



Oregon Health and Science University

Group No.: G0033731

Dental Advantage Plus 0-20-50 50-1500 S3

Effective: 2022-2023



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Welcome to your PacificSource Student plan. Your plan includes a wide range of benefits and services.

Using this Certificate of Coverage (Herein Called Student Guide)

This student guide will help you understand how your plan works and how to use it. Many terms used in this student guide are defined in the Definitions section of this student guide. You can identify such terms by their being capitalized.

If anything is unclear to you, our Customer Service team is available to answer your questions. Please give us a call, email, or visit our website. We look forward to serving you.

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. Unless federal law is found to apply, the validity and interpretation of this plan, and the rights and obligations of the Members, will be governed by the state's laws where your Policyholder's plan is issued.

Additional Information

You may request information regarding premiums, cost sharing, Provider networks, utilization review, Appeals and Grievances, accreditation, benefits, definitions of terms, and confidentiality policies. This information is available from our Customer Service team or on the PacificSource website.

If you are in need of a PacificSource Member ID card you may contact our Customer Service team or visit our website, [PacificSource.com/members/getting-care/id-card](https://www.pacificsource.com/members/getting-care/id-card).

PacificSource Customer Service

Phone 541-225-1934 or 866-373-7053

Email dental@pacificsource.com

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

PacificSource Headquarters

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PacificSource Website

www.pacificsource.com/OHSU

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Benefit Year: 09/22/2022 - 09/21/2023

Who is eligible?

All registered Oregon Health & Science University (OHSU) GRU Students in eligible programs are automatically enrolled in the OHSU-sponsored Student Health Insurance Plan unless they choose to submit an online insurance waiver application of comparable coverage. Eligible Students will be charged the applicable Health Insurance fee.

	Per Member
Monthly	\$25.58

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

In-network dentists contract with PacificSource to furnish dental services and supplies for a set fee. That fee is called the contracted allowable fee. In-network providers agree not to collect more than the contracted allowable fee. When you use an in-network provider, you will pay only the in-network provider amounts below. If you choose not to use an in-network provider, or don't have access to one, reimbursement is based on the allowable fee. If charges exceed the allowable fee, the excess charges are your responsibility.

Deductible Per Benefit Year	In-network	Out-of-network
Individual	\$50	\$100
Benefit Maximum Per Benefit Year		
\$1,500 per person. Applies to all covered services.		
Exclusion Period	Number of Consecutive Months	
Class II Services	None	
Class III Services (Initial placement of dentures, fixed bridges, and implants)	36	
Class III Services (All other benefits)	None	

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

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Class I Services		
Examinations	No deductible, 0%	No deductible, 0%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Bitewing films, full mouth x-rays, cone beam x-rays, and/or panorex	No deductible, 0%	No deductible, 0%
Dental cleaning (prophylaxis and periodontal maintenance)	No deductible, 0%	No deductible, 0%
Fluoride (topical or varnish applications)	No deductible, 0%	No deductible, 0%
Brush biopsies	No deductible, 0%	No deductible, 0%
Class II Services		
Fillings	After deductible, 20%	After deductible, 50%
Simple extractions	After deductible, 20%	After deductible, 50%
Periodontal scaling and root planing	After deductible, 20%	After deductible, 50%
Full mouth debridement	After deductible, 20%	After deductible, 50%
Complicated oral surgery	After deductible, 20%	After deductible, 50%
Pulp capping	After deductible, 20%	After deductible, 50%
Pulpotomy	After deductible, 20%	After deductible, 50%
Root canal therapy	After deductible, 20%	After deductible, 50%
Periodontal surgery	After deductible, 20%	After deductible, 50%
Tooth desensitization	After deductible, 20%	After deductible, 50%
Class III Services		
Crowns	After deductible, 50%	After deductible, 50%
Dentures	After deductible, 50%	After deductible, 50%
Bridges	After deductible, 50%	After deductible, 50%
Replacement of existing prosthetic device	After deductible, 50%	After deductible, 50%
Implants	After deductible, 50%	After deductible, 50%

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

Additional information

What is the deductible?

Your plan's deductible is the amount of money that you pay first, before your plan starts to pay. You'll see that some services are covered by the plan without you needing to meet the deductible.

Note that there is a separate category for in-network and out-of-network when it comes to meeting your deductible. Only in-network expense applies to the in-network deductible and only out-of-network expense applies to the out-of-network deductible. Deductible does not apply to Class I Services.

What is the benefit maximum?

The benefit maximum is the maximum amount payable by this plan for covered services received each benefit year.

What is an exclusion period?

A member must be enrolled under the plan for the period of time stated above before this plan pays benefits. The exclusion period is waived for members who are covered under this plan on the plan's original effective date if the member was continuously covered under a predecessor plan.

Prior authorization

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

Discrimination is against the law

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

UNDERSTANDING HOW YOUR BENEFITS ARE PAID

This section of the student guide contains information to help you understand the benefits of the plan and how certain aspects of your plan work, including Deductibles, Copayments, Coinsurance, and benefit maximums. For more information, see the benefit summaries for plan details.

BENEFIT YEAR

Contract Year

A contract year is a 12 month period beginning on the date the insurance contract is issued or the anniversary of the date the insurance contract was issued. Many benefits and provisions in this plan are calculated on a contract year basis. Each year these provisions renew and may change, and you must satisfy the new or revised amounts for that year.

YOUR DEDUCTIBLE

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

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

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

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

YOUR COPAYMENT

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

YOUR COINSURANCE

After a Member has satisfied the individual Deductible or the family Deductible, if any applies, this plan may include a Coinsurance payment on certain services or supplies each time the Member receives a specified service or supply. Coinsurance is a percentage of the Allowable Fee. Any Coinsurance required will be based on the lesser of the billed charges or the Allowable Fee. The Provider will bill you and collect any Coinsurance payment.

BENEFIT MAXIMUM

The benefit maximum is the total amount that PacificSource will pay for a Member's dental care within the Benefit Year. After a Member has reached the benefit maximum, the Member will be responsible for all subsequent charges for the duration of the Benefit Year.

UNDERSTANDING DENTAL NECESSITY

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

Be careful – just because a treatment is prescribed or recommended by a Provider does not mean it is Dentally Necessary under the terms of this plan. This plan provides coverage only when such care is

necessary to treat an Illness or Injury or the service qualifies as preventive care. All treatment is subject to review for Dental Necessity. Review of treatment may involve prior authorization, concurrent review of the continuation of treatment, post-treatment review, or any combination of these. A second opinion (at no cost to the Member when requested by PacificSource) may be required for a Dental Necessity determination.

