PLAN AMENDMENT #3

Client Name:	Deschutes County
Group Number:	G0037173
IRS Tax ID Number:	93-6002292
Plan:	Dental Plan

Effective January 1,2026, the Plan Document is amended as follows, all other language and sections remains the same:

The following bullet point has been added to the Class I Services under the Covered Dental Services section, the remainder of the section remains the same:

CLASS I SERVICES

- **Caries arresting medicament** is limited to one application every six months per tooth.

The following bullet points within the Benefit Exclusions section are amended to read as follows, the remainder of the section remains the same:

This Plan does not cover the following:

- Biopsies or histopathologic exams – A separate charge for a biopsy or oral tissue or histopathologic exam.
- **The bullet point for "Scheduled and/or emergent care outside of the United States" has been removed.**
- **The bullet point for "Services for which no charge is normally made in the absence of insurance" has been removed.**
- Services, supplies, and medications outside of the United States.
- **The bullet point for "Services otherwise available – Include, but not limited to" has been removed.**

The Prior Authorization section has been amended to read as follows:

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

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

Your Provider can submit a prior authorization request on your behalf. If your Provider is unable to do so, you may contact PacificSource directly. In some cases, they may ask for more details or require a second opinion (provided at no cost to you if requested by

PacificSource or the Plan Sponsor) before approving coverage. You and/or your Provider are responsible for ensuring PacificSource has all the information needed to make a Benefit Determination.

- When services are received from an In-network Provider, the Provider is responsible for contacting PacificSource to obtain prior authorization. If your service is denied as not Dentally Necessary and your Provider did not obtain prior authorization, the Provider will be held responsible for the denied expense, and they cannot bill you for these charges.

- When services are received from an Out-of-network Provider, the Provider is **not** responsible for contacting PacificSource to obtain prior authorization. If you choose an Out-of-network Provider for services requiring prior authorization, you are responsible for obtaining the prior authorization before receiving services. If prior authorization is not obtained, you may be responsible for the expense if it is later determined not Dentally Necessary. If the service is deemed Dentally Necessary, out-of-network benefits (which may involve higher out-of-pocket costs) will apply.

Because of the changing nature of care, PacificSource, on behalf of the Plan Sponsor, continually reviews new technologies and standards. Therefore, procedures and services requiring prior authorization are subject to change. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business). The prior authorization search tool is not intended to suggest that all items listed are covered by the benefits in this Plan.

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

If more information or a second opinion is needed (at no cost to you if requested by PacificSource), you or your Provider may be asked to supply additional documentation before coverage is approved. You will receive confirmation (via letter, fax, or electronic transmission) once PacificSource has made its Benefit Determination. If time is critical you may be notified by phone, with written follow up to follow. For more information regarding the timelines for review of Pre-service Review and Post-service Claims, see Benefit and Claim Determinations in the Benefit Determinations and Claims Payment section.

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

PacificSource reserves the right to contract with a third party to perform prior authorization procedures on its behalf and such third parties may impose independently developed, evidence-based criteria for making prior authorization determinations. If you have questions about any third party criteria, please contact the PacificSource Customer Service team.

If your Provider's prior authorization request is denied for reasons such as not Dentally Necessary or as Experimental, Investigational, or Unproven, your Provider may Appeal on your behalf. You also maintain the right to Appeal this Plan's decision independently of your Provider.

The *Timelines for Responding to Appeals* section under Complaints, Grievances, and Appeals has been amended to read as follows:

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

In addition, if your Appeal qualifies for an expedited response, a decision in response to the Appeal will be completed as soon as possible, but not later than 72 hours of receipt of the request.

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.

"Plan Sponsor"
Deschutes County

By: Nick Lelack

Print: Nick Lelack

Title: Deschutes County Administrator

Date: 10-23-2025