, if the combined expenses of three or more family members meet the family deductible amount, then every member of the family is considered to have met their plan's deductible for the year.

Participating provider expense and non-participating provider expense apply together toward your deductibles.

### 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.



# BECOMING COVERED

## ELIGIBILITY

### *Employees*

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 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; related to you by blood, marriage, or 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/or your eligible family members become eligible for this plan. Starting on the date you become eligible, you and/or your family members have 45 days to enroll. We call this 45 day window the initial enrollment period. To enroll you must complete and sign an enrollment application provided by your employer. Return the application to your employer, and your employer will send to PacificSource.

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

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 16th 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 16th of the month will begin on the first day of the following month.

## **ENROLLING NEW FAMILY MEMBERS**

### ***Newborns***

Your newborn child is eligible from the moment of birth for 31 days. If you wish to continue providing coverage for the child beyond 31 days, you must enroll them on the plan. To enroll the child, PacificSource must receive your completed enrollment application and any additional premium from your employer within 45 days of birth. If additional premium is required, it is charged from the date of birth or placement 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 45 days from the date of placement to enroll them in your plan. To enroll the child, PacificSource must receive your completed enrollment application and any additional premium from your employer within 45 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 45 days from the date of placement to enroll them in your plan. To enroll the child, PacificSource must receive your completed enrollment application and any additional premium from your employer within 45 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 45 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 completed enrollment application and any additional premium from your employer within 45 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 same-gender 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 45 day initial enrollment period after the registration of the domestic partnership. PacificSource must receive your completed enrollment application 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 45 day initial enrollment period after the requirements of the Affidavit of Domestic Partnership are satisfied. PacificSource must receive your completed enrollment application, 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 45 days from the court appointment to enroll them in your plan. PacificSource must receive your completed enrollment application and any additional premium from your employer within 45 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 45 days from the date of the court order to enroll them in this plan. PacificSource must receive your completed enrollment application and any additional premium from your employer within 45 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 an enrollment application within the 45 day initial enrollment period following your return to work.

If the employee's exclusion period were satisfied (or partially satisfied) before the layoff, they will be credited at the same level when the employee returns to work. However, your family members will be subject to a new exclusion period unless they had creditable coverage during a layoff of more than 63 days. For information about creditable coverage, please see 'Exclusion Periods' and 'Credit for Prior Coverage' in the Benefit Limitations and Exclusions section of this handbook.

### ***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 an enrollment application within the 45 day initial enrollment period following your return to work.

Both you and your family members will be subject to a new exclusion period unless you had creditable coverage during a leave of absence of more than 63 days. For information about creditable coverage, please

see 'Exclusion Periods' and 'Credit for Prior Coverage' in the Benefit Limitations and Exclusions section of this handbook.

### **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 or any previously satisfied exclusion period under this plan. Your dental coverage will resume the day you return to work and meet your employer's minimum hour requirement. If your family members were covered before your leave, they can also resume coverage at that time if you re-enroll them within the 45 day initial enrollment period following your return.

### **Special Enrollment Periods**

If you enroll during your initial enrollment period, your family members may decline coverage, and they may enroll in the plan later if they qualify under the Special Enrollment Rules below.

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.

You and/or your dependents may enroll under this dental plan if the enrollment coincides with a permissible enrollment event according to the terms of a group dental policy sponsored by your employer. Enrollment events may include an involuntary loss of other coverage, marriage, registration of a domestic partnership, birth of a child, adoption of a child, coverage ordered by a court or state agency, or enrollment allowed by a leave of absence or layoff rehire provision.

**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.

The plan's exclusion periods apply from the date of coverage unless you have prior creditable coverage (see 'Credit for Prior Coverage' in the Benefit Limitations and Exclusions section of this handbook).

## **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.

You can voluntarily discontinue coverage for your enrolled family members at any time by completing a Termination of Dependent Coverage form and submitting it to your employer. Keep in mind that once coverage is discontinued, your family members may be subject to the late enrollment waiting period if they wish to re-enroll later.

### ***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 beyond age 25. 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, and continuation coverage may be available for your domestic partner. 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 policy's coverage under COBRA independent of the employee (see COBRA Continuation in the Continuation of Insurance section).

## **CONTINUATION OF INSURANCE**

Under federal 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
- Your children no longer qualify as dependents

The following sections describe your rights to continuation under 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).