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

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

UNDERSTANDING EXPERIMENTAL, INVESTIGATIONAL, OR UNPROVEN SERVICES

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

To ensure you receive the highest quality care at the lowest possible cost, we review new and emerging technologies and medications on a regular basis. Our internal committees make decisions about PacificSource coverage of these methods and medications based on literature reviews, standards of care and coverage, consultations, and review of evidence-based criteria. You and your Provider may request information regarding our criteria for determining these services or treatments.

ELIGIBLE PROVIDERS

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

COVERED SERVICES

This section of the student guide contains information about the benefits provided under the plan. The following list of benefits is exhaustive. You are responsible for all charges for services that are not a Covered Service. Covered Services are organized into different classes, starting with preventive care and advancing into specialized dental treatments.

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

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

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

Subject to all the terms of this plan, the following services and supplies are covered according to the benefit summary.

These dental services are for Members age 19 and older.

CLASS I SERVICES

- **Examinations (routine or other diagnostic exams)** are limited to two examinations per Benefit Year. Separate charges for review of a proposed treatment plan or for diagnostic aids are not covered. Problem focused examinations are limited to two per Benefit Year. Emergency examinations are covered.
- **Complete full mouth series of X-rays, a cone beam X-ray, or panorex** are limited to one complete full mouth series of X-rays, in any 60 month period and further limited to one bitewing set in a six month period. When an accumulative charge for additional periapical X-rays in a one year period matches that of a complete full mouth series of X-rays, no further benefits for periapical X-rays, cone beam X-rays, complete full mouth series of X-rays, or panorex are available for the remainder of the year.
- **Dental cleaning (Prophylaxis and Periodontal Maintenance)** are limited to a combined total of two procedures per Benefit Year. The limitation for dental cleaning applies to any combination of Prophylaxis and/or Periodontal Maintenance in the Benefit Year. A separate charge for periodontal charting is not a Covered Service. Periodontal Maintenance is not covered when performed within three months of Periodontal Scaling and Root Planing and/or Curettage.
- **Fluoride (topical or varnish applications)** are limited to a combined total of four applications per Benefit Year.
- **Brush biopsies** used to aid in the diagnosis of oral cancer are covered.

CLASS II SERVICES

- **Palliative (emergency) treatment of dental pain** is covered.
- **Composite Resin and Amalgam Restoration (fillings)** are limited to the same tooth once every 24 months, up to four surfaces per tooth.
- **Simple extractions of teeth** and other minor oral surgery procedures are covered. A separate charge for Alveolectomy performed in conjunction with removal of teeth is not a Covered Service.
- **Periodontal Scaling and Root Planing and/or Curettage** is 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.
- **Full mouth debridement** is limited to once every 36 months. This procedure is only covered if the teeth have not received a Prophylaxis in the prior 36 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 a dental cleaning (Prophylaxis or Periodontal Maintenance).
- **Complicated oral surgery procedures**, such as the removal of impacted teeth are covered. A separate charge for Alveolectomy performed in conjunction with removal of teeth is not a Covered Service.
- **Pulp capping** is only covered when there is an exposure to the pulp. These are direct pulp caps. Coverage for indirect pulp caps are covered as part of the Restoration fee and are not covered as a separate charge.
- **Pulpotomy** is only covered for primary teeth.
- **Root canal therapy** on the same tooth is only covered for one charge in a 36 month period.
- **Periodontal surgery** is limited to procedures accompanied by a periodontal diagnosis and history of conservative (non-surgical) periodontal treatment.
- **Tooth desensitization** is covered as a separate procedure from other dental treatment.

- **General anesthesia** administered by a Provider in their office when used in conjunction with approved oral surgery procedures is covered.

CLASS III SERVICES

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

BENEFIT EXCLUSIONS

EXCLUDED SERVICES

This plan does not cover the following:

- Aesthetic (cosmetic) dental procedures – Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.
- Alveolectomy when performed in conjunction with tooth extraction – Separate charge not covered.
- Anesthesia when performed in conjunction with a restorative procedure – Separate charge not covered.
- Antimicrobial agents – Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.
- Athletic injuries sustained while competing or practicing for a professional or semiprofessional athletic contest.
- Athletic mouth guards.
- Biopsies or histopathologic exams – A separate charge for a biopsy of oral tissue or histopathologic exam.
- Cast Restorations for partial denture Abutment teeth or for splinting purposes unless the tooth in and of itself requires a Cast Restoration.
- Charges for phone consultations, missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims.

- Collection of cultures and specimens.
- Comprehensive periodontal exams.
- Connector bar or stress breaker.
- Core build-ups unless used to restore a tooth that has been treated endodontically (root canal).
- Cosmetic/reconstructive services and supplies – Procedures, appliances, Restorations, or other services that are primarily for cosmetic purposes (does not apply to emergency services).
- Denture adjustment or relines performed within six months of the initial placement.
- Denture replacement due to loss, theft, or breakage, unless otherwise noted in Covered Services.
- Diagnostic casts (study models) and occlusal appliances.
- Drugs and medications that are prescribed drugs and take-home medicine or supplies distributed by a Provider for any Member. As well as premedication drugs, analgesics, and any other euphoric drugs.
- Educational programs – Instructions and/or training in plaque control and oral hygiene.
- Expense incurred by a Member; not a United States citizen; for services performed within the Student's home country; if the Student's home country has a socialized medicine program.
- Expense incurred for Injury resulting from the play or practice of athletics and intramurals.
- Experimental, Investigational, or Unproven – This plan does not cover services, supplies, protocols, procedures, devices, chemotherapy, drugs or medicines, or the use thereof that are Experimental, Investigational, or Unproven for the diagnosis and treatment of the Member. This limitation also excludes treatment that, when and for the purpose rendered: has not yet received recognized compendia support (for example, UpToDate, Lexicomp, FDA) for other than Experimental, Investigational, or Unproven, or clinical testing; is not of generally accepted medical practice in your plan's state of issuance or as determined by medical advisors, medical associations, and/or technology resources; is not approved for reimbursement by the Centers for Medicare and Medicaid Services; is furnished in connection with medical or other research; or is considered by any governmental agency or subdivision to be Experimental, Investigational, or Unproven, not reasonable and necessary, or any similar finding.

If you or your Provider have any concerns about whether a course of treatment will be covered, we encourage you to contact our Customer Service team. We will arrange for medical review of your case against our criteria, and notify you of whether or not the proposed treatment will be covered.

