# Oregon Health and Science University

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PacificSource HEALTH PLANS

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## *Introduction*

Welcome to your PacificSource student plan. Your plan includes a wide range of preventive and comprehensive dental benefits and services, and we hope you will take the time to become familiar with them.

## *Using this Student Guide*

This student guide will help you understand how your plan works and how to use it. Please read it carefully and thoroughly.

Within this guide you will find Member Benefit Schedules for your plan and any other dental benefits provided under the Policyholder's student plan. The schedules work with this guide to explain your plan benefits. The guide explains the services covered by your plan; the benefit schedules tell you how much your plan pays toward expenses and the amount for which you will be responsible.

If anything is unclear to you, the PacificSource Customer Service team is available to answer your questions. Please give us a call, visit us on the Internet, or stop by our office. We look forward to serving you.

## *Governing Law*

This student 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.


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

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

| Deductible Per Contract Year | In-network | Out-of-network |
|---|---|---|
| **Individual** | $50 | $100 |
| **Benefit Maximum Per Contract Year** | | |
| $1,500 per person. Applies to all covered services. | | |

## 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% |

| Service/Supply | In-network Member Pays | Out-of-network Member Pays |
|---|---|---|
| **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% |
| **Miscellaneous** | | |
| **Emergency office visit** | After deductible, 50% | After deductible, 50% |

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

# Additional information

## What is the deductible?

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

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

## What is the benefit maximum?

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

## Predetermination

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

# BECOMING COVERED

## ELIGIBILITY

### *Requirements for enrollment*

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

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

Enrollment changes made more than one full month after the start of a new term will be effective after the enrollment is processed. There is no prorating of premium under any circumstances. Once an eligible student makes a coverage selection under this student plan, he or she may not change his or her election unless by qualifying event.

### *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.

### *Family members*

Family members are not eligible for coverage under this student plan.

## 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 completed qualifying waiver 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.

- Special Enrollment Rule #1

  If you declined enrollment for yourself because of other dental 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.

## 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.

Summer B coverage runs from August 1, 2020 through September 21, 2020.

Fall term coverage runs from September 22, 2020 through January 3, 2021.

Winter term coverage runs from January 4, 2021 through March 28, 2021.

Spring term coverage runs from March 29, 2021 through June 30, 2021.

Spring and Summer term coverage runs from March 29, 2021 through September 21, 2021.

Summer A coverage runs from June 15, 2021 through September 21, 2021.

# GENERAL PLAN PROVISIONS

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

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

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

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

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

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

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

Only employees or agents of the Policyholder who may receive or have access to PHI are those who require the information in order to resolve claims, referral, or other benefit issues on behalf of the

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

The Policyholder certifies and agrees to the following:

- The Policyholder has sufficient administrative, physical and technical safeguards in place to protect the privacy of the PHI from any unauthorized use or disclosure in compliance with all applicable state and federal laws;
- No PHI shall be used or disclosed other than as permitted or required by this student plan or as required by law;
- Ensure that any agent agrees to the same restrictions and conditions that apply to the Policyholder with respect to such PHI;
- No PHI shall be used in employment-related actions or in connection with any other benefit or employee benefit plan of the Policyholder;
- The Policyholder has a written policy for investigating and appropriately reporting any security incidents that relate to PHI to PacificSource;
- The Policyholder shall make available PHI in accordance with HIPAA;
- The Policyholder shall make available PHI for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- The Policyholder shall make available the information required to provide an accounting of disclosure in accordance with HIPAA;
- The Policyholder shall make its internal practices, books, and records relating to the use and disclosure of PHI received from this student plan available to the Secretary for purposes of determining compliance by this student plan with the provisions of HIPAA;
- That, if feasible, Policyholder shall return or destroy all PHI received from this student plan that the Policyholder still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- The Policyholder shall ensure that the adequate separation between employees who need access to PHI to perform their assigned job functions and those who do not is established and enforced.

