Oregon State University SHIP

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PacificSource HEALTH PLANS

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

Using this Student Guide

This Student guide will help you understand how your plan works and how to use it.

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

Governing Law

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

PacificSource Customer Service Team
Phone (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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Website
pacificsource.com/osu

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Contract Year: 09/11/2021 - 09/10/2022

Who is eligible?

International Students registered for a minimum of one on-campus credit at Oregon State University are required to enroll in the OSU Student Health Insurance Plan. All eligible Students are automatically enrolled and charged for the OSU Student Health Insurance Plan. Eligible dependents of those enrolled in the plan may participate on a voluntary basis.

	Cost per Person
International – Fall	$47.00
International – Winter	$47.00
International – Spring/Summer	$47.00
International – Summer	$35.00
INTO OSU – Fall	$47.00
INTO OSU – Winter	$47.00
INTO OSU – Spring/Summer	$47.00
INTO OSU – Summer	$35.00

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).

Deductible Per Contract Year	All Providers
Individual/Family	$150/$450
Benefit Maximum Per Contract Year	
$1,000 per person. Applies to all covered services.	

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

Service/Supply	All Providers Member Pays
Class I Services	
Examinations	No deductible, 0%
Bitewing films, full mouth x-rays, cone beam x-rays, and/or panorex	No deductible, 0%
Dental cleaning (prophylaxis and periodontal maintenance)	No deductible, 0%

Service/Supply	All Providers Member Pays
Fluoride (topical or varnish applications)	No deductible, 0%
Brush biopsies	No deductible, 0%
Class II Services	
Fillings	After deductible, 30%
Simple extractions	After deductible, 30%
Periodontal scaling and root planing	After deductible, 30%
Full mouth debridement	After deductible, 30%
Complicated oral surgery	After deductible, 30%
Pulp capping	After deductible, 30%
Pulpotomy	After deductible, 30%
Root canal therapy	After deductible, 30%
Periodontal surgery	After deductible, 30%
Tooth desensitization	After deductible, 30%
Class III Services	
Crowns	After deductible, 50%
Dentures	After deductible, 50%
Bridges	After deductible, 50%
Replacement of existing prosthetic device	After deductible, 50%
Implants	After deductible, 50%
Miscellaneous	
Emergency office visit	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. The individual deductible applies if you enroll without dependents. If you and one or more dependents enroll, the individual deductible applies for each member only until the family deductible has been met.

Deductible does not apply to Class I Services.

What is the benefit maximum?

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

Predetermination

Coverage of certain dental services and surgical procedures are by review. When a planned dental service exceeds $300, PacificSource recommends a predetermination to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Predeterminations are not a guarantee of payment and do not change your out-of-pocket expense.

BECOMING COVERED

ELIGIBILITY

Requirements for Enrollment

See the Policyholder for eligibility requirements to determine if you and your family members are eligible to enroll in this plan. No family or household members other than those determined eligible by the Policyholder can enroll under 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 family members eligible to enroll on this plan.

International Students registered for a minimum of one on-campus credit at Oregon State University are required to enroll in the OSU Student Health Insurance Plan. All eligible Students are automatically enrolled and charged for the OSU Student Health Insurance Plan. Eligible dependents of those enrolled in the plan may participate on a voluntary basis.

Family Members

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

- Your legal Spouse or your Domestic Partner.
- Your, your Spouse's, or your Domestic Partner's 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 over who are mentally or physically disabled. To qualify as dependents, they must have been continuously unable to support themselves since turning age 26 because of a mental or physical disability. PacificSource requires documentation of the disability from the child's 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.

ENROLLING NEW FAMILY MEMBERS

To enroll new family members 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 family member due to a qualifying event must be received, as instructed by your school within 31 days of the qualifying event.

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. PacificSource may ask for legal documentation to confirm the status of the dependent.

Qualifying Events

Coverage for newly eligible family members 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 health benefit coverage for the child of a member.

ENROLLING AFTER THE INITIAL ENROLLMENT PERIOD

Special Enrollment Periods

You and/or your family members may decline coverage during your initial enrollment period. To do so, you must submit a completed qualifying waiver provided by your school before your school's required deadline. You and/or your family members may enroll in this plan later if you qualify under the Special Enrollment Rules below.