- Fractures of the maxilla and mandible – Surgery, services, and supplies provided in connection with the treatment of simple or compound fractures of the maxilla or mandible.
- General anesthesia except when administered by a Provider in connection with oral surgery in their office, unless otherwise noted in Covered Services.
- Gingivectomy, gingivoplasty, or crown lengthening in conjunction with crown preparation or fixed bridge services done on the same date of service.
- Gnathological recordings, occlusal equilibration procedures, or similar procedures.
- Hospital charges or additional fees charged by the Provider for hospital treatment.
- Hypnotherapy.
- Indirect pulp caps are to be included in the Restoration process, and are not a separate Covered Service.
- Infection control – A separate charge for infection control or sterilization.

- Intra and extra coronal splinting – Devices and procedures for intra and extra coronal splinting to stabilize mobile teeth.
- Mail order or Internet/web based Provider are not eligible Providers.
- Orthodontic services – Repair or replacement of orthodontic appliances.
- Orthodontic services – Treatment of misalignment of teeth and/or jaws, or any ancillary services performed because of orthodontic treatment, except as specified in the Covered Services section.
- Orthognathic surgery – Services and supplies to augment or reduce the upper or lower jaw, except to repair an Accidental Injury or for removal of a malignancy, including reconstruction of the jaw.
- Periodontal probing, charting, and re-evaluations.
- Photographic images.
- Pin retention in addition to Restoration.
- Precision attachments.
- Pulpotomies on permanent teeth.
- Removal of clinically serviceable Amalgam Restorations to be replaced by other materials free of mercury, except with proof of allergy to mercury.
- Services covered by the Member's medical plan.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth.
- Services or supplies covered under any plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law.
- Services or supplies not listed as a Covered Service, unless required under federal or state law.
- Services or supplies with no charge, or for which the Member is not legally required to pay, or for which a Provider or facility is not licensed to provide even though the service or supply may otherwise be eligible. This exclusion includes any services provided by the Member, or any licensed professional that is directly related to the Member by blood or marriage.
- Services or supplies provided outside of the United States, except in cases of emergency.
- Sinus lift grafts to prepare sinus site for implants.
- Stress-breaking or habit-breaking appliances.
- Temporomandibular joint (TMJ) – Services or supplies for treatment of any disturbance of the temporomandibular joint.
- Third party liability, motor vehicle liability, motor vehicle insurance coverage, workers' compensation – Any services or supplies for Illness or Injury for which a third party is responsible or which are payable by such third party or which are payable pursuant to applicable workers' compensation laws, motor vehicle liability, uninsured motorist, underinsured motorist, and Personal Injury Protection (PIP) insurance and any other liability and voluntary medical payment insurance to the extent of any recovery received from or on behalf of such sources, except in a situation where such exclusion is expressly prohibited by state law.
- Tooth transplantation – Services and supplies provided in connection with tooth transplantation, including re-implantation from one site to another, splinting, and/or stabilization. This exclusion does not relate to the re-implantation of a tooth into its original socket after it has been avulsed.
- Treatment after insurance ends – Services or supplies a Member receives after the Member's coverage under this plan ends. The only exception is for Class III Services ordered and fitted before enrollment ends and are placed within 31 days after enrollment ends.

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

EXCLUSION PERIODS

If the benefit summaries provide for an Exclusion Period, Members will need to complete this period before benefits are covered.

The Exclusion Period is waived for Members who are covered under this plan on the plan's original effective date if the Member was continuously covered under a predecessor plan.

Initial placement of full or partial dentures, fixed bridges (including acid-etch metal bridges), and implants for the replacement of natural teeth have a 36 month Exclusion Period. However, this Exclusion Period is waived if the natural tooth has been lost or extracted while covered under this plan. You may receive credit towards this Exclusion Period if you have had qualifying dental coverage before enrolling in this plan.

Credit for Prior Coverage

Members can receive credit toward the Exclusion Period for having qualifying dental coverage before enrolling in this plan. To qualify for this credit, there may not have been more than a 63 day gap between your last day of coverage under the previous dental coverage and the first day of coverage under this plan.

To demonstrate Creditable Coverage, a Member may provide PacificSource with a Certificate of Creditable Coverage from a prior dental plan. If, after making a reasonable effort, a Member is unable to obtain a Certificate of Creditable Coverage or other documentation, PacificSource will attempt to assist in obtaining the proof of coverage.

UTILIZATION REVIEW

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

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

PRIOR AUTHORIZATION

Coverage of certain services requires a Benefit Determination by PacificSource before the services are performed. This process is called prior authorization.

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

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

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

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

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

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

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

PREDETERMINATION

PacificSource provides a Predetermination service for expensive treatment plans. Prior to receiving treatment, a Member or the Provider may request an estimate of what the plan would pay and what the Member would pay. This estimate is based on the Member's benefits at the time the request is made and is not a guarantee of payment.

INDIVIDUAL/SUPPLEMENTAL BENEFITS

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

USING THE DENTAL NETWORK

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

All Providers are independent contractors. PacificSource cannot be held liable for any claim for damages or injuries you experience while receiving care.

Under this plan, you are free to seek care from any Provider without a referral. You may, however, be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan.

IN-NETWORK PROVIDERS

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

FINDING AN IN-NETWORK PROVIDER

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

- On the PacificSource website, www.pacificsource.com/OHSU, go to Find a Doctor to easily look up In-network Providers. You can also print your own customized directory.
- Contact our Customer Service team. Our team can answer your questions about specific Providers and can mail you a directory free of charge.

OUT-OF-NETWORK PROVIDERS

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

Allowable Fee for Out-of-network Providers

PacificSource's payment to Out-of-network Providers may be derived from several sources, depending on the service or supply and the service area where it is provided. To calculate our payment to Out-of-network Providers, we determine the Allowable Fee, then subtract the Out-of-network Provider benefits.

Balance Billing

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

TERMINATION OF PROVIDER CONTRACTS

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

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

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

CLAIMS PAYMENT

How to File a Claim

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

If you receive care from an Out-of-network Provider, the Provider may submit the claim to PacificSource for you. If not, you are responsible for sending the claim to us for processing. Your claim must include a copy of your Provider's itemized bill, including the Provider name and address, the Provider tax identification number and National Provider Identifier (NPI), procedure codes, and diagnosis codes. It must also include your name, PacificSource Member ID number, group 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 should be turned in to PacificSource within 90 days of the date of service. Failure to submit a claim within 90 days may result in a denial of coverage. If you are unable to submit a claim within 90 days, present the claim with an explanation for consideration for coverage. We will never pay a claim that was submitted more than a year after the date of service.