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

The following requirements apply to USERRA continuation:

- 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 health 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:



Qualifying Event	Continuation Period
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.

### **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.
- Your employer discontinues its dental plan and no longer offers a group dental plan to any of its employees.
- Your continuation period was extended from 18 to 29 months due to disability, and you are no longer considered disabled.

### **Type of Coverage**

Under COBRA, you may continue any coverage you had before the qualifying event. If 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 plan or eliminate the plan entirely. If that happens, any changes to the group dental plan will also apply to everyone enrolled in continuation coverage.

### **Your Responsibilities and Deadlines**

*You must notify your employer within 60 days if you divorce, 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 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.

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**

You or your family members 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. Most dental offices will bill PacificSource directly. If your dentist has any questions regarding billing procedures, he or she can call PacificSource toll-free at (888) 977-9299.

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. Your dentist may submit claims and treatment programs on a standard American Dental Association form.

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 stated 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 booklet.

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 usual, customary, and reasonable (UCR) charges. If that non-participating dentist's fees exceed the UCR charges, 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 usual, customary and reasonable 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 he or she is operating within the scope of his or her license as required under law in the State of Oregon.

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

### CLASS I SERVICES

- 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 certain lab tests, are not covered. Problem focused examinations are limited to two per contract year.
- Benefits for **full mouth x-rays and/or panorex** are limited to one complete mouth series and/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.
- 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 members through age 18.
- Benefits for **the application of sealants** are limited to one application in a 36 month period to permanent molars and bicuspid and only for members through age 18.
- Benefits for **space maintainers** are covered for members through age 18.
- Benefits for **athletic mouth guards** are limited to one per lifetime through age 18 if the member 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

- 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. Only one filling is allowed per tooth surface. 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.
- **Simple surgical extractions of teeth** and other minor oral surgery procedures are covered. General anesthesia used in conjunction with these extractions administered by a dentist in a dental office is also covered. A separate charge for alveolectomy performed in conjunction with removal of teeth is not a covered benefit.

- Benefits for **periodontal scaling and root planing and/or curettage** are 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.
- 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

- **Complicated oral surgery procedures** such as the removal of impacted teeth are limited to procedures that have been preauthorized by PacificSource. Benefits for complicated oral surgery procedures include general anesthesia administered by a dentist in a dental office. A separate charge for alveolectomy performed in conjunction with removal of teeth is not a covered benefit.
- Benefits for **pulp capping** are payable only when there is an exposure to the pulp. These are direct pulp caps. Indirect pulp caps are not covered.
- Benefits for a **pulpotomy** are payable only for deciduous teeth.
- Benefits for **root canal therapy** on the same tooth are payable only for one charge in a 36 month period.
- Benefits for **periodontal surgery** are limited to procedures that have been preauthorized by PacificSource and accompanied by a periodontal diagnosis and history of conservative (non-surgical) periodontal treatment.
- Benefits for **tooth desensitization** are covered as a separate procedure from other dental treatment.

## CLASS III SERVICES

- Benefits for **crowns** and other cast or laboratory-processed restorations are limited to the restoration of any one tooth in a 60 month period. If a tooth can be restored with a material such as amalgam or composite resin, covered charges are limited to the cost of amalgam or non-laboratory composite resin restoration even if another type of restoration is selected by the patient and/or dentist.
- Benefits for 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 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 120 months. Benefits for temporary full or partial dentures must be preauthorized by PacificSource. Benefits for the initial placement of full or partial dentures or fixed bridges (including acid-etch metal bridges) are provided only if the denture or bridgework 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
- **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**
- **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) malformation, 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), gnathological recordings, occlusal appliances, occlusal equilibration procedures, or similar procedures
- **Drugs and medications** that are prescribed drugs, premedication drugs, analgesics (e.g., non-intravenous sedation), any other euphoric drugs, or any take-home medicine or supplies distributed by a provider
- **Educational programs** - Instructions and/or training in plaque control and oral hygiene
- **Experimental or investigational procedures** - Services, supplies, protocols, procedures, devices, drugs or medicines, or the use thereof that are experimental or investigational for the diagnosis and treatment of the patient. An experimental or investigational service is not made eligible for benefits by the fact that other treatment is considered by the member's dental care provider to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.
- **Fractures of the mandible** - Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible
- **General anesthesia** except when administered by a dentist in connection with oral surgery in his/her office
- **Gingivectomy, gingivoplasty or crown lengthening** in conjunction with crown preparation or fixed bridge services done on the same date of service
- **Hospital charges** or additional fees charged by the dentist for hospital treatment
- **Hypnosis**
- **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
- **Oral surgery treating any fractured jaw**