- Special Enrollment Rule #1

  If you declined enrollment for yourself or your family members because of other dental insurance coverage, you or your family members may enroll in the plan later if the other coverage ends 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 family members due to a qualifying event, you may be able to enroll your newly eligible family members at that time. For more information, see the Enrolling New Family Members section.

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.

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 family members to enroll in this plan.

International and INTO OSU Students- Fall term coverage runs from September 11, 2021 through December 18, 2021. Waiver or Enrollment deadline is October 15, 2021.

International and INTO OSU Students- Winter term coverage runs from December 19, 2021 through March 19, 2022. Waiver or Enrollment deadline is January 14, 2022.

International and INTO OSU Students- Spring/Summer term coverage runs from March 20, 2022 through September 10, 2022. Waiver or enrollment deadline is April 15, 2022.

International and INTO OSU Students- Summer only coverage runs from June 12, 2022 through September 10, 2022. Waiver or enrollment deadline is July 8, 2022.

GENERAL PLAN PROVISIONS

This plan is renewable at the option of the Policyholder. In the event this plan is terminated, coverage will end at 11:59:59 p.m. local time on the date of termination.

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.

Members have the sole right to choose their Providers. PacificSource is not liable for quality of dental care. PacificSource is not responsible for the quality of care a person receives since all those who provide care do so as independent contractors. PacificSource cannot be held liable for any claim for damages or injuries you experience while receiving dental services or supplies.

Recovery of Overpayment. If a benefit payment is made by PacificSource, to or on behalf of a member, which exceeds the benefit amount such member is entitled to receive in accordance with the terms of this plan, PacificSource has the right to require the return of the overpayment on request and to reduce, by the amount of the overpayment, any future benefit payment made to or on behalf of the member that is covered under this plan. Such right does not affect any other right of recovery that PacificSource may have with respect to such overpayment.

Disclosure of Protected Health Information (PHI). PacificSource may, at the request of the Policyholder, disclose PHI or electronic PHI (ePHI) relating to the members on this plan to the Policyholder to allow the Policyholder to perform Plan Administration functions as that term is defined by Health Insurance Portability and Accountability Act (HIPAA).

Only employees or agents of the Policyholder who may receive or have access to PHI are those who require the information in order to resolve claims, referral, or other benefit issues on behalf of the members; or those who require it to resolve enrollment and payment issues on behalf of this plan; and only those for whom such work is part of their job description. The Policyholder shall have a process in place prior to the receipt of any PHI for the sole purpose of investigating and resolving any suspected incidents where PHI has been improperly accessed, used, or disclosed by the Policyholder's employee or agent.

The Policyholder certifies and agrees to the following:

- The Policyholder has sufficient administrative, physical and technical safeguards in place to protect the privacy of the PHI from any unauthorized use or disclosure in compliance with all applicable state and federal laws;
- No PHI shall be used or disclosed other than as permitted or required by this plan or as required by law;
- Ensure that any agent agrees to the same restrictions and conditions that apply to the Policyholder with respect to such PHI;
- No PHI shall be used in employment-related actions or in connection with any other benefit or employee benefit plan of the Policyholder;
- The Policyholder has a written policy for investigating and appropriately reporting any security incidents that relate to PHI to PacificSource;
- The Policyholder shall make available PHI in accordance with HIPAA;
- The Policyholder shall make available PHI for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- The Policyholder shall make available the information required to provide an accounting of disclosure in accordance with HIPAA;
- The Policyholder shall make its internal practices, books, and records relating to the use and disclosure of PHI received from this plan available to the Secretary for purposes of determining compliance by this plan with the provisions of HIPAA;

- That, if feasible, Policyholder shall return or destroy all PHI received from this plan that the Policyholder still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- The Policyholder shall ensure that the adequate separation between employees who need access to PHI to perform their assigned job functions and those who do not is established and enforced.