Proofs of Loss

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

Claims 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.

Neither the benefits of this plan nor a claim for payment of benefits under the plan are assignable in whole or in part to any person or entity.

Claim Handling Procedures

Claim Determination – PacificSource will make a claim determination within the time period noted in the chart below for the specific type of claim, unless additional information is necessary to process the claim. In that event, we will send you notice that the claim was received and explain what additional information is necessary to process the claim. 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. No extension is permitted for Urgent Care Claims.

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

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

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

Payment of Claims

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

Questions About Claims

If you have questions about the status of a claim, you are welcome to contact our Customer Service team or go online to view your claims information via our website. You may also contact our Customer Service team if you believe a claim was denied in error. We will review your claim and your plan benefits to determine if the claim is eligible to be reprocessed accordingly. Then we will either reprocess the claim 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.

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

Legal Procedures

You may not take legal action against PacificSource to enforce any provision of the plan 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.

COORDINATION OF BENEFITS

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

Double Coverage

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

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

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

Primary or Secondary?

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

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

When This Plan is Primary

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

Your Own Expenses

- The claim is for your own healthcare expenses.

Your Spouse's or Domestic Partner's Expenses

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

Your Child's Expenses

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

Other Situations

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

We will always be secondary when you are also covered by a system of socialized medicine or when another insurance plan or insurance program outside the United States provides benefits for the Covered Services.

How We Pay Claims When We Are Primary

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

How We Pay Claims When We Are Secondary

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

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An allowable expense is a healthcare expense covered by one of the plans, including Copayments, Coinsurance, and Deductibles.

- If there is a difference between the amounts the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the Provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the primary plan, whichever is higher.
- We will determine our payment by calculating the amount we would have paid if we had been primary, and apply that calculated amount to any allowable expense that is left unpaid by the primary plan. We may limit our payment by any amount so that, when combined with the amount paid by the primary plan, the total benefits paid do not exceed the total allowable expense for your claim. We will credit any amount we would have paid in the absence of your other dental care coverage toward our own plan Deductibles.
- If the primary plan covers similar kinds of dental care expenses, but allows expenses that we do not cover, we may pay for those expenses.
- We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain prior authorization, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

**Questions about Coordination of Benefits?
Contact the Division of Financial Regulation.**

THIRD PARTY LIABILITY

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

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

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

When we receive a claim that might involve a third party, we may 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 that you claim is, or that is alleged to be, the responsibility of another party, you will hold the right of recovery against the other party in trust for PacificSource.
- PacificSource is entitled to reimbursement for any paid claims out of the recovery from a third party if there is a settlement, judgment, or recovery from any source. This is regardless of whether the other party or insurer admits liability or fault, or otherwise disputes the relatedness of the claims paid by PacificSource to the Injury caused by the third party. PacificSource shall have the first right of reimbursement in advance of all other parties, including the participant, and a priority to any money recovered from third parties (with the exception of claims arising from motor vehicle Accidents).

- 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 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, as allowed by state law.
- If you receive a third party settlement, that money must be used to pay your related expenses incurred both before and after the settlement. If you have ongoing expenses after the settlement, PacificSource may deny your related claims until the full settlement (less reasonable attorney's fees) has been used to pay those expenses (with the exception of claims arising from motor vehicle Accidents).
- You and/or your agent or attorney must agree to keep segregated in its own account any recovery or payment of any kind to you or on your behalf that relates directly or indirectly to an Injury or Illness giving rise to PacificSource's right of reimbursement or subrogation, until that right is satisfied or released.
- If any of these conditions are not met, then PacificSource may recover any such benefits paid or advanced for any Illness or Injury through legal action, as well as reasonable attorney fees incurred by PacificSource.
- Unless Federal Law is found to apply.
- Unless expressly prohibited by state law, PacificSource's right to reimbursement overrides the made whole doctrine and this plan disclaims the application of the made whole doctrine to the fullest extent permitted by law.

Right of Recovery – Time Limit for Reimbursements

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

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

Motor Vehicle and Other Accidents

In accordance with state law, and notwithstanding the information above, you must provide PacificSource notice, by personal service or by registered or certified mail, if you make a claim or bring legal action for damages for injuries against any other person arising from a motor vehicle Accident. If PacificSource elects to seek reimbursement out of any recovery from such a claim or legal action, PacificSource will provide you with written notice to that effect by personal service or by registered or certified mail within 30 days of receipt of notice from you of such claim or legal action. Further, in such situations, PacificSource will take no action to reduce payments or subrogate until you receive full compensation for your injuries and the reimbursement or subrogation is paid only from the total amount of the recovery in excess of the amount that fully compensates you for your injuries.

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

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

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

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

- You are an owner, partner, or principal, are injured in the course of self-employment, and are otherwise exempt from the applicable state or federal workers' compensation insurance program;
- The appropriate state or federal workers' compensation insurance program has determined that coverage is not available for your Injury; or
- You are employed by an Oregon based group, and have timely filed an application for coverage with the State Accident Insurance Fund or other Workers' Compensation carrier, and are waiting for determination of coverage from that entity.

The contractual rules for third party liability, motor vehicle and other Accidents, and on-the-job Illness or Injury are complicated and specific. Please contact our Third Party Claims team if you have questions.

COMPLAINTS, GRIEVANCES, AND APPEALS

QUESTIONS, CONCERNS, OR COMPLAINTS

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

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

GRIEVANCE PROCEDURES

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

PacificSource will attempt to address your Grievance, generally within 30 days of receipt. For more information, see the How to Submit Grievances or Appeals section.

APPEAL PROCEDURES

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

- Denial of eligibility for or termination of enrollment in a dental plan;
- Rescission or cancellation of your plan whether or not the Rescission has an adverse effect on any particular benefit at the time;

- Imposition of a third party liability, network exclusion, annual benefit limit, or other limitation on otherwise Covered Services or items;
- Determination that a dental item or service is Experimental, Investigational, or Unproven, not a Dental Necessity, effective, or appropriate.

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

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

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

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

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

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

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

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

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

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

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

Timelines for Responding to Appeals

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

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

Information Available with Regard to an Adverse Benefit Determination

The final Adverse Benefit Determination will include:

- A reference to the specific internal rule or guideline 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, Investigational, or Unproven treatment, or a similar exclusion.