- **Orthodontic services** - Repair or replacement of orthodontic appliances furnished under this plan.
- **Orthognathic surgery** - Surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship to the facial bones
- **Periodontal probing, charting, and re-evaluations**
- **Photographic images**
- **Pin retention** in addition to restoration.
- **Precision attachments**
- **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 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 for which no charge is made**, 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 includes services provided by you or an immediate family member.
- **Services or supplies provided outside of the United States**, except in cases of emergency
- **Services, supplies, and treatment resulting from** an illegal occupation or attempted felony, or treatment received while in the custody of any law enforcement authority
- **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 provided after enrollment in this plan ends, except as provided for under Extension of Benefits in the Plan Benefits section. 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 prior to enrollment** - Dental services begun 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 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.
- **Work-related conditions** - Services or supplies for treatment of illness or injury arising out of or in the course of employment or self-employment for wages or profit, whether or not the expense for the service or supply is paid under workers' compensation.

## EXCLUSION PERIODS

If the Dental Summary provides for an exclusion period, there may be an exclusion period that must be completed before benefits will be paid by PacificSource. The exclusion period does not apply to persons insured under this policy on the policy's original effective date if the person was continuously covered under a predecessor policy of the policyholder.

## CREDIT FOR PRIOR COVERAGE

Waiting periods for benefits will be reduced by an amount of time equal to the member's or late enrollee's aggregate period of creditable coverage if the most recent period of creditable coverage ended within 63 days of, or remains in effect on, the effective date of coverage under this policy. The credit for prior coverage will be applied without regard to the specific benefits covered during the prior period.

To demonstrate creditable coverage, a member may provide PacificSource with a Certificate of Creditable Coverage from a prior dental benefit plan. If, after making reasonable effort, a member is unable to obtain a Certificate of Creditable Coverage, PacificSource will attempt to assist in obtaining the certificate.

## 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 pre-scribe, 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 an individual 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.

If you receive care from a non-participating provider, the provider may submit the claim to PacificSource for you. If not, you are responsible for sending the claim to us for processing. Your claim must include a copy of your provider's itemized bill. It must also include your name, PacificSource ID number or social security number, group name, group number, and the patient's name. If you were treated for an accidental injury, please include the date, time, place, and circumstances of the accident.

All claims for benefits must be turned in to PacificSource within 90 days of the date of service. If it is not possible to submit a claim within 90 days, turn in the claim with an explanation as soon as possible. In some cases PacificSource may accept the late claim. We will never pay a claim that was submitted more than a year after the date of service, though.

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 submitting, within the time fixed in the policy for filing proofs of loss, 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

*If you, or your enrolled family members, are covered by more than one group insurance plan, PacificSource will work with your other insurance carriers to pay up to 100 percent of your covered expenses. This is called 'coordination of benefits'. We do this so you receive the maximum benefits available from all sources for the cost of your care.*

When benefits are coordinated, one plan pays benefits first (the 'primary coverage') and the other pays based on the remaining balance (the 'secondary coverage'). If your primary and/or secondary coverage include a deductible, you will be required to satisfy each of those deductibles concurrently before benefits are available. The secondary plan shall credit to its deductible any amounts it would have credited to its deductible in the absence of the primary plan. This plan's rules for coordination of benefits are consistent with the requirements of coordination of benefits provision in Oregon Insurance regulations.

