



Oregon Health and Science University

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

Effective: 2026-2027



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

Using this Certificate of Coverage (Herein Called Student Guide)

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

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

Governing Law

This plan must comply with both state and federal law, including required changes occurring after the plan's effective date. Therefore, coverage is subject to change as required by law. Unless federal law is found to apply, the validity and interpretation of this plan, and the rights and obligations of the Members, will be governed by the state's laws where your Policyholder's plan is issued.

Additional Information

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

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

PacificSource Customer Service

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

Email dental@pacificsource.com

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

PacificSource Headquarters

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PacificSource Website

pacificsource.com/students

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Benefit Year: September 22, 2026 – September 21, 2027

Who is eligible?

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

	Student only
Fall	\$111.00
Winter	\$111.00
Spring	\$86.57
Spring/Summer	\$111.00
Summer A	\$89.91

The premiums above include a fee charged by your school.

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

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

Deductible Per Benefit Year	In-network	Out-of-network
Individual	\$50	\$100
Benefit Maximum Per Benefit Year		
\$1,500 per individual. Applies to all covered services.		
Exclusion Period	Number of Consecutive Months	
Class II Services	None	
Class III Services	None	

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

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

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

Additional information

What is the deductible?

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

What is the benefit maximum?

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

What is an exclusion period?

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

Prior authorization

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

Discrimination is against the law

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

UNDERSTANDING HOW YOUR BENEFITS ARE PAID

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

BENEFIT YEAR

Contract Year

Many benefits and provisions in this plan are calculated on a contract year basis. 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. Any benefit with a separate maximum benefit (for example, not on a contract year basis) is identified in the Covered Services section of this student guide. Frequency limitations are calculated from the previous date of service or initial placement, unless otherwise specified.

If this plan renews or is modified mid-contract year, the previously satisfied Deductibles, out-of-pocket limits, and benefit maximums will be credited toward the renewed or modified plan.

YOUR DEDUCTIBLE

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

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

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

If this plan includes Cosmetic Orthodontia, those charges do not apply toward the Deductible. Covered 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.

YOUR BENEFIT MAXIMUM

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

UNDERSTANDING DENTAL NECESSITY

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

Be careful – just because a treatment is prescribed or recommended by a Provider does not mean it is Dentally Necessary under the terms of this plan. This plan provides coverage only when such care is necessary to treat an Illness or Injury or the service qualifies as preventive care. All treatment is subject to review for Dental Necessity. Review of treatment may involve prior authorization, concurrent review of the continuation of treatment, post-treatment review, or any combination of these. A second opinion (at no cost to the Member when requested by PacificSource) may be required for a Dental Necessity determination.

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

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

UNDERSTANDING EXPERIMENTAL, INVESTIGATIONAL, OR UNPROVEN SERVICES

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

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

ELIGIBLE PROVIDERS

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

COVERED SERVICES

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

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

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

As described in the prior section, these services and supplies may require you to satisfy a Deductible, make a Copayment, and/or pay Coinsurance. They may be subject to additional limitations or maximum dollar amounts. For an expense to be eligible for payment, you must be a Member of this plan on the date the expense is incurred and eligible Providers practicing within the scope of their licenses must

render the services. A treatment or service may be a Dental Necessity, yet not be a Covered Service. For information about exclusions, see the Benefit Exclusions section.

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

These dental services are for Members age 19 and older.

CLASS I SERVICES

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

CLASS II SERVICES

- **Palliative (emergency) treatment of dental pain** is covered.
- **Composite Resin and Amalgam Restoration (fillings)** are limited to the same tooth once every 24 months, up to four surfaces per tooth.
- **Simple extractions of teeth** and other minor oral surgery procedures are covered. A separate charge for Alveolectomy performed in conjunction with removal of teeth is not a Covered Service.
- **Periodontal Scaling and Root Planing and/or Curettage** is limited to only one procedure per quadrant in any 36 month period. For the purpose of this limitation, eight or fewer teeth existing in one arch will be considered one quadrant.
- **Full mouth debridement** is limited to once every 36 months. This procedure is only covered if the teeth have not received a Prophylaxis in the prior 36 months and if an evaluation cannot be performed due to the obstruction by plaque and calculus on the teeth. This procedure is not covered if performed on the same date as a dental cleaning (Prophylaxis or Periodontal Maintenance).
- **Complicated oral surgery procedures**, such as the removal of impacted teeth are covered. A separate charge for Alveolectomy performed in conjunction with removal of teeth is not a Covered Service.