Upon request and free of charge, PacificSource will provide you with any additional documents, records, or information that is relevant to the Adverse Benefit Determination.

HOW TO SUBMIT GRIEVANCES OR APPEALS

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

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

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

Fax 541-225-3628

Assistance Outside PacificSource

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

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

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

Email: dfr.insurancehelp@oregon.gov

BECOMING COVERED

ELIGIBILITY

Requirements for Enrollment of Student

See the Policyholder for eligibility requirements to determine if you and your Dependents are eligible to enroll in this plan.

The Policyholder will use its established eligibility criteria and initial enrollment period for this plan, which will be provided to PacificSource. The Policyholder will only send PacificSource enrollment information for those Students and Dependents eligible to enroll on this plan.

All registered Oregon Health & Science University (OHSU) GRU Students in eligible programs are automatically enrolled in the OHSU-sponsored Student Health Insurance Plan unless they choose to submit an online insurance waiver application of comparable coverage. Eligible Students will be charged the applicable Health Insurance fee.

Once an eligible Student makes a coverage selection under this Student plan, he or she may not change his or her election unless by qualifying event.

Requirements for Enrollment of Dependents

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

- Your legal Spouse or your Domestic Partner.
- Your, your Spouse's, or your Domestic Partner's Dependent Children between the age of 19 and 26 regardless of the child's place of residence, marital status, or financial dependence on you.
- Your, your Spouse's, or your Domestic Partner's unmarried Dependent Children age 26 or older who are mentally or physically disabled. To qualify as Dependents, they must have been continuously unable to support themselves since turning age 26 because of a mental or physical disability. PacificSource requires documentation of the disability from the child's Provider, and will review the case before determining eligibility for coverage.

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

EFFECTIVE DATE OF COVERAGE

Coverage for each Student who enrolls is effective on the first day of the period in which you are eligible and premium has been paid. See Policyholder for premium payment requirements for you and your Dependents to enroll in this plan.

Monthly coverage that runs between September 22, 2022 and September 21, 2023.

ENROLLING AFTER THE INITIAL ENROLLMENT PERIOD

Enrolling New Dependents

To enroll new Dependents that become eligible for coverage after your effective date, complete and submit an enrollment change as instructed by your school. Requests for enrollment of a new Dependent due to a qualifying event must be received as instructed by your school within 31 days of the qualifying event. PacificSource may ask for legal documentation to confirm the status of the Dependent.

If additional premium is required, it is charged from the date of the qualifying event. Premium for the first 31 days of coverage and any additional premium is due 31 days from the date billing for the required premium is received by you.

Qualifying Events

Coverage for newly eligible Dependents due to the following events will begin on the date of the event.

- Marriage or domestic partnership.
- Qualified medical child support order (QMCSO).

This plan complies with a 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 benefit coverage for the child of a Member.

Special Enrollment Periods

You and/or your Dependents may decline coverage during your initial enrollment period. To do so, you must submit a waiver of coverage provided by your school before your school's required deadline. You and/or your Dependents may enroll in this plan later if you qualify under the Special Enrollment Rules below. To do so, you must submit an enrollment change within 31 days of the qualifying event. For more information, see the Enrolling New Dependents section.

- Special Enrollment Rule #1

If you declined enrollment for yourself or your Dependents because of other insurance coverage, you or your Dependents may enroll in the plan later if the other coverage ends involuntarily. The Student may also enroll any eligible Dependents at this time, regardless of whether the Dependents have other coverage or not. Coverage will begin on the day after the other coverage ends.

- Special Enrollment Rule #2

If you acquire new Dependents due to a qualifying event, you may be able to enroll your newly eligible Dependents at that time.

Medical Leave of Absence

Students with a College/University approved medical leave can have up to one term extension of benefits per academic career. For example, if the Student leaves mid-Fall, coverage can be extended through the Winter term only.

GENERAL PLAN PROVISIONS

Time Limit on Certain Defenses

After two years from the date of issue of this plan, no misstatements, except fraudulent misstatements, made by the Member during enrollment for such plan shall be used to void this plan or to deny a claim for loss incurred or disability, commencing after the expiration of such two year period.

No claim for loss incurred or disability, commencing after two years from the date of issue of this plan, shall be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of coverage of this plan.

Representations Not Warranties

In the absence of fraud, all statements made by the Policyholder or Member will be considered representations and not warranties. No statement made for the purpose of effecting insurance will void the insurance or reduce benefits unless it is contained in a written document signed by the Policyholder or the Member, a copy of which has been furnished to that person.

Rescissions

PacificSource may Rescind a Member's coverage if the Member, or the person seeking coverage on their behalf, performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of a material fact. The Member will be given 30 days prior written notice of any Rescission of coverage, and offered an opportunity to Appeal that decision.

TERM AND TERMINATION – COVERAGE

- **Students.** Insurance for a Student will end on the first of the following events:
 - the date this plan terminates;
 - the last day for which any required premium has been paid;
 - the date on which the Student withdraws from the school because of entering the armed forces of any country. Premiums will be refunded, on a pro-rata basis, when application is made within 30 days from withdrawal; or
 - the date the Student is no longer in an eligible Student classification.

If withdrawal from school is for reasons other than entering the armed forces, no premium refund will be made. Students will be covered for the term for which they are enrolled and for which premium has been paid.

- **Dependents.** Insurance for a Student's Dependent will end when insurance for the Student ends. Coverage will end prior to that time in the event of one of the following:
 - the date the Student fails to pay any required premium;
 - the date Dependents are no longer eligible under this plan;
 - for a Dependent Child, on the last day of the month of the child's 26th birthday;
 - for a Spouse, the date the marriage ends in divorce or annulment; or
 - for a Domestic Partner, the date of termination of the domestic partnership (the Student must provide written notice of such termination to PacificSource).

Mid-semester terminations due to a qualifying event (for example, access to other group coverage) is allowed. Premiums will be refunded, on a pro-rata basis, when application is made within 30 days from the qualifying event.

Any Student who requests to terminate coverage prior to the end of the Benefit Year shown on the Medical Benefit Summary may be terminated on the last day of the month prior to PacificSource receiving the request for termination and will not be eligible for a refund of premium.

Termination will not prejudice any claim for a charge that is incurred prior to the date coverage ends.