Here is how this plan's benefits are coordinated with your other group coverage:

- If the other plan does not include 'coordination of benefits,' that plan is primary and this plan is secondary. This standalone dental plan will be primary over any policy benefits applicable to a covered pediatric dental benefit within a medical plan.
- If you are covered as an employee on one plan and a dependent on another, the plan that covers you as an employee is primary.
- When a child is covered under both parents' policies and the parents are either married or are living together (regardless of whether or not they have ever been married):
  - The parent whose birthday falls first in a calendar year has the primary plan; or
  - If both parents have the same birthday, the parent who has been covered the longest has the primary plan

### EXAMPLE

*If your birthday is March 1 and your spouse's birthday is October 15, your plan is primary for your children.*

- When a child is covered under both parents' policies and the parents are divorced, separated, or not living together (regardless of whether or not they have ever been married):
  - If a court order specifies that one parent is responsible for the child's healthcare expenses, the mandated parent's coverage is primary regardless of custody.
  - If a court order specifies that both parents are responsible for the child's healthcare expenses, the parent whose birthday falls first in a calendar year has the primary plan. If both parents have the same birthday, the parent who has been covered the longest has the primary plan.
  - If a court order specifies that both parents have joint custody without specifying that one parent has responsibility for the child's healthcare expenses, the parent whose birthday falls first in a calendar year has the primary plan. If both parents have the same birthday, the parent who has been covered the longest has the primary plan.
- If there is no court order, the order of benefits for the child are as follows:
  - The custodial parent's coverage is primary;
  - The spouse or qualified domestic partner of the custodial parent's coverage pays second;
  - The natural parent without custody's coverage pays third; and
  - The spouse or qualified domestic partner of the natural parent without custody's coverage pays fourth.

- If a plan covers you as an active employee or a dependent of an active employee, and another plan covers you as inactive, laid off or retired, the plan that covers you as an active employee, or dependent of an active employee is primary.
- If none of these rules apply, the coverage that has been in place longest is primary.

Most insurance companies send you an explanation of benefits, or EOB, when they pay a claim. If your other plan's coverage is primary, send PacificSource the other plan's EOB with your original bill and we will process your claim. If this plan is primary, send your PacificSource EOB and the original bill to your other insurance company. In most cases that is all the insurer needs to process your claim.

If you receive more than you should when your benefits are coordinated, you will be expected to repay any over-payment.

## 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. If you use this plan's benefits for an illness or injury you think may involve another party, contact PacificSource immediately.

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

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

When 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.
- In a third party liability situation, PacificSource will ask you to agree to the third party liability terms of the group health policy by signing an agreement. PacificSource is not required to pay benefits until that agreement is signed and returned.

### 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. But before we do that, you must sign a written agreement to reimburse PacificSource out of any money you recover.

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

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

This plan does not cover any work-related illness or injury, including those arising from self-employment. The only exception is if you are an owner, partner, or principal of the employer group insured by PacificSource, injured in the course of employment of the employer group insured by PacificSource, and are otherwise exempt from, and not covered by, state or federal workers' compensation insurance.

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. But before we do that, you must sign a written agreement to reimburse PacificSource out of any money you recover from the workers' compensation coverage.

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

Your policy 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 healthcare services; or claims payment, handling or reimbursement for healthcare 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, reduced or terminated a healthcare item or service, or failed or refused to provide or make a payment in whole or in part for a healthcare item or service, that is based on any of the reasons listed below, you or your authorized representative may appeal (request a review) our decision. Except in the case of an expedited review request, 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 healthcare plan;
- Rescission or cancellation of your policy;

- Imposition of a source-of-injury exclusion\*, network exclusion, annual benefit limit or other limitation on otherwise covered services or items;
- Determination that a healthcare item or service is experimental, investigational or not medically necessary, 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 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.

You will receive continued coverage under the health 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 healthcare 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 healthcare setting and with the appropriate level of care, you or your authorized representative may request an external review by an independent review organization (see How to Submit Grievances or Appeals below).

Your request for an independent review must be made within 180 days of the date of the second internal appeal response. External independent review is available at no cost to you, but is generally only available when coverage has been denied for the reasons stated above and only after all internal grievance levels are exhausted.

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 copy of 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 are 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, or by email at [cs@pacificsource.com](mailto:cs@pacificsource.com). 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** a message to [lc@pacificsource.com](mailto:lc@pacificsource.com), with 'Grievance' as the subject

**Faxing** your message to (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://insurance.oregon.gov/consumer/consumer.html>

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.