- **Pulp capping** is only covered when there is an exposure to the pulp. These are direct pulp caps. Coverage for indirect pulp caps are covered as part of the Restoration fee and are not covered as a separate charge.
- **Pulpotomy** is only covered for primary teeth.
- **Root canal therapy** on the same tooth is only covered for one charge in a 36 month period.
- **Periodontal surgery** is limited to procedures accompanied by a periodontal diagnosis and history of conservative (non-surgical) periodontal treatment.
- **Tooth desensitization** is covered as a separate procedure from other dental treatment.
- **General anesthesia** administered by a Provider in their office when used in conjunction with approved oral surgery procedures is covered.

CLASS III SERVICES

- **Crowns** and other cast or laboratory-processed Restorations are limited to the Restoration of any one tooth in a ten year period.
- **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 only covered when the device being replaced is unserviceable, cannot be made serviceable, and has been in place for at least 60 months.
- **Crowns, onlays, bridges.** The completion date is the cementation date (seat date) regardless of the type of cement utilized.
- **Implants.** Surgical placement and removal of implants are limited to a Lifetime Maximum of one per tooth space. Benefits include final crown and implant Abutment over a single implant, final implant-supported bridge Abutment, and implant Abutment or pontic. An alternative benefit per arch of a conventional full or partial denture for the final implant-supported full or partial denture prosthetic device is available.
- **Occlusal guards (night guards)** are limited to a Lifetime Maximum of one.

BENEFIT EXCLUSIONS

EXCLUDED SERVICES

This plan does not cover the following:

- Aesthetic (cosmetic) dental procedures – Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.
- Alveolectomy when performed in conjunction with tooth extraction – Separate charge not covered.
- Anesthesia when performed in conjunction with a restorative procedure – Separate charge not covered.
- Antimicrobial agents – Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.

- Application of sealants.
- Athletic Injuries sustained while competing or practicing for a professional or semiprofessional athletic contest.
- Athletic mouth guards.
- Biopsies or histopathologic exams – A separate charge for a biopsy of oral tissue or histopathologic exam.
- Charges for phone consultations, missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims.
- Collection of cultures and specimens.
- Connector bar or stress breaker.
- Core build-ups unless used to restore a tooth that has been treated endodontically (root canal).
- Cosmetic/reconstructive services and supplies – Procedures, appliances, Restorations, or other services that are primarily for cosmetic purposes (does not apply to emergency services).
- Denture replacement due to loss, theft, or breakage, unless otherwise noted in Covered Services.
- Diagnostic casts (study models).
- Drugs and medications that are prescribed drugs and take-home medicine or supplies distributed by a Provider for any Member. As well as premedication drugs, analgesics, and any other euphoric drugs.
- Educational programs – Instructions and/or training in plaque control and oral hygiene.
- Expense incurred by a Member; not a United States citizen; for services performed within the Student's home country; if the Student's home country has a socialized medicine program.
- Expense incurred for Injury resulting from the play or practice of athletics and intramurals.
- Experimental, Investigational, or Unproven – This plan does not cover services, supplies, protocols, procedures, devices, chemotherapy, drugs or medicines, or the use thereof that are Experimental, Investigational, or Unproven for the diagnosis and treatment of the Member. This limitation also excludes treatment that, when and for the purpose rendered: has not yet received recognized compendia support (for example, UpToDate, Lexicomp, FDA) for other than Experimental, Investigational, or Unproven, or clinical testing; is not of generally accepted medical practice in your plan's state of issuance or as determined by medical advisors, medical associations, and/or technology resources; is not approved for reimbursement by the Centers for Medicare and Medicaid Services; is furnished in connection with medical or other research; or is considered by any governmental agency or subdivision to be Experimental, Investigational, or Unproven, not reasonable and necessary, or any similar finding.

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

- Fractures of the maxilla and mandible – Surgery, services, and supplies provided in connection with the treatment of simple or compound fractures of the maxilla or mandible.
- General anesthesia except when administered by a Provider in connection with oral surgery in their office, unless otherwise noted in Covered Services.
- Gingivectomy, gingivoplasty, or crown lengthening in conjunction with crown preparation or fixed bridge services done on the same date of service.
- Gnathological recordings, occlusal equilibration procedures, or similar procedures.