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;
  - the date an international Student withdraws from the school or the day they receive an approved medical withdrawal from the school;
  - mid semester termination due to a qualifying event (for example, access to other group coverage) is not allowed and no refund will be given; 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 family member 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 family members 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).

Any Student who requests to terminate coverage prior to the end of the Contract Year shown on the Dental Schedule of Benefits 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.

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, and Coinsurance. 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.

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. For your Contract Year, please see the Medical Schedule of Benefits.

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 Contract 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 Out-of-network Allowable Fee for services of Out-of-network Providers;
- Charges for non-Covered Services; and
- Charges for any Coinsurance or Copayments.

Covered Services 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.

Please note that Out-of-network Providers can bill you for amounts that exceed the Out-of-network Allowable Fee, in addition to the Coinsurance amount.

Eligible Providers

This plan provides benefits only for Covered Services and supplies rendered by a Provider and when determined to be necessary by the generally accepted standards of dental practice for the prevention or treatment of oral disease or for Accidental Injury, including masticatory function (chewing of food). 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

HOW TO USE YOUR PLAN

When you first visit your Provider after becoming covered under this plan, let the office staff know you have dental benefits through PacificSource. You will need to show your PacificSource Member ID card, which contains your PacificSource Member ID number and benefit information. Most Provider offices will bill PacificSource directly. Your Provider may submit claims and treatment programs on a standard American Dental Association form. If your Provider has any questions regarding billing procedures, they can call PacificSource at (866) 373-7053.

For extensive dental work, we recommend that your Provider submit a Predetermination request to PacificSource. We then determine how much your plan will pay toward the proposed treatment and review the estimate with your Provider prior to treatment.

DENTAL PLAN BENEFITS

When this plan pays for Covered Services, it actually pays the percentage of charges based on the Usual, Customary, and Reasonable Fee (UCR). A charge is Usual, Customary, and Reasonable when it falls within a general range of charges being made by most Providers in your service area for similar treatment of similar conditions. If the charge for a treatment or service is more than the Usual, Customary, and Reasonable Fee in your service area, you may be required to pay the difference. The Usual, Customary, and Reasonable Fee for dental expense is the covered charge referred to in this Student guide.

If you or your family member 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.

Subject to all the terms of this plan, incurred dental expense for the following services and supplies are covered according to your Schedule of Benefits.

COVERED DENTAL SERVICES

These dental services are for Members age 19 and older.

This section of the Student guide contains information about the benefits provided under the plan. 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.

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.

CLASS I SERVICES

- **Examinations (routine or other diagnostic exams)** are limited to two examinations per Contract Year. Separate charges for review of a proposed treatment plan or for diagnostic aids, such as study models and diagnostic lab tests (other than brush biopsies) are not covered. Problem focused examinations are limited to two per Contract Year.
- **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 Contract Year. The limitation for dental cleaning applies to any combination of Prophylaxis and/or Periodontal Maintenance in the Contract Year. A separate charge for periodontal charting is not a Covered 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 Contract Year.
- **Fluoride varnish applications** are limited to four applications per Contract Year.
- **Brush biopsies** used to aid in the diagnosis of oral cancer are covered.

CLASS II SERVICES

- **Composite Resin or similar Restoration (fillings) in a posterior (back) tooth** are limited to the amount that would be paid for a corresponding Amalgam Restoration. A separate charge for anesthesia when used during restorative procedures is not a Covered Service. PacificSource will pay for a filling on a tooth surface only once every 24 months. Three or more surface fillings are limited to one per surface every 24 months.
- **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 covered only 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 covered only for deciduous teeth.
- **Root canal therapy** on the same tooth is covered only 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.
- **Replacement of an existing prosthetic device** is covered only 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 once per lifetime 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.

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.