## 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, PacificSource.com. You may also write to us at:

PacificSource Health Plans  
Attn: Executive Vice President and Chief Operating Officer

## 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 healthcare.*

### **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 healthcare without regard to race, religion, gender, national origin, or disability.
- You have a right to honest discussion of appropriate or medically 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 healthcare 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 participating 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 healthcare 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 to supply 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 to follow 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 medical 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 discretionary 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
- The owner or partners of the business
- 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 health policy terminates and your employer does not replace the coverage with another group policy, 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 state 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)

**This is a Federal provision. Nothing in this language is to be considered to grant an individual eligibility on this plan outside of the rules found in the *Eligibility* section of this handbook.**

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 you. Although PacificSource offers you the opportunity of a second level appeal and an independent review, ERISA permits civil action after you have received our decision at the first level appeal as described under 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 health plan coverage.

- Continue healthcare coverage for yourself or family members if there is a loss of coverage under the plan as a result of a qualifying event. You or your family members 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.
- Reduction or elimination of exclusionary periods of coverage under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect continuation coverage, when your continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to an exclusion period of six months (12 months for late enrollees) after your enrollment date in your coverage.

#### 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 medical 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 policy 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 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 PacificSource Health Plans or nationally recognized databases.

**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 contest of a person may act on behalf of the person.

**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 and ending on the next December 31.

**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 for covered services and supplies the member receives. It is the percentage the member is responsible for, not including co-pays and deductible. The co-insurance the member is responsible for is listed in the Dental Benefit Summary for participating and non-participating providers.

**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 fixed up-front dollar amount the member is required to pay for certain covered services. The co-pay applicable to a specific covered service is listed under that specific benefit in the Dental Benefit Summary.

**Covered expense** is an expense for which benefits are payable under by this policy subject to applicable deductible, co-payment, co-insurance, out-of-pocket maximum, 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 in the state of Oregon, 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;
- 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 siblings, nieces, nephews, foster children under age 19 who are unmarried, or not in a qualified domestic partnership, and expected to live in your household for at least a year, if you are the court appointed legal custodian or

guardian. Eligible dependent children may be covered under the policy only if they meet the eligibility requirements of the policy (see Becoming Covered - Eligibility).

**Eligible dental provider** means a physician, 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 works on a regularly scheduled basis, with a normal workweek of 17.5 or more hours. Eligible employee does not include employees who work on a temporary, seasonal or substitute basis. Employees who have been employed for fewer than 30-90 days are not eligible employees unless the employer and PacificSource so agree. Eligible employees may be covered under the group health policy only if they meet the eligibility requirements according to the terms of the policy (see Administrative Provisions - Eligibility).

**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 policy.

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

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

**External appeal** or review means the request by an appellant for an independent review organization to determine whether 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; or
- 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 45 days following the date 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 policy.

**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 a same gender individual, 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 at least 18 years of age;
  - Not related to the policyholder 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 policyholder 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 policyholder and has no other domestic partner;
  - Does not have a legally binding marriage nor has had another domestic partner within the previous six months;
  - Was mentally competent to consent to contract when the domestic partnership began and remains mentally competent.

**Rescind or rescission** means to retroactively cancel or discontinue coverage under a health benefit plan or group or individual health 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.

**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 established by PacificSource for reimbursement of eligible charges for specific services or supplies provided by non-participating providers. PacificSource uses several sources to determine UCR. Depending on the service or supply and the geographical area in which it is provided, UCR may be based on data collected from PacificSource Health Plans or nationally recognized databases.

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	<i>Idaho</i> <b>208.333.1596</b> Local ( <i>Boise</i> ) <b>800.688.5008</b> Toll-free
	<i>Montana</i> <b>406.442.6589</b> Local ( <i>Helena</i> ) <b>877.590.1596</b> Toll-free
	<i>Oregon</i> <b>541.684.5582</b> Local ( <i>Eugene/Springfield</i> ) <b>888.977.9299</b> Toll-free <b>541.225.3631</b> Fax <b>cs@pacificsource.com</b> Email
Headquarters	<b>PO Box 7068</b> <b>Springfield, OR 97475-0068</b> <b>541.686.1242</b> Local ( <i>Eugene/Springfield</i> ) <b>800.624.6052</b> Toll-free
Website	<b>PacificSource.com</b>



# Our Privacy Policy

*This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.*

## Our Commitment to Ensure Your Privacy

The privacy of your medical information is important to us. Although we are required by law to maintain the privacy of your protected health information and provide you with this notice, we are sincere in our pledge to ensure the confidentiality of your nonpublic personal information, including your medical records. This information pertains to you and any covered dependents, so please be sure to share it with any family members covered under your plan.