- Hospital charges or additional fees charged by the Provider for hospital treatment.
- Hypnotherapy.
- Indirect pulp caps are to be included in the Restoration process, and are not a separate Covered Service.
- Infection control – A separate charge for infection control or sterilization.
- Intra and extra coronal splinting – Devices and procedures for intra and extra coronal splinting to stabilize mobile teeth.
- Mail order or Internet/web based Provider are not eligible Providers.
- Orthodontic services – Repair or replacement of orthodontic appliances.
- Orthodontic services – Treatment of misalignment of teeth and/or jaws, or any ancillary services performed because of orthodontic treatment, except as specified in the Covered Services section.
- Orthognathic surgery – Services and supplies to augment or reduce the upper or lower jaw.
- Periodontal probing, charting, and re-evaluations.
- Photographic images.
- Pin retention in addition to Restoration.
- Precision attachments.
- Pulpotomies on permanent teeth.
- Removal of clinically serviceable Amalgam Restorations to be replaced by other materials free of mercury, except with proof of allergy to mercury.
- Services covered by the Member's medical plan.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth.
- Services or supplies covered under any plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law.
- Services or supplies not listed as a Covered Service, unless required under federal or state law.
- Services or supplies with no charge, or for which the Member is not legally required to pay, or for which a Provider or facility is not licensed to provide even though the service or supply may otherwise be eligible. This exclusion includes any service provided by the Member, or any licensed professional that is an Immediate Family Member.
- Services or supplies provided outside of the United States, except in cases of emergency.
- Sinus lift grafts to prepare sinus site for implants.
- Space maintainers.
- Stress-breaking or habit-breaking appliances.
- Temporomandibular joint (TMJ) – Services or supplies for treatment of any disturbance of the temporomandibular joint.
- Third party liability, motor vehicle liability, motor vehicle insurance coverage, workers' compensation – Any services or supplies for Illness or Injury for which a third party is responsible or which are payable by such third party or which are payable pursuant to applicable workers' compensation laws, motor vehicle liability, uninsured motorist, underinsured motorist, and Personal Injury Protection (PIP) insurance and any other liability and voluntary medical payment insurance to the extent of any

recovery received from or on behalf of such sources, except in a situation where such exclusion is expressly prohibited by state law.

- Tooth transplantation – Services and supplies provided in connection with tooth transplantation, including re-implantation from one site to another, splinting, and/or stabilization. This exclusion does not relate to the re-implantation of a tooth into its original socket after it has been avulsed.
- Treatment after insurance ends – Services or supplies a Member receives after the Member's coverage under this plan ends. The only exception is for Class III Services ordered and fitted before enrollment ends and are placed within 31 days after enrollment ends.
- Treatment not Dentally Necessary, according to acceptable dental practice, or treatment not likely to have a reasonably favorable prognosis.
- Treatment of any Illness or Injury resulting from an illegal occupation or attempted felony, or treatment received while in the custody of any law enforcement.
- Treatment prior to enrollment or satisfaction of an Exclusion Period, if applicable.
- Unwilling to release information – Charges for services or supplies for which a Member is unwilling to release dental or eligibility information necessary to determine the benefits covered under this plan.
- War-related conditions – The treatment of any condition caused by or arising out of an act of war, armed invasion, or while in the service of the armed forces unless not covered by the Member's military or veterans coverage.

EXCLUSION PERIODS

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

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

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

Credit for Prior Coverage

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

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

UTILIZATION REVIEW

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

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

PRIOR AUTHORIZATION

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

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

Your Provider can submit a prior authorization request on your behalf. If your Provider is unable to do so, you may contact us directly.

We may ask for more details or require a second opinion (provided at no cost to you if requested by PacificSource) before authorizing coverage. You and/or your Provider are responsible for providing PacificSource with all information necessary to make a Benefit Determination.

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

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

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

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

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

PacificSource reserves the right to contract with a third party to perform prior authorization procedures on its behalf and such third parties may impose independently developed, evidence-based criteria for

making prior authorization determinations. If you have questions about any third party criteria, please contact our Customer Service team.