**Rescissions.** PacificSource may rescind a student's coverage if the student, 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 student 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 student plan terminates;
  - the last day for which any required premium has been paid;
  - the date on which the student withdraws from the school because of entering the armed forces of any country. Premiums will be refunded, on a pro-rata basis, when application is made within 30 days from withdrawal;
  - the date 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

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

# HOW TO USE YOUR PLAN

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

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

## USING THE DENTAL NETWORK

This section explains how your plan's benefits differ when you use in-network providers 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 dental care providers are independent contractors. PacificSource cannot be held liable for any claim for damages or injuries you experience while receiving dental care.

## IN-NETWORK PROVIDERS

In-network providers contract with PacificSource, directly or indirectly, to provide dental services and supplies to members enrolled in this plan for a set fee. That fee is called the contracted allowable fee. In-network providers agree not to collect more than the contracted allowable fee. In-network providers bill PacificSource directly, and we pay them directly. When you receive covered dental services or supplies from an in-network provider, you are only responsible for the amounts stated in your Schedule of Benefits. Depending on your plan, those amounts can include deductibles, co-payments, and/or co-insurance payments.

## OUT-OF-NETWORK PROVIDERS

When you receive dental services or supplies from an out-of-network provider, payment and application of benefits are as follows:

- Eligible charges considered for payment to out-of-network providers are based on the contracted allowable fee.
- PacificSource makes payment for out-of-network providers at the percentage stated in your Schedule of Benefits. As the out-of-network provider's usual charge may exceed the contracted allowable fee, the dollar amount PacificSource pays may be a lower percentage of the provider's total charge than the out-of-network provider co-insurance stated in your Schedule of Benefits.

### *Example of Provider Payment*

The following illustrates how payment could be made to providers for a covered service billed at $110 for a Class II procedure. This is only an example, your plan's benefits may be different:

| | In-network Provider | Out-of-network Provider |
|---|---|---|
| Provider's usual charge | $110 | $110 |
| Provider discount | $10 | $0 |
| PacificSource allowable fee | $100 | $90 |
| Member's co-insurance | 20% | 20% |
| PacificSource's payment | $80 | $72 |
| Member's amount of allowable fee | $20 | $18 |
| Charges above allowable fee | $0 | $20 |
| Member's total payment due to provider | $20 | $38 |
| Percent of charge paid by PacificSource | 80% | 65% |
| Percent of charge paid by member | 20% | 35% |

## FINDING IN-NETWORK PROVIDER INFORMATION

You can find up-to-date in-network provider information:

- On the PacificSource website, www.pacificsource.com/OHSU. Go to Find a Doctor or Dentist 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. If you'd like a complete provider directory for your plan, just ask. We will be glad to send you a directory free of charge.
- Ask your dental care provider if they are an in-network provider for your network.

## TERMINATION OF PROVIDER CONTRACTS

PacificSource will use best efforts 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.

Note: On the date a provider's contract with PacificSource terminates, they become an out-of-network provider and any services you receive from them will be paid at the percentage shown in the Out-of-network Provider column of your Schedule of Benefits. To avoid unexpected costs, be sure to verify each time you see your provider that they are still participating in the network. Contact our Customer Service team for additional information.

# COVERED EXPENSES

## DENTAL PLAN BENEFITS

In-network dentists agree to write off any charges over and above the negotiated, contracted fees for most services. When you use an in-network dentist, you will not be responsible for any excess charges and will pay only your plan's deductible and/or co-insurance amounts. If you choose not to use an in-network dentist, or don't have access to one, reimbursement will continue to be based on the contracted allowable fee. If that out-of-network dentist's fees exceed the contracted allowable fee, the excess charges are also your responsibility.

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 contracted allowable fee, are not covered under this plan and become your responsibility.