We protect your health information through a framework of policies and procedures that govern when and how our employees may use, disclose, or otherwise discuss that information. These protections extend to internal oral, written, and electronic protected health information across our organization. Should a breach of your unsecured protected health information occur, we will notify you as required by law.

### How We May Use and Disclose Medical Information About You

We may share a member's personal information for the purpose of claims processing and payment. By signing an application for enrollment, the member acknowledges that personal information can be shared for that express purpose.

We may use and disclose medical information as follows:

#### Treatment

We may share your information with doctors or hospitals to help them provide medical care to you. For example, we might create a treatment plan with your doctor to help improve your health.

#### Payment

We may use and disclose medical information to process your medical claims or coordinate your benefits with other health plans. For example, we may need to disclose medical information to determine your eligibility for benefits, or to examine medical necessity.

#### Healthcare Operations

We may use and disclose medical information for regular health plan operations. For example, we may disclose medical information to underwrite your policies (although we are prohibited from using or disclosing protected health information that is genetic information for such a purpose), ensure proper billing, engage in case coordination or case management, protect you against fraud, and provide you with excellent customer service. Please note that we are prohibited from using or disclosing protected health information that is genetic information about you for underwriting purposes.

#### Business Associates

Business associates provide necessary services to our organization through contracts. Some examples of business associates are prescription drug benefit administrators, utilization management organizations, and entities that perform quality assurance or peer review on our behalf. We may disclose the minimum necessary medical information to our business associates so they can perform the job we have asked them to do. To protect your medical information, we require our business associates to appropriately safeguard your information. We will not share your information with these outside groups unless there is a business need to do so and they agree to keep it protected.

We require our business partners to treat your private information with the same high degree of confidentiality that we do.

#### Plan Administration

We may share enrollment information with your employer to verify your coverage and your family's coverage for benefits. We may share summary data that cannot be individually identified. We do not share any other information with employers unless we have your written authorization.

#### Marketing

We will never sell information about you to any third party for marketing or any other purpose not described in this notice. Further, we do not use personal information for investigative consumer research or reporting.

#### Individuals Involved in Your Care or Payment for Your Care

We may disclose your medical information to a family member, friend, or other person who you indicate is involved in your care or payment for your care. This only pertains to your medical information that is directly relevant to their involvement. We will only make this disclosure if you agree or when required or authorized by law. In the event of your incapacity or in an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest.

#### As Required By Law and For Law Enforcement

We may use or disclose your medical information when required or permitted by federal, state, or local law, or by a court order.

#### Public Health and Safety

We may disclose medical information about you to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others.

#### State and Federal Agencies

We may be required to report information to state and federal agencies that regulate us, such as the United States Department of Health and Human Services.

#### Lawsuits and Disputes

If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved

in the dispute. We will only make such disclosures if efforts have been made to tell you about the request.

### **Military and National Security**

Under certain circumstances, we may disclose to military authorities the medical information of armed forces personnel. To authorized federal officials, we may disclose medical information required for lawful intelligence, counterintelligence, and other national security activities.

### **Workers' Compensation**

We may disclose medical information to coordinate benefits with workers' compensation insurance carriers.

### **Information About Health-Related Benefits**

We, or our Business Associate, may communicate to you about other services or health-related benefits that may be of interest to you.

### **Other Uses and Disclosures**

If we use or disclose your information for any reason other than those listed above, we will first obtain your written authorization. State laws may prohibit us from disclosing the following types of sensitive personal information without your authorization: chemical dependency, mental health, psychotherapy, genetic, or HIV/AIDS records. If you give us written authorization, you may revoke it at any time. This will not affect information that has already been shared. Examples of uses or disclosure that require your authorization include the release of psychotherapy notes, to market unrelated products to you, and if your protected health information is going to be sold. Please note that we do not use or disclose your personal information for marketing of unrelated products, nor do we sell your personal information.

## **Your Rights Regarding Your Medical Information**

You have these rights regarding protected health information we maintain about you:

### **Right to Inspect and Copy**

You have the right to inspect and obtain a copy of most information we maintain about you. To do so, request and complete a form we will provide. You may be charged a fee for the cost of copying your records.

### **Right to Request a Correction**

If you believe that medical information we have about you is incorrect or incomplete, you have the right to ask us to change or amend the information. To do so, request and complete a correction form available from us.