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

PREDETERMINATION

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

INDIVIDUAL/SUPPLEMENTAL BENEFITS

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

USING THE DENTAL NETWORK

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

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

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

IN-NETWORK PROVIDERS

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

FINDING AN IN-NETWORK PROVIDER

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

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

OUT-OF-NETWORK PROVIDERS

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

Allowable Fee for Out-of-network Providers

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

Balance Billing

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

TERMINATION OF PROVIDER CONTRACTS

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

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

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

BENEFIT DETERMINATIONS AND CLAIMS PAYMENT

How to File a Claim

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

If you receive care from an Out-of-network Provider, the Provider may submit the claim to PacificSource for you. If not, you are responsible for sending the claim to us for processing. Your claim must include a copy of your Provider's itemized bill, including the Provider name and address, the Provider tax identification number and National Provider Identifier (NPI), procedure codes, and diagnosis codes. It must also include your name, PacificSource Member ID number, group number, and the patient's name. If you were treated for an Accidental Injury, please include the date, time, place, and circumstances of the Accident.

All claims for benefits should be turned in to PacificSource within 90 days of the date of service. Failure to submit a claim within 90 days may result in a denial of coverage. If you are unable to submit a claim

within 90 days, present the claim with an explanation for consideration for coverage. Claims submitted more than a year following the date of service may be denied as untimely.

Proofs of Loss

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

Claims Payment Practices

Unless additional information is needed to process your claim, we will make every effort to pay or deny your claim within 30 days of receipt. If a claim cannot be paid within 30 days of receipt because additional information is needed, we will acknowledge receipt of the claim and explain why payment is delayed.

Benefit and Claim Determinations

Benefit Determination – PacificSource will make a Benefit Determination for healthcare services, including those subject to prior authorizations, within the time period noted in the chart below.

Benefit Determination	Pre-service Review
Initial determination by PacificSource	2 business days
If PacificSource requires additional information, PacificSource will make request within	2 business days
Provider or Member must provide requested additional information within	15 business days
Once PacificSource receives the information, decision will be made and written notice sent within	2 business days

Claim Determination – PacificSource will make a claim determination within the time period noted in the chart below, unless additional information is necessary to process the claim. In that event, we will send you notice that the claim was received and explain what additional information is necessary to process the claim. If we do not receive the necessary information within 15 days of the delay notice, we will either deny the claim or notify you every 45 days while the claim remains under investigation.

Claim Determination	Post-service Claim
Initial determination by PacificSource	30 calendar days
If PacificSource requires additional information, PacificSource will make request within	30 calendar days
Provider or Member must provide requested additional information within	15 calendar days
Once PacificSource receives the information, decision will be made and written notice sent within	30 calendar days

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

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

Payment of Claims

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

Questions about Benefit Determinations and Claims

If you have questions about the status of a Benefit Determination or claim, you are welcome to contact our Customer Service team or go online to view the information via our website.

Benefits Paid in Error

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

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

Legal Procedures

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

You must exhaust this plan's Appeal procedures, including but not limited to, seeking an External Review before filing benefits litigation under this plan.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a person has healthcare coverage under more than one plan. Plan is defined below.

The order of Benefit Determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100 percent of the total allowable expense.

Definitions

For the purpose of this section only, the following definitions apply:

A **plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

- Plan includes: group and non-group health insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

- Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; Accident only coverage; specified disease or specified Accident coverage; school Accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage described above is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

This plan means, in a COB provision, the part of the contract providing the healthcare benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing healthcare benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order of Benefit Determination Rules. The rules that determine whether this plan is a primary plan or secondary plan when the person has healthcare coverage under more than one plan.

- When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits.
- When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100 percent of the total allowable expense.

Allowable Expense. A healthcare expense, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

- The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.
- If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
- If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
- If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the Provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.
- The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred Provider arrangements.

Closed Panel Plan. A plan that provides healthcare benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial Parent. The parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other plans.

Except as provided below, a plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary.

- Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

Each plan determines its order of benefits using the first of the following rules that apply:

Non-Dependent or Dependent. The plan that covers the person other than as a Dependent, for example as an employee, member, Policyholder, subscriber, or retiree is the primary plan and the plan that covers the person as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Dependent; and primary to the plan covering the person as other than a Dependent (for example, a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, Policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan.