BENEFIT EXCLUSIONS

This plan does not cover the following:

- Aesthetic dental procedures – Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.
- Antimicrobial agents – Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.
- Athletic activities – Any injuries sustained while competing or practicing for a professional or semiprofessional athletic contest.
- Athletic mouth guards.
- Biopsies or histopathologic exams – A separate charge for a biopsy of oral tissue or histopathologic exam.
- Charges for missed appointments.
- Collection of cultures and specimens.
- Comprehensive periodontal exams.
- Connector bar or stress breaker.
- Core build-ups are not covered unless used to restore a tooth that has been treated endodontically (root canal).
- Cosmetic/reconstructive services and supplies – Procedures, appliances, Restorations, or other services that are primarily for cosmetic purposes (does not apply to emergency services). This includes services or supplies rendered primarily to correct congenital or developmental malformations including, but not limited to, peg laterals, maxillary and mandibular (upper and lower jaw)

malformations, enamel hypoplasia, veneers, and fluorosis (discoloration of teeth). However, the replacement of congenitally missing teeth is covered.

- Denture replacement made necessary by loss, theft, or breakage.
- Diagnostic casts – Diagnostic casts (study models) and occlusal appliances.
- Diagnostic casts – Gnathological recordings, occlusal equilibration procedures, or similar procedures.
- Drugs and medications that are prescribed drugs and take-home medicine or supplies distributed by a Provider for any Member. As well as premedication drugs, analgesics (for example, nitrous oxide or non-intravenous sedation), and any other euphoric drugs.
- 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 – Services, supplies, protocols, procedures, devices, drugs or medicines, or the use thereof that are Experimental, Investigational, or Unproven for the diagnosis and treatment of the Member. An Experimental, Investigational, or Unproven service is not made eligible for benefits by the fact that other treatment is considered by the Member's dental care Provider to be ineffective or not as effective as the service, or that the service is prescribed as the most likely to prolong life.
- Fractures of the maxilla and mandible – Surgery, services, and supplies provided in connection with the treatment of simple or compound fractures of the maxilla or mandible.
- General anesthesia except when administered by a Provider in connection with oral surgery in their office.
- Gingivectomy, gingivoplasty, or crown lengthening in conjunction with crown preparation or fixed bridge services done on the same date of service.
- Hospital charges or additional fees charged by the Provider for hospital treatment.
- Hypnosis.
- 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 furnished under this plan.
- Orthodontic services – Treatment of misalignment of teeth and/or jaws, or any ancillary services expressly performed because of orthodontic treatment.
- Orthognathic surgery – Surgery to manipulate facial bones, including the jaw, in Members with facial bone abnormalities performed to restore the proper anatomic and functional relationship to the facial bones.
- Periodontal probing, charting, and re-evaluations.
- Periodontal splinting, night guards, or appliances used to increase vertical dimensions, restore the occlusion, or correct habits such as tongue thrust and grinding teeth. Periodontal splinting including crowns and bridgework used in conjunction with periodontal splinting.
- 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 not listed as a Covered Service, unless required under federal or state law.
- Services or supplies provided by or payable 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 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 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 – Dental services begun before you or your family member became eligible for those services under this plan.
- Unwilling to release information – Charges for services or supplies for which you are unwilling to release dental or eligibility information necessary to determine the benefits payable under this plan.

- War-related conditions – The treatment of any condition caused by or arising out of any act of war, or any war declared or undeclared, or while in the service of the armed forces.

EXCLUSION PERIODS

If your Schedule of Benefits provide for an Exclusion Period, you may need to complete this period before benefits will be paid by PacificSource. The Exclusion Period does not apply to persons insured under this plan on the plan's original effective date if the person was continuously covered under a predecessor plan of the Policyholder.

CREDIT FOR PRIOR COVERAGE

You can receive credit toward the plan's Exclusion Period if you had qualifying dental coverage before enrolling in the 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 your first day of coverage under this individual stand-alone dental plan.

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

NECESSITY ACCORDING TO ACCEPTABLE DENTAL PRACTICE

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

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

INDIVIDUAL/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.

CLAIMS PAYMENT

How to File a Claim

Your Provider may submit the claim to PacificSource for you. If not, you are responsible for sending the claim to us for processing. Your claim must include a copy of your Provider's itemized bill. It must also include your name, PacificSource Member ID 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. 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 Member 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 Member 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 Member then must submit the proofs of loss within 90 days of the date of the loss or as soon as reasonably possible. Proofs of loss include written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

All claims should be sent to:

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

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. 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.