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

## COVERED DENTAL SERVICES

**These dental services are for enrolled individuals age 19 and older.**

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

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

## CLASS I SERVICES

- Benefits for **examinations (routine or other diagnostic exams)** are limited to two examinations per contract year. Separate charges for review of a proposed treatment plan or for diagnostic aids, such as study models and diagnostic lab tests (other than brush biopsies), are not covered. Problem focused examinations are limited to two per contract year.
- Benefits for a **full mouth series of x-rays, a cone beam x-ray, or panorex** are limited to one complete full mouth series, cone beam x-ray, or panorex in any 60 month period and further limited to four bitewing films in a six month period. When an accumulative charge for additional periapical x-rays in a one year period matches that of a complete full mouth series, no further benefits for periapical x-rays, cone beam x-rays, complete full mouth series x-rays, or panorex are available for the remainder of the year.
- Benefits for **dental cleaning (prophylaxis and periodontal maintenance)** are limited to a combined total of two procedures per contract year. The limitation for dental cleaning applies to any combination of prophylaxis and/or periodontal maintenance in the contract year. A separate charge for periodontal charting is not a covered benefit. Periodontal maintenance is not covered when performed within three months of periodontal scaling and root planing and/or curettage.
- Benefits for **fluoride (topical or varnish applications)** are limited to a combined total of four applications per contract year.
- Benefits for **brush biopsies** used to aid in the diagnosis of oral cancer are covered.

## CLASS II SERVICES

- Benefits for a **composite, resin, or similar restoration (fillings) in a posterior (back) tooth** are limited to the amount that would be paid for a corresponding amalgam restoration. A separate charge for anesthesia when used during restorative procedures is not a covered benefit. PacificSource will pay for a filling on a tooth surface only once per contract year. Three or more surface fillings are limited to one per surface per contract year.
- **Simple 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 benefit.
- Benefits for **periodontal scaling and root planing and/or curettage** are limited to only one procedure per quadrant in any 36 month period. For the purpose of this limitation, eight or fewer teeth existing in one arch will be considered one quadrant.
- Benefits for **full mouth debridement** are limited to once every 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 the prophylaxis.
- **Complicated oral surgery procedures,** such as the removal of impacted teeth, are limited to procedures that have been predetermined by PacificSource. A separate charge for alveolectomy performed in conjunction with removal of teeth is not a covered benefit.
- Benefits for **pulp capping** are payable only when there is an exposure to the pulp. These are direct pulp caps. Coverage for indirect pulp caps are covered as part of the restoration fee and are not covered as a separate charge.
- Benefits for a **pulpotomy** are payable only for deciduous teeth.
- Benefits for **root canal therapy** on the same tooth are payable only for one charge in a 36 month period.
- Benefits for **periodontal surgery** are limited to procedures that have been predetermined by PacificSource and accompanied by a periodontal diagnosis and history of conservative (non-surgical) periodontal treatment.
- Benefits for **tooth desensitization** are covered as a separate procedure from other dental treatment.
- Benefits for **general anesthesia** administered by a dentist in a dental office in conjunction with approved oral surgery procedures are covered.

## CLASS III SERVICES

- Benefits for **crowns** and other cast or laboratory-processed restorations are limited to the restoration of any one tooth in a ten year period. If a tooth can be restored with a material such as amalgam or composite resin, covered charges are limited to the cost of amalgam or non-laboratory composite resin restoration even if another type of restoration is selected by the patient and/or dentist.
- Benefits for an 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 benefit. Benefits for subsequent relines are provided only once in a 12 month period. Cast restorations for partial denture abutment teeth or for splinting purposes are not covered unless the tooth in and of itself requires a cast restoration.
- Benefits for an initial **fixed bridge or removable cast partial** are covered. Benefits for temporary full or partial dentures must be predetermined by PacificSource.
- Benefits for the **replacement of an existing prosthetic device** are provided only when the device being replaced is unserviceable, cannot be made serviceable, and has been in place for at least 60 months.

- Benefits for the surgical placement and removal of **implants** are limited to once per lifetime per tooth space. Services must be predetermined by PacificSource to be covered. 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.

There is a 36 month exclusion period for benefits for the **initial placement of full or partial dentures, fixed bridges (including acid-etch metal bridges), and implants** for the replacement of natural teeth. However, this exclusion period is waived if the natural tooth has been lost or extracted while covered under this dental plan.

# BENEFIT LIMITATIONS AND EXCLUSIONS

## EXCLUDED SERVICES

This plan does not provide benefits in any of the following circumstances or for any of the following conditions:

- Aesthetic dental procedures – Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.
- Antimicrobial agents – Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.
- Athletic activities – Any injuries sustained while competing or practicing for a professional or semiprofessional athletic contest.
- Athletic mouth guards.
- Benefits not stated – Services and supplies not specifically described as benefits under the