Dependent Children. Unless there is a court decree stating otherwise, when a Dependent Child is covered by more than one plan the order of benefits is determined as follows. The following is known as the birthday rule:

- For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:
 - The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
 - If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
- For a Dependent Child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
 - If a court decree states that one of the parents is responsible for the Dependent Child's healthcare expenses or healthcare coverage, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given

notice of the court decree;

- If a court decree states that both parents are responsible for the Dependent Child's healthcare expenses or healthcare coverage, the provisions above shall determine the order of benefits;
- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the Dependent Child, the provisions above shall determine the order of benefits; or
- If there is no court decree allocating responsibility for the Dependent Child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
 - The plan covering the custodial parent;
 - The plan covering the Spouse of the custodial parent;
 - The plan covering the non-custodial parent; and then
 - The plan covering the Spouse of the non-custodial parent.
- For a Dependent Child covered under more than one plan of individuals who are not the parents of the child, the provisions above shall determine the order of benefits as if those individuals were the parents of the child.

Active Employee or Retired or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the non-Dependent or Dependent rule above can determine the order of benefits.

COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a Dependent of an employee, member, subscriber, or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the non-Dependent or Dependent rule above can determine the order of benefits.

Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, Policyholder, subscriber, or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of this Plan

When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other healthcare coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other healthcare coverage.

If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

Right to Receive and Release Needed Information

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. PacificSource may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. PacificSource need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give PacificSource any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, PacificSource may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. PacificSource will not have to pay that amount again. The term payment made includes providing benefits in the form of services, in which case payment made means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by PacificSource is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The amount of the payments made includes the reasonable cash value of the benefits provided in the form of services.

THIRD PARTY LIABILITY

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

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

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

When we receive a claim that might involve a third party, we may send you a questionnaire to help us determine responsibility.

In all third party liability situations, this plan's coverage is secondary. By enrolling in this plan, you automatically agree to the following terms regarding third party liability situations:

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

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

Right of Recovery – Time Limit for Reimbursements

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

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

Motor Vehicle and Other Accidents

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

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

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

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

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

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

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

COMPLAINTS, GRIEVANCES, AND APPEALS

QUESTIONS, CONCERNS, OR COMPLAINTS

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

If you do not speak English, have literacy difficulties, or have physical or mental disabilities that impede your ability to file a Grievance and/or Appeal, you may contact our Customer Service team for assistance. We can usually arrange for a multilingual staff member or interpreter to speak with you in your 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 orally or 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 plan;

- Rescission or cancellation of your plan whether or not the Rescission has an adverse effect on any particular benefit at the time;
- Imposition of a third party liability, network exclusion, annual benefit limit, or other limitation on otherwise Covered Services or items;
- Determination that a dental item or service is Experimental, Investigational, or Unproven, not a Dental Necessity, effective, or appropriate.

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

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

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

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

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

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

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

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

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

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

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

Timelines for Responding to Appeals

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

In addition, if your Appeal qualifies for an expedited response, a decision in response to the Appeal will be completed as soon as possible, but no later than 72 hours of receipt of the request.

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

Information Available with Regard to an Adverse Benefit Determination

The final Adverse Benefit Determination will include:

- A reference to the specific internal rule or guideline PacificSource used in the Adverse Benefit Determination; and
- An explanation of the scientific or clinical judgment for the Adverse Benefit Determination, if the Adverse Benefit Determination is based on Dental Necessity, Experimental, Investigational, or Unproven treatment, or a similar exclusion.

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

HOW TO SUBMIT GRIEVANCES OR APPEALS

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

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

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

Call 888-977-9299

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@dcbs.oregon.gov

Website dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx

BECOMING COVERED

ELIGIBILITY

Requirements for Enrollment of Student

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

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

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

During the first 30 days of any term, a Student can make enrollment changes and those changes are effective the first date of term. If outside of the first 30 days changes are only permitted with a qualifying life event.

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 to enroll in this plan.

Fall term coverage runs from September 22, 2026 through January 2, 2027.

Winter term coverage runs from January 3, 2027 through March 27, 2027.

Spring term coverage runs from March 28, 2027 through June 30, 2027.

Spring and Summer term coverage runs from March 28, 2027 through September 21, 2027.

Summer A coverage runs from June 15, 2027 through September 21, 2027.