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 if we receive an agreement from you in writing.

In the same manner, if PacificSource applies expenses to the plan Deductibles 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.

COORDINATION OF BENEFITS

This is a summary of only a few of the provisions of your healthcare 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 healthcare 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 healthcare 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 family member are covered under another plan in addition to this one, we will be primary when:

Your Own Expenses

- The claim is for your own healthcare expenses, unless you are covered by Medicare and both you and your Spouse or Domestic Partner are retired.

Your Spouse's or Domestic Partner's Expenses

- The claim is for your Spouse or your Domestic Partner, who is covered by Medicare, and you are not both retired.

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. Health maintenance organizations (HMOs) and preferred Provider organizations (PPOs) usually have contracts with their Providers.
- 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 preauthorization, 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 healthcare 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 healthcare expenses incurred both before and after the settlement. If you have ongoing healthcare 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.

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, including those arising from self-employment. The only exception is if you are otherwise exempt from, and not covered by, state or federal workers' compensation insurance.

Any expense for Injury or illness that arises out of or in the course of employment or self-employment for wages or profit, and that is coverable by workers' compensation, is not a Covered Service under this plan and will not be paid by PacificSource.

PacificSource may pay your dental claims if a workers' compensation claim has been denied on the basis that the illness or Injury is not work related, and the denial is under Appeal.

The contractual rules for third party liability, motor vehicle and other Accidents, and on-the-job illness or Injury are complicated and specific. Please contact 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 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;
- Imposition of a third party liability, annual benefit limit, or other limitation on otherwise Covered Services or items;
- Determination that a dental item or service is Experimental, Investigational, Unproven, not a Dental Necessity, effective, or appropriate; or
- Determination that a course or plan of treatment you are undergoing is an active course of treatment for the purpose of continuity of care.

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 is located on our website, 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 must sign a waiver granting the review organization access to medical records relevant to the decision. 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 Appeal process and have a dispute referred directly to External Review. You shall be deemed to have exhausted the Internal Appeal if PacificSource fails to strictly comply with its Appeal process and with state and federal requirements for Internal Appeal.

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, 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. You can reach us by phone or email at the contact information found on the first page of this Student guide. 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

Website dfr.oregon.gov

RESOURCES FOR INFORMATION AND ASSISTANCE

Assistance

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.

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 at 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 health 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 our Predetermination and utilization review procedures; and
- Information about any dental 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 healthcare 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: DFR.InsuranceHelp@oregon.gov

Website dfr.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, pacificsource.com/osu. 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 Provider obtains Predetermination 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 health 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 insurance contract between the Policyholder and PacificSource Health Plans. Under the blanket group insurance contract, 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

Legal Procedures

You may not take legal action against PacificSource to enforce any provision of the plan until 60 days after your claim is properly submitted in accordance with established procedures. Also, you must exhaust this plan's claims procedures, and Grievance and Appeals procedures, before filing benefits

litigation. You may not take legal action against PacificSource more than three years after the deadline for claim submission has expired.

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 a dental item or service, or PacificSource's failure or refusal to provide or to make a payment in whole or in part for a dental item or service 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, annual benefit limit, or other limitation on otherwise Covered Services or items;
- Determination that a dental item or service is Experimental, Investigational, 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.

- **Contracted Allowable Fee** is an amount PacificSource agrees to pay a 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.
- **Usual, Customary, and Reasonable Fee (UCR)** is the fee based on charges being made by Providers in the same service area for similar treatment of similar dental conditions. A Usual, Customary, and Reasonable Fee is based on Provider billing data gathered by PacificSource and adjusted to the 90th percentile. Usual, Customary, and Reasonable Fees are reviewed by PacificSource annually.

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

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

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

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.

Contract Year means a 12 month period beginning on the date the insurance contract is issued or the anniversary of the date the insurance contract was issued. If changes are made to the insurance contract on a date other than the anniversary of issuance, a new Contract Year may start on the date the changes become effective if so agreed by PacificSource and the Policyholder. A Contract Year may or may not coincide with a calendar year.

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/or public health plans.