### **Right to an Accounting of Disclosures**

You have the right to request a list of disclosures we have made of your medical information for purposes other than treatment, payment, healthcare operations, and other limited activities. To do so, request and complete a form available from us. Your request may not be for a record of more than six years and may not include dates before April 14, 2003.

### **Right to Request Restrictions**

You have the right to ask us to restrict how we use or disclose your information for treatment, payment, or healthcare operations. You also have the right to ask us to restrict information we may give to those involved in your care, such as a family member or friend. You must make this request using a form we will provide. While we may honor your request for restrictions, we are not required to agree to these restrictions, unless the request relates to a health care item or service that you paid for in full and disclosure is not otherwise required by law. If we agree, we will comply with your request unless the information is needed to provide

you with emergency treatment or comply with a legal requirement.

### **Right to Request Confidential Communications**

You have the right to ask that we communicate with you about health matters in a certain way or at a certain location. We will attempt to accommodate all reasonable requests and may require that you make your request in writing.

### **Right to Receive a Paper Copy of This Notice**

You have the right to ask for a paper copy of this notice at any time, and it will always be available on our website at [PacificSource.com/privacy.aspx](http://PacificSource.com/privacy.aspx).

If you wish to exercise any of these rights, please contact PacificSource. You will find our contact information below

## **How to Report a Problem or File a Complaint**

You may contact any of the people listed below to report a problem or file a complaint. You must do so in writing. Your benefits will not be affected by any complaints you make. We will not take any action against you for filing a complaint, cooperating in an investigation, or refusing to agree to something that you believe is unlawful.

## **Changes to this Notice of Privacy Practices**

This Notice of Privacy Practices takes effect on April 14, 2003, and will remain in effect until we update or replace it. In the future, we may change our Notice of Privacy Practices. Any changes will apply to medical information we already have about you as well as any information we receive in the future. Before we make a significant change to our privacy practices, we will change this notice and supply a copy to you within 60 days.

You may request that this notice be mailed to you at any time, and it will always be available on our website at [PacificSource.com/privacy.aspx](http://PacificSource.com/privacy.aspx).

## **Contact Information**

If you have any questions about this notice or want more information, you're welcome to contact us.

### **PacificSource Health Plans**

Contact: Customer Service Department,  
PacificSource Health Plans

Office Hours: Monday through Friday,  
8:00 A.M. to 5:00 P.M.

Address: PO Box 7068  
Springfield, OR 97475

Telephone: (541) 684-5582 or  
toll-free (888) 977-9299

Fax: 541) 684-5264

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

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

### **Health and Human Services**

Contact: Office for Civil Rights, U.S. DHHS

Address: 2201 Sixth Ave - Mail Stop RX-11  
Seattle, WA 98121

Telephone: (206) 615-2290

TDD: (206) 615-2296

Fax: (206) 615-2297

Email: [ocrcomplaint@hhs.gov](mailto:ocrcomplaint@hhs.gov)



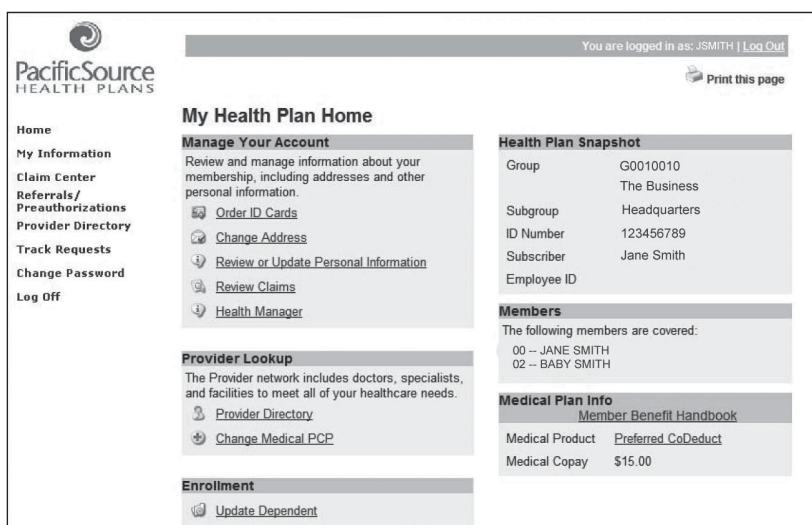
# Convenient Online Access to Your Information

## Access Your Coverage Information Online with InTouch

We know your busy schedule doesn't always coincide with our customer service hours. To help, we offer PacificSource InTouch for Members, a secure Web site available to any individual who is covered under a PacificSource health plan.