RESOURCES FOR INFORMATION AND ASSISTANCE

Assistance

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

Information Available from PacificSource

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

- A directory of Providers under your plan;
- Information about our Drug List (also known as a formulary);
- A copy of our annual report on Complaints and Appeals;
- A summary of Adverse Benefit Determinations and Grievance processes;

- Information about our policy for protecting the confidentiality of your information;
- Information about the cost of premiums and Member cost sharing requirements;
- An annual statement of all benefit payments made by PacificSource for a Member's coverage, including payments that have been counted against any applicable benefit limitations;
- A description (consistent with risk-sharing information required by the Centers for Medicare and Medicaid Services) of any risk-sharing arrangements we have with Providers;
- A description of our efforts to monitor and improve the quality of dental services, including accreditation status with a national managed care accreditation organization and Health Effectiveness Data and Information Set (HEDIS) data results;
- Information about how we check the credentials of our network Providers and how you can obtain the names and qualifications of your Providers;
- Information about our prior authorization, Predetermination, and utilization review procedures; and
- Information about any plan offered by PacificSource.

Information Available from the Division of Financial Regulation about PacificSource

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

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

You can request this information by contacting:

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

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

Email: dfri.insurancehelp@oregon.gov

Website dfri.oregon.gov

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, www.pacificsource.com/OHSU. You may also write to us at:

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

RIGHTS AND RESPONSIBILITIES

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

Your Rights as a Member

- You have a right to receive information about PacificSource, our services, our Providers, and your rights and responsibilities.
- You have a right to expect clear explanations of your plan benefits and exclusions.
- You have a right to be treated with respect and dignity.
- You have a right to impartial access to dental care without regard to race, religion, gender, national origin, or disability.
- You have a right to honest discussion of appropriate or Dentally Necessary treatment options. You are entitled to discuss those options regardless of how much the treatment costs or if it is covered by this plan.
- You have a right to the confidential protection of your 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 Provider in decision-making regarding your care.
- You have a right to know why any tests, procedures, or treatments are performed and any risks involved.
- You have a right to refuse treatment and be informed of any possible medical or dental consequences.
- You have a right to refuse to sign any consent form you do not fully understand, or cross out any part you do not want applied to your care.
- You have a right to change your mind about treatment you previously agreed to.
- 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 student guide and all other communications from PacificSource, and for understanding your plan's benefits. You are responsible for contacting our Customer Service team if anything is unclear to you.
- You are responsible for making sure your Out-of-network Provider obtains prior authorization 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 Provider complete information to help accurately diagnose and treat you.
- You are responsible for telling your Providers you are covered by PacificSource and showing your PacificSource Member ID card when you receive care.
- You are responsible for being on time for appointments, and calling your Provider ahead of time if you need to cancel.
- You are responsible for any fees the Provider charges for late cancellations or no shows.
- You are responsible for contacting PacificSource if you believe you are not receiving adequate care.

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

PRIVACY AND CONFIDENTIALITY

PacificSource has strict policies in place to protect the confidentiality of your personal information, including dental records. Detailed information is available at PacificSource.com/privacy.

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 Authorized 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. To request receipt of confidential communications in a different manner or at a different address, you will need to complete and return the form provided at PacificSource.com/resources/documents-and-forms.

PLAN ADMINISTRATION

Insurance Contract

This plan is fully insured. Benefits are provided under a blanket group policy between the Policyholder and PacificSource Health Plans. Under the blanket group policy, PacificSource – not the Policyholder – is responsible for paying claims. However, the Policyholder and PacificSource share responsibility for administering the plan's eligibility and enrollment requirements. The Policyholder has given PacificSource authority to determine eligibility for benefits under the plan and to interpret the terms of the plan.

Our address is:

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

DEFINITIONS

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

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

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

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

- Denial of eligibility for or termination of enrollment in a dental plan;
- Rescission or cancellation of a plan or coverage;
- Imposition of a third party liability, network exclusion, annual benefit limit, or other limitation on otherwise Covered Services or items;

- Determination that a dental item or service is Experimental, Investigational, or Unproven, not a Dental Necessity, effective, or appropriate; or
- Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care.

Allowable Fee is the maximum amount PacificSource will reimburse Providers. In-network Providers are paid the contracted Allowable Fee and Out-of-network Providers are paid the out-of-network Allowable Fee.

- **Contracted Allowable Fee** is an amount PacificSource agrees to pay an In-network Provider for a given service or supply through direct or indirect contract.
- **Out-of-network Allowable Fee** is the dollar amount established by PacificSource for reimbursement of charges for specific services or supplies provided by Out-of-network Providers. PacificSource uses several sources to determine the out-of-network Allowable Fee. Depending on the service or supply and the service area in which it is provided, the out-of-network Allowable Fee may be based on data collected from the Centers for Medicare and Medicaid Services (CMS), contracted vendors, other nationally recognized databases, or PacificSource, as documented in PacificSource's payment policy.

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

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

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

Appeal means a written or verbal request from a Member or, if authorized by the Member, the Member's Authorized Representative, to change a previous decision made under this plan concerning:

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

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

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

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

- Eligibility and coverage determinations (including coordination of benefits), and adjudication or subrogation of claims;
- Review of dental services with respect to Dental Necessity (including underlying criteria), coverage under the plan, appropriateness of care, Experimental, Investigational, or Unproven treatment, justification of charges; and

- Utilization review activities, including precertification and prior authorization of services and concurrent and post-service review of services.

Benefit Year refers to the period of time during which benefits accumulate toward plan maximums and is on a contract year basis, beginning on the plan's date of issuance or date of renewal through the last day of that contract year.

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

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

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

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

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

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

Covered Service means a service or supply for which benefits are payable under this plan subject to applicable Deductibles, Copayments, Coinsurance, out-of-pocket limit, or other specific limitations.

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

- There was no more than a 63 day break between the last day of coverage under the previous plan and the first day of coverage under this plan.
- The 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 dental 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 expense for a Covered Service that must be paid by the Member before the benefits of this plan are applied. A plan may include more than one Deductible.

Dentally Necessary or Dental Necessity means those services and supplies that are required for diagnosis or treatment of Illness or Injury and that are:

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

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

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

Dependent Children means the following:

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

Domestic Partner means an individual that meets the following definition:

- **Registered Domestic Partner** means an individual, age 18 or older, who is joined in a domestic partnership, and whose domestic partnership is legally registered in any state.
- **Unregistered Domestic Partner** means an individual of same or opposite gender who is joined in a domestic partnership with the Student and meets the following criteria:
 - Is age 18 or older;
 - Not related to the Student 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 Student 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 Student and has no other Domestic Partner;
 - Does not have a legally binding marriage nor has had another Domestic Partner within the previous six months; and
 - Was mentally competent to consent to contract when the domestic partnership began and remains mentally competent.