Curettage is the scraping and cleaning of the walls of a real or potential space, such as a gingival pocket or bone, to remove pathological material.

Deductible means the portion of the dental expense 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.

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

Dentally Necessary 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 in the policy's state of issuance, 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 disease or Injury involved and the patient's overall health condition;
- Not for the convenience of the member or a Provider of services or supplies; and
- The least costly of the alternative services or supplies that can be safely provided.

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

Dependent Children means any natural, step, adopted, or eligible child you, your Spouse, or your Domestic Partner are legally obligated to support or contribute support. This may include eligible Dependent Children for which you are the court appointed legal custodian or guardian. Eligible Dependent Children may be covered under the plan only if they meet the eligibility requirements of the plan. For more information, see the Eligibility section.

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.

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

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, 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, 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 a member or an Authorized Representative of a member regarding:
  - The availability, delivery, or quality of a dental service; or

- Claims payment, handling, or reimbursement for dental services and, unless the member has not submitted a request for an Internal Appeal, the Complaint is not disputing an Adverse Benefit Determination.

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 and does not include muscular strain sustained while performing a physical activity.

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

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

Member means a person covered by this plan.

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

Periodontal Maintenance is a periodontal procedure for patients who have previously been treated for periodontal disease. In addition to cleaning the visible surfaces of the teeth (as in Prophylaxis) surfaces below the gum line are also cleaned. This is a more comprehensive service than a regular cleaning (Prophylaxis).

Periodontal Scaling and Root Planing means the removal of plaque and calculus deposits from the root surface under the gum line.

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

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 dental 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.

Radiographic Image means any x-ray or computerized image of the teeth and jaws that provide information for detecting, diagnosing, and treating conditions that can threaten oral and general health. It includes cone beam x-rays, bitewing x-rays, Periapical X-rays, intraoral x-rays, extraoral x-rays, panoramic x-rays, and cephalometric x-rays.

Rescind or Rescission means to retroactively cancel or discontinue coverage under this healthcare 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.

Schedule of Benefits means the page entitled Dental Schedule attached to this dental plan.

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

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

Contact us.