ENROLLING AFTER THE INITIAL ENROLLMENT PERIOD

Special Enrollment Periods

You may decline coverage during your initial enrollment period. To do so, you must submit a waiver of coverage provided by your school before your school's required deadline. You may enroll in this plan later if you qualify under the special enrollment rules below. To do so, you must submit an enrollment change within 31 days of the qualifying event.

- **Special Enrollment Rule #1**

If you declined enrollment for yourself because of other insurance coverage, you may enroll in the plan later if the other coverage ends involuntarily. Coverage will begin on the day after the other coverage ends.

Medical Leave of Absence

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

GENERAL PLAN PROVISIONS

Time Limit on Certain Defenses

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

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

Representations Not Warranties

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

Rescissions

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

TERM AND TERMINATION – COVERAGE

- **Students.** Insurance for a Student will end on the first of the following events:

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

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

If you withdraw from school within the first 14 days of the coverage period, you will receive a full refund of the insurance premium provided that you did not file a medical claim during this period. Written proof of withdrawal from the school must be provided. If you withdraw after 14 days of the coverage period, your coverage will remain in effect until the end of the term for which you have paid the premium.

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

Any Student who requests to terminate coverage prior to the end of the Benefit Year shown on the Dental Benefit Summary may be terminated on the last day of the month prior to PacificSource receiving the request for termination and be eligible for a pro-rated refund of premiums.

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

RESOURCES FOR INFORMATION AND ASSISTANCE

Assistance

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

Information Available from PacificSource

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

- A directory of Providers under your plan;
- Information about our drug list (also known as a formulary);
- A copy of our annual report on Complaints and Appeals;
- A summary of Adverse Benefit Determinations and Grievance processes;
- Information about our policy for protecting the confidentiality of your information;
- Information about the cost of premiums and Member cost sharing requirements;
- An annual statement of all benefit payments made by PacificSource for a Member's coverage, including payments that have been counted against any applicable benefit limitations;
- A description (consistent with risk-sharing information required by the Centers for Medicare and Medicaid Services) of any risk-sharing arrangements we have with Providers;
- A description of our efforts to monitor and improve the quality of dental services, including accreditation status with a national managed care accreditation organization and Health Effectiveness Data and Information Set (HEDIS) data results;
- Information about how we check the credentials of our network Providers and how you can obtain the names and qualifications of your Providers;
- Information about our prior authorization, Predetermination, and utilization review procedures;
- Information about any plan offered by PacificSource; and
- Information about PacificSource's price transparency for all Covered Services, items, and prescription drugs is available on our website. This allows Members to understand their cost share information such as Deductible and Coinsurance amounts. A paper form of the estimate is available upon request.

Information Available from the Division of Financial Regulation about PacificSource

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

- The results of all publicly available accreditation surveys;
- A summary of our health promotion and disease prevention activities;

- Samples of the written summaries delivered to PacificSource Policyholders;
- An annual summary of Grievances and Appeals against PacificSource;
- An annual summary of our utilization review policies;
- An annual summary of our quality assessment activities; and
- An annual summary of the scope of our Provider network and accessibility of services.

You can request this information by contacting:

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

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

Email: dfr.insurancehelp@dcbs.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/students. You may also write to us at:

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

RIGHTS AND RESPONSIBILITIES

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

Your Rights as a Member

- You have a right to receive information about PacificSource, our services, our Providers, and your rights and responsibilities.
- You have a right to expect clear explanations of your plan benefits and exclusions.
- You have a right to be treated with respect and dignity.
- You have a right to impartial access to dental care without regard to race, religion, gender, national origin, or disability.
- You have a right to honest discussion of appropriate or Dentally Necessary treatment options. You are entitled to discuss those options regardless of how much the treatment costs or if it is covered by this plan.
- You have a right to the confidential protection of your records and personal information.
- You have a right to voice Complaints about PacificSource or the care you receive, and to Appeal decisions you believe are wrong.
- You have a right to participate with your Provider in decision-making regarding your care.

- You have a right to know why any tests, procedures, or treatments are performed and any risks involved.
- You have a right to refuse treatment and be informed of any possible medical or dental consequences.
- You have a right to refuse to sign any consent form you do not fully understand, or cross out any part you do not want applied to your care.
- You have a right to change your mind about treatment you previously agreed to.
- You have a right to make recommendations regarding PacificSource Health Plans' Member rights and responsibilities policy.