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

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

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

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

- Experimental, Investigational, or Unproven services and supplies include, but not limited to, services, supplies, procedures, devices, chemotherapy, drugs or medicines, or the use thereof, which at the time they are rendered and for the purpose and in the manner they are being used:

- Have not yet received full U.S. government agency required approval (for example, FDA) for other than Experimental, Investigational, or Unproven, or clinical testing;
- Are not of generally accepted dental practice in your plan's state of issue or as determined by dental advisors, dental associations, and/or technology resources;
- Are not approved for reimbursement by the Centers for Medicare and Medicaid Services;
- Are furnished in connection with dental or other research; or
- Are considered by any governmental agency or subdivision to be Experimental, Investigational, or Unproven, not considered reasonable and necessary, or any similar finding.
- When making decisions about whether treatments are Experimental, Investigational, or Unproven, PacificSource relies on the above resources as well as:
 - Expert opinions of specialists and other dental authorities;
 - Published articles in peer-reviewed dental literature;
 - External agencies whose role is the evaluation of new technologies and drugs; and
 - External Review by an independent review organization.
- The following will be considered in making the determination whether the service is in an Experimental, Investigational, or Unproven status:
 - Whether there is sufficient evidence to permit conclusions concerning the effect of the services on health outcomes;
 - Whether the scientific evidence demonstrates that the services improve health outcomes as much or more than established alternatives;
 - Whether the scientific evidence demonstrates that the services' beneficial effects outweigh any harmful effects; and
 - Whether any improved health outcomes from the services are attainable outside an investigational setting.

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

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

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

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

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

Inquiry means a written request for information or clarification about any subject matter related to the Member's plan.

Internal Appeal means a review by PacificSource of an Adverse Benefit Determination.

Lifetime Maximum means the maximum benefit that will be provided toward the expenses incurred by any one Member during the Member's lifetime.

Member means a person covered by this plan.

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

Periodontal Maintenance is a periodontal procedure for 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.

Policyholder is the plan administrator that offers this plan to its eligible Students and Student Dependents.

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

Pre-service Claim means a request for benefits that requires approval by PacificSource in advance (prior authorization) in order for a benefit to be paid.

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

Prophylaxis is a cleaning and polishing of all teeth.

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

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

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

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

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

Student means an individual that meets College/University eligibility guidelines.

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

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



Contact us.

Phone: 888-977-9299

TTY: 711

En Español: 541-684-5456

Email: CS@PacificSource.com

Web: PacificSource.com

Your privacy is important to us.

To learn more about how we protect our members' personal information, check out our privacy policy at PacificSource.com/privacy.

Discrimination is Against the Law

PacificSource Health Plans ("PacificSource") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PacificSource does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PacificSource:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Customer Service at (888) 977-9299.

If you believe that PacificSource has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 7068, Springfield, OR 97475-0068, (888) 779-9299, TTY: 711, Fax (541) 684-5264, or email CRC@pacificsource.com. Please indicate you wish to file a civil rights grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Customer Service Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Amharic	ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የPacificSource Health Plans ሽፋን አስፈላጊ መረጃ አለው። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖችን ፈልጉ። የጤናን ሽፋንዎን ለመጠበቅና በአካፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት። (888) 977-9299 ይደውሉ።
Arabic	يحتوي هذا الإشعار معلومات هامة. يحتوي هذا الإشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال PacificSource Health Plans. ابحث عن التواريخ الهامة في هذا الإشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصول على المعلومات والمساعدة بلغتك (888) 9299-977 من دون أي تكلفة. اتصل بـ

Bantu-Kirundi	Iyi notice ifise akamaro k'ingenzi. Iyi notice ifise akamaro kingene utegerezwa gusaba canke ivyerekeye PacificSource Health Plans, ucuraba ko ibikenewe kuriyi notice, ushobora gufata umwanzuro ukungene wokurikirana ubuzima bwawe uburihiye. Kandi ukongera kugira uburenganzira bwo kwigenga kuronka amakuru n'ubufasha mu rurimi gwawe atacyo utanze. Hamagara (888) 977-9299.
Cambodian-Mon-Khmer	បសចកតិដូនែនឈីងបនេះ ម្ចាស់ព័ត៌មានយ៉ាងសំខាន់ ។ បសចកតិដូនែនឈីងបនេះ ម្ចាស់ព័ត៌មានយ៉ាងសំខាន់ អំពីប្លង់សុខភាព ឬ ការរ៉ាំរ៉ៃ របស់អ្នកតាមរយៈ PacificSource Health Plans។ សូមដឹងឯកភាពរបស់អ្នកចាំបាច់ ចៀកនុងបសចកតិដូនែនឈីងបនេះ ។ អ្នកប្រុងប្រយ័ត្នការបច្ចេកទេសកម្មភាព ដែលកំណត់ថ្លៃជាក់លាក់នានា បើបើបីនឹងការកាត់ការរ៉ាំរ៉ៃ សុខភាពរបស់អ្នក ឬប្រាក់ជំនួយបច្ចេកទេស ។ អ្នកម្ចាស់ព័ត៌មានយ៉ាងសំខាន់បនេះ នឹងជួយចៀកនុងភាសារបស់អ្នកដោយមិនអ្វីលុយបើយ ។ សូមទូរស័ព្ទ (888) 977-9299។
Chinese	本通知含有重要的訊息。本通知對於您透過 PacificSource Health Plans 所提出的申請或保險有重要的訊息。請在本通知中查看重要的日期。您可能要在特定的截止日期之前採取行動，以保留您的健康保險或有助於省錢。您有權利免費以您的母語得到幫助和訊息 請致電 (888) 977-9299。
Cushite-Oromo	Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa PacificSource Health Plans tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa (888) 977-9299 tii bilbilaa.
French	Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de PacificSource Health Plans. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez (888) 977-9299.
German	Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch PacificSource Health Plans. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter (888) 977-9299.
Italian	Questo avviso contiene informazioni importanti sulla tua domanda o copertura attraverso PacificSource Health Plans. Cerca le date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama (888) 977-9299.
Japanese	この通知には重要な情報が含まれています。この通知には、PacificSource Health Plans の申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。(888) 977-9299までお電話ください。