Idaho:	(208) 333-1596 | (800) 688-5008
Montana:	(406) 442-6589 | (877) 590-1596
Oregon:	(541) 684-5582 | (888) 977-9299
TTY:	(800) 735-2900
En Español:	(541) 684-5456 | (800) 624-6052, ext. 1009
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 በአከፋፈል 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	يحوي هذا الاشعار معلومات هامة. يحوي هذا الاشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال PacificSource Health Plans ابحث عن التواريخ الهامة في هذا الاشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصور على المعلومات والمساعدة بلغتك (888) 977-9299 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	បសចកតីជូនែំណឹងបនេះ ម្ននព័ែ៌ម្ននយ៉ា ងសំខាន់ ។ បសចកតីជូនែំណឹងបនេះ ម្ននព័ែ៌ម្ននយ៉ា ងសំខាន់ អ្ំពីេបឹង៉ងរេ ឬ ការ៉ា រ់ង រស់អ្នកតាមរយៈ PacificSource Health Plans។ សូមដសែងរកកាលរបិចេេសំខាន់ចាំច់ ជាកនុងបសចកតីជូនែំណឹងបនេះ ។ អ្នកប្រដែលជាប្ែូវការរបចេញសកមមភាព ែល់កំណែ់ថ្ងៃជាក់ចាស់នានា បែេមបីនឹងរកាេុកការ៉ា រ់ង សុខភាពរស់អ្នក ឬប្ាក់ជំនួយបចញថ្ងៃ ។ អ្នកម្ននសិេធិេួលព័ែ៌ម្ននបនេះ និងជំនួយជាកនុងភាសារស់អ្នកជោយមិនអ្ស់លុយប េើយ ។ សូមេូរស័ពទ (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	본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 PacificSource Health Plans 을 통한 커버리지 에 관한 정보를 포함하고 있습니다. 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.
Laotian	ການແຈ້ງການນ້ ມ໋ຂໍ້ ມູ ນໍສາຄັ ນ. ການແຈ້ງການນ້ ມ໋ຂໍ້ ມູ ນ່ທໍສາຄັ ນກ່ ງວກັ ບໍຄາຮ້ ອງສະໝັ ກຫ ືື ການຄ້ ມ ຄອງຂອງທ່ ານໂດຍຜ່ ານ PacificSource Health Plans. ເິ່ບງໍສາລັ ບກໍ ານົ ດວັ ນ່ທ ໍສາຄັ ນໃນແຈ້ ງການນ້ . ທ່ ານອາດໍຈາເປັ ນຕ້ ອງໃຊ້ ເວລາໍດາເນນການໂດຍກໍ ານົ ດເວລາ່ທແນ່ ນອນ ຈະ ຮັ ກສາການຄ້ ມຄອງສຂະພາບຂອງທ່ ານຫ ືື ການຊ່ ວຍເຫ ືື ອ່ທມຄ່ າໃຊ້ ຈ່ າຍ. ທ່ ານມີສດ່ທຈະໄດ້ ຮັ ບໍຂໍ້ ມູ ນ ຂ່ າວສານນ້ ແລະການຊ່ ວຍເຫ ືື ອໃນພາສາຂອງທ່ ານ່ທໍ່ບມຄ່ າໃຊ້ ຈ່ າຍ. ໂທ (888) 977-9299.
Nepali	यो स चनामा् महत्त्वप र्ु् जानकारी छ । यो स चनामा् तपाईकं ो आवेिन वा PacificSource Health Plans का माध्यमबाटप्राप्त हुने सदु विबारे महत्त्वपर्् ु जानकारी छ । यो सचू नामा भएका महत्त्वपर्् ु दमदतहरू ख्याल िनुहु ोस् । तपाईलं े पाइरहके ो स्वास््य दबमा पाइरहन वा तपाईकं ो खचुको भक्तानीमाुसहायता पाउन के ही समयकारवाही िन -सीमामा काम-ुपनु हनसक्छु । तपाईलं े यो जानकारी र सहायता आफ्नो मातभृ ाषामा दन शल्ु क पाउनु तपाईकं ो अदिकार: हो (888) 977-9299 मा फोन िनुहु ोस् ।
Norweigen	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.
Pennsylvania Dutch	Die Bekanntmaching gebt wichdichi Auskunft. Die Bekanntmaching 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 beschtimmde 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
Persian	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 977-9299 (888) باشید
Punjabi	ਇਸ ਨੋ ਜਿਸ ਜਵਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੋ ਜਿਸ ਜਵਚ PacificSource Health Plans ਵਲੋਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਿਾਰੇ ਮਹਿੱ ਤਵਪ ਰਨ ਜਾਣਕਾਰੀ ਹੈ . ਇਸ ਨੋ ਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਲਈ ਵੇਖੋ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱ ਚ ਮਦਦ ਦੇ ਇਛੁਿੱ ਕ ਹੋ ਤਾਂ ਤੁਹਾਨ ੂੰ ਅੂੰ ਤਮ ਤਾਜਰਖ਼ ਤੋਂ ਪਜਹਲਾਂ ਕੁਿੱ ਝ ਖਾਸ ਕਦਮ ਚੁਿੱ ਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ. ਤੁਹਾਨ ੂੰ ਮੁਫ਼ਤ ਜਵਚ 'ਤੇ ਆਪਣੀ ਭਾਸਾ ਜਵਿੱ ਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪਰਾਪਤ ਕਰਨ ਦਾ ਅਜਿਕਾਰ ਹੈ. ਕਾਲ (888) 977-9299
Romanian	Prezenta notificare conține informații importante. Această notificare conține informații importante privind cererea sau acoperirea asigurării dumneavoastre 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.

Russian	Настоящее уведомление содержит важную информацию. Это уведомление содержит важнуюинформацию 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 određenje 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	ประกาศนี้มีข้อมูลสาคัญประกาศนี้มีข้อมูลที่สาคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน PacificSource Health Plans ดูกาหนดการในประกาศนี้คุณอาจจะต้องดาเนินการภายในกาหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่ายคุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่ายโทร (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.