Your Responsibilities as a Member

- You are responsible for reading this student guide and all other communications from PacificSource, and for understanding your plan's benefits. You are responsible for contacting our Customer Service team if anything is unclear to you.
- You are responsible for making sure your Out-of-network Provider obtains prior authorization for any services that require it before you are treated.
- You are responsible for providing PacificSource with all the information required to provide benefits under your plan.
- You are responsible for giving your Provider complete information to help accurately diagnose and treat you.
- You are responsible for telling your Providers you are covered by PacificSource and showing your PacificSource Member ID card when you receive care.
- You are responsible for being on time for appointments, and contacting 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-policy](https://pacificsource.com/privacy-policy).

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 Oregon Request for Confidential Communication form provided at [PacificSource.com/resources/documents-and-forms](https://pacificsource.com/resources/documents-and-forms).

PLAN ADMINISTRATION

Insurance Contract

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

Our address is:

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

DEFINITIONS

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

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

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

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

- Denial of eligibility for or termination of enrollment in a plan;
- Rescission or cancellation of your coverage;
- Imposition of a third party liability, network exclusion, annual benefit limit, or other limitation on otherwise Covered Services or items;
- Determination that a dental item or service is Experimental, Investigational, or Unproven, not a Dental Necessity, effective, or appropriate; or
- Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care.

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

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

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

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

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

Appeal means a written request from a Member or 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;
- Rescission of the Member's benefit coverage; and
- Other matters as specifically required by law.

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

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

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

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

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

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

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

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

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

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

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

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

- There was no more than a 63 day break between the last day of coverage under the previous plan and the first day of coverage under this plan.
- The prior coverage was one of the following types of insurance: group coverage (including Federal Employee Health Benefit Plans and Peace Corps), individual coverage (including student health plans), Medicaid, Medicare, TRICARE, Indian Health Service or tribal organization coverage, state high-risk pool coverage, and public dental plans.

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

Deductible means the portion of the expense for a Covered Service that must be paid by the Member before the benefits of this plan are applied. A plan may include more than one Deductible.

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

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

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

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

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

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

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

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

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

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

Immediate Family Member means:

- Your Dependents, your parents, your parent's Spouse or Domestic Partner, your siblings, and your half-siblings;
- Your Spouse's or Domestic Partner's parents, siblings, and half-siblings;
- Your Dependent Child's Spouse or Domestic Partner; and
- Any other of your relatives by blood or marriage who shares a residence with you.

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

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

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

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

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

Member means a person covered by this plan.

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

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

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

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

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

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

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

Prophylaxis is a cleaning and polishing of all teeth.

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

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

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

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

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

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

Contact us.

Phone: 888-977-9299

TTY: 711

En Español: 541-684-5456

Email: CS@PacificSource.com

Web: PacificSource.com

Your privacy is important to us.

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

Discrimination is against the law



PacificSource Health Plans and PacificSource Community Health Plans ("PacificSource") complies with applicable Federal civil rights laws, including Section 1557 of the Affordable Care Act. PacificSource does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), sex (consistent with the scope of sex discrimination described at 45 CFR 92.101(a)(2)), age or disability. PacificSource does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

In compliance with Section 1557 and other federal civil rights laws, we provide individuals the following in a timely manner and free of charge:

Language assistance services

PacificSource will provide language assistance services for individuals with limited English proficiency (including individuals' companions with limited English proficiency) to ensure meaningful access to our programs, activities, services, and other benefits. Language assistance services may include:

- Electronic and written translated documents
- Qualified interpreters
- Appropriate auxiliary aids and services for individuals with disabilities (including individuals' companions with disabilities) to ensure effective communication

Appropriate auxiliary aids and services may include:

- Qualified interpreters, including American Sign Language interpreters
- Video remote interpreting
- Information in alternate formats (including but not limited to large print, recorded audio, and accessible electronic formats)

Reasonable modifications

PacificSource will provide reasonable modifications for qualified individuals with disabilities, when necessary to ensure accessibility and equal opportunity to participate in our programs, activities, services, or other benefits.

To access our language assistance services, auxiliary aids and services, and for assistance in getting a reasonable modification, please contact Customer Service at **888-977-9299**, TTY: 711. We accept all relay calls.