Once you've registered, you can review claim and coverage information, check your family enrollment history and more—at your convenience from any computer with Internet access.

*With InTouch for Members, you have secure, online access to your dental coverage information.*



## Online Access to Your Coverage Information

InTouch makes it easy for you to manage your dental coverage information.

### Manage Claims and Expenses

- Look up your dental claims information for the past two years
- See how much expense has accumulated towards your plan's deductible, stop-loss, or out-of-pocket maximum
- See how much expense has accumulated towards your PacificSource dental plan's annual maximum benefit

- Track your share of dental expenses (deductibles, copayments, etc.) by family member and year

### Manage Your Account Information

- Track your family's enrollment history and check the coordination of benefits information we have on file
- Check the status of preauthorizations or referrals
- Notify us when your name or address changes



(541) 684-5582  
toll-free (888) 977-9299

**PacificSource.com**

*Continued on reverse.*

*Registration is quick and easy ...*

## Register for InTouch Today!

### Easy Online Registration

To start using PacificSource InTouch, simply visit our Web site and register:

1. Browse to PacificSource.com
2. Click on For Members
3. Click on InTouch
4. Click on Register Now and follow the instructions.




Once you accept the registration agreement, you will be asked to enter your member ID number, Group ID number, birth date and your e-mail address. Your member number is the member number

shown on the card, plus the two-digit ID number next to your name. These numbers can be found on your PacificSource ID card (see the example below).

After entering all required information, click Submit. In a few seconds, you'll automatically be redirected to the login page where you can create and enter your new user ID and password for instant access to InTouch.

For security reasons, no confirmation e-mail will be sent. Be sure to keep your user ID and password in a secure place. Should you forget your password, simply select the Forgot My Password link on the login page.

### Example of Member ID Card

		Group: Robert and Sons Electrical Wizardry, Inc.	
HEALTH PLANS		Group # <u>G100100</u>	
Plan: <b>Choice PSN (Referral Not Required)</b>			
Subscriber Name: <b>John Smith</b>		Copayment (DUE AT TIME OF SERVICE)	
Member ID: <u>112345000</u>			
Card Issued: 06/01/92			
ID	Member	PCP	Health Dental Vision
00	John	R. Smith MD	✓ ✓ *
01	Susie	W. Bennington DO	✓ ✓
02	David	P. Sheppard MD	✓ ✓
03	Elizabeth	PeaceHealth Group	✓ ✓
04	Nathanial	F. Worthington DO	✓ ✓
05	Lily	P. Sheppard MD	✓ ✓
		RxBin	610415
		RxGroup	V1549079
		RxPCN	73227
		Caremark®	
		OV	\$15
		ER	\$100
*VISION EXAM ONLY			
<b>PRESENT THIS CARD EACH TIME YOU MAKE A HEALTHCARE VISIT.</b>			
<b>BENEFIT QUESTIONS:</b> Contact our Customer Service Department at (541) 684-5582 or (888) 977-9299 or cs@pacificsource.com.			
<b>PREAUTHORIZATION (PROVIDERS ONLY):</b> Contact our Health Services Department at (541) 684-5584 or (888) 691-8209.			
<b>ELECTRONIC CLAIMS:</b> Payer ID# 93029			
When you travel or live outside Oregon, southwest Washington, and western Idaho, you have access to participating providers through The First Health® Network: (800) 449-9905 or visit www.pacificsource.com.			
			
<b>PacificSource Health Plans</b>			
PO Box 7068, Eugene, OR 97401-0068			
<a href="http://www.pacificsource.com">www.pacificsource.com</a>			
			
THIS CARD IS NOT AN AUTHORIZATION FOR SERVICES OR A GUARANTEE OF PAYMENT.			

Your member number is the Member ID number shown on the card, plus the two-digit ID number next to your name. Your Group ID number is listed under the group's name at the top right corner of the card.

## More Information

If you have questions, you're welcome to contact our Customer Service Department at (541) 684-5582, or toll-free at (888) 977-9299, or e-mail us at cs@pacificsource.com.