Korean	<p>본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 PacificSource Health Plans 을 통한 커버리지 에 관한 정보를 포함하고 있습니다.</p> <p>본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 리가 있습니다. (888) 977-9299 로 전화하십시오.</p>
Laotian	<p>ການແຈ້ງການນີ້ ມີຂໍ້ ມູ ນສຳຄັນ. ການແຈ້ງການນີ້ ມີຂໍ້ ມູ ນສຳຄັນ ນັກ ງົວກັ ບໍ່ຄາຮ້ ອງສະໜັ ກຫ ັ້ ການຄ້ ມ ອອງຂອງທ່ ານໂດຍຜ່ ານ PacificSource Health Plans. ຕື່ ບງໍ ສາລັ ບກໍ ານີ ດວັ ນທ ັ ສາຄັ ນໃນແຈ້ງການນີ້ . ທ່ ານອາດຈາຕັ ນຕັ ອງໃຊ້ ເວລາດ່ ານນການໂດຍກໍ ານີ ດເວລາທ່ ານນອນ ຈະ ຮັ ກສາການຄ້ ມອອງສະພາບຂອງທ່ ານຫ ັ້ ການຊໍ ອຍເຫ ັ້ ອ່ ທມຄໍ າໃຊ້ ຈໍ າຍ. ທ່ ານມີສດທະໄດ້ ຮັ ບໍ່ຂໍ້ ມູ ນ ນ ຂໍ າວສານນີ້ ແລະການຊໍ ອຍເຫ ັ້ ອໃນພາສາຂອງທ່ ານທ່ ບມຄໍ າໃຊ້ ຈໍ າຍ. ໂທ (888) 977-9299.</p>
Nepali	<p>यो स चनामाा महत्त्वप र्ु जानकारी छ । यो स चनामाा तपाईंको ओ आवेिन वा PacificSource Health Plans का माध्यमबाट प्राप्त हुने सद्ु विबारे महत्त्वपर्ु जानकारी छ । यो सचू नामा भएका महत्त्वपर्ु दमदतहरू ख्याल िनुहु ोस् । तपाईंले पाइरहके ो स्वास््य दबमा पाइरहन वा तपाईंको खचुको भक्तानीमा सहायता पाउन के ही समयकारवाही िन -सीमामा काम-ुपनु हनसक्छु । तपाईंले यो जानकारी र सहायता आफ्नो मातभृ ाषामा दन शल्ु क पाउनु तपाईंको ओ अधिकार: हो (888) 977-9299 मा फोन िनुहु ोस् ।</p>
Norweigen	<p>Denne kunngjøringen har viktig informasjon. Kunngjøringen inneholder viktig informasjon om programmet eller dekning gjennom PacificSource Health Plans. Se etter viktige datoer i denne kunngjøringen. Du må kanskje ta affære ved visse frister for å beholde helse-dekning eller økonomisk bistand. Du har rett til å få denne informasjonen og hjelp i ditt spark uten kostnad. Ring (888) 977-9299.</p>
Pennsylvania Dutch	<p>Die Bekanntmachung gebt wichdichi Auskunft. Die Bekanntmachung gebt wichdichi Auskunft baut dei Application oder Coverage mit PacificSource Health Plans. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmdede Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix. Kannscht du (888) 977-9299 uffrufe</p>
Persian	<p>این اعلامیه حامی اطلاعات مهم میباشد. این اعلامیه حامی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما مربوط به PacificSource Health Plans به تاریخ های مهم در این اعلامیه توجه نمایید. شما ممکن است تا به تاریخ های مشخصی برای حفظ پوشش مزایای یا برای کمک به مخارج مزایای ملزوم به انجام کارهایی شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید (888) 977-9299 باشید</p>
Punjabi	<p>ਇਸ ਨੇ ਜਿਸ ਜਵਾਬ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੇ ਜਿਸ ਜਵਾਬ PacificSource Health Plans ਵਲੋਂ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਿਾਰੇ ਮਹਿੰ ਤਵਧ ਰਨ ਜਾਣਕਾਰੀ ਹੈ . ਇਸ ਨੇ ਜਿਸ ਜਵਾਬ ਖਾਸ ਤਾਰੀਖਾਂ ਲਈ ਵੇਖੋ. ਜੇਕਰ ਤੁਸੀਂ ਜਸਹਤਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱ ਚ ਮਦਦ ਦੇ ਇਛਿੱ ਕ ਹੋ ਤਾਂ ਤੁਹਾਨ ੂੰ ਮੁੰ ਤਮ ਤਾਜਰਖ ਤੋਂ ਪਜਹਲਾਂ ਕੁਿੱ ਝ ਖਾਸ ਕਦਮ ਚੁਿੱ ਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ. ਤੁਹਾਨ ੂੰ ਮੁਫਤ ਜਵਾਬ 'ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਜਵਿੱ ਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪਰਾਪਤ ਕਰਨ ਦਾ ਅਜਿਕਾਰ ਹੈ. ਕਾਲ (888) 977-9299</p>
Romanian	<p>Prezenta notificare conține informații importante. Această notificare conține informații importante privind cererea sau acoperirea asigurării dumneavoastră de sănătate prin PacificSource Health Plans. Căutați datele cheie din această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la (888) 977-9299.</p>

Russian	Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через PacificSource Health Plans. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону (888) 977-9299.
Serbo-Croatian	U ovom obavještenju su sadržane važne informacije. U ovom obavještenju su sadržane važne informacije o Vašoj prijavi ili osiguranju preko PacificSource Health Plans. Pogledajte nalaze li se u ovom obavještenju neki ključni datumi. Možda ćete morati poduzeti određene radnje u datom roku kako biste i dalje zadržali svoje osiguranje ili pomoć pri plaćanju. Imate pravo da ove informacije, kao i pomoć, dobijete besplatno na svom jeziku. Nazovite (888) 977-9299.
Spanish	Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de PacificSource Health Plans. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al (888) 977-9299.
Tagalog	Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng PacificSource Health Plans. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa (888) 977-9299.
Thai	ประกาศนี้มีข้อมูลสำคัญประกาศนี้มีข้อมูลที่สำคัญเกี่ยวกับการสมัครหรือขอเขตประกันสุขภาพของคุณผ่าน PacificSource Health Plans ดูกำหนดการในประกาศนี้คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่ายคุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่ายโทร (888) 977-9299.
Ukrainian	Це повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про Ваше звернення щодо страхувального покриття через PacificSource Health Plans. Зверніть увагу на ключові дати, вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону (888) 977-9299.
Vietnamese	Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin nộp hoặc hợp đồng bảo hiểm qua chương trình PacificSource Health Plans. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình hoàn toàn miễn phí. Xin gọi số (888) 977-9299.