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 PacificSource's Section 1557 Coordinator.

Phone: **888-977-9299**, TTY: 711. We accept all relay calls. | Email: 1557Coordinator@PacificSource.com

Mail: PacificSource
PO Box 7068
Springfield, OR 97475

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

Electronically: [OCRPortal.hhs.gov](https://ocrportal.hhs.gov)

Mail: U.S. Department of Health & Human Services
200 Independence Avenue, S.W., Room 509F
Washington, D.C. 2020

**Contact our commercial
Customer Service team:**

Phone Toll-free: 888-977-9299, TTY: 711

We accept all relay calls.

Email CS@PacificSource.com

PacificSource.com

Contact our Medicare Customer Service team:

Oct. 1 – Mar. 31: 8:00 a.m. – 8:00 p.m., seven days a week

Apr. 1 – Sept. 30: 8:00 a.m. – 5:00 p.m., Monday – Friday

Phone Toll-free: 888-863-3637, TTY: 711

We accept all relay calls.

En Español: 866-281-1464

Email MedicareCS@PacificSource.com

Medicare.PacificSource.com

Notice of availability of language assistance services and auxiliary aids and services

English	ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 800-431-4135 (TTY: 800-735-2900) or speak to your provider.
አማርኛ Amharic	ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 800-431-4135 (TTY: 800-735-2900) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على وسائل أو تحدث إلى مقدم الخدمة الرقم 4135-431-800 (800-735-2900)
Bantu-Kirundi	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 800-431-4135 (TTY: 800-735-2900).
ភាសាខ្មែរ Cambodian Non-Khmer	សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ សេវាកម្មជំនួយភាសាភគគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។ ហៅទូរសព្ទទៅ 800-431-4135 (TTY: 800-735-2900) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។
中文 Simplified Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 800-431-4135（文本电话：800-735-2900）或咨询您的服务提供者。
中文 Traditional Chinese	注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 800-431-4135（TTY：800-735-2900）或與您的提供者討論。
Cushite-Oromo	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-431-4135 (TTY: 800-735-2900).
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 800-431-4135 (TTY: 800-735-2900) an oder sprechen Sie mit Ihrem Provider.

فارسی Farsi	توجه: اگر فارسی صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود تماس بگیرید یا با ارائه‌دهنده خود می‌باشند. با شماره 4135-431-800 (تله‌تایپ: 2900-735-800) صحبت کنید.
Français French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-431-4135 (ATS : 800-735-2900).
Italiano Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-431-4135 (TTY: 800-735-2900).
日本語 Japanese	注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。800-431-4135（TTY：800-735-2900）までお電話ください。または、ご利用の事業者にご相談ください。
한국어 Korean	주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 800-431-4135 (TTY: 800-735-2900) 번으로 전화하거나 서비스 제공업체에 문의하십시오.
ລາວ Laotian	ເລື່ອງລາວ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 800-431-4135 (TTY: 800-735-2900) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.
Nepali	ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 800-431-4135 (टिपिवाइ: 800-735-2900) ।
Norwegian	MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 800-431-4135 (TTY: 800-735-2900).
Pennsylvania Dutch	Wann du Deitsch (Pennsylvania German/Dutch) schwetztscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 800-431-4135 (TTY: 800-735-2900).
ਪੰਜਾਬੀ Punjabi	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੂਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। 800-431-4135 (TTY: 800-735-2900) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।
Romanian	ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 800-431-4135 (TTY: 800-735-2900).
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 800-431-4135 (TTY: 800-735-2900) или обратитесь к своему поставщику услуг.
Srpsko-hrvatski Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 800-431-4135 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 800-735-2900).

Soomaali Somali	FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 800-431-4135 (TTY: 800-735-2900) ama la hadal bixiyahaaga.
Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 800-431-4135 (TTY: 800-735-2900) o hable con su proveedor.
Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 800-431-4135 (TTY: 800-735-2900) o makipag-usap sa iyong provider.
Thai	เรียน: หากคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-431-4135 (TTY: 800-735-2900).
українська мова Ukrainian	УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 800-431-4135 (TTY: 800-735-2900) або зверніться до свого постачальника.
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 800-431-4135 (Người khuyết tật: 800-735-2900) hoặc trao đổi với người cung cấp dịch vụ của bạn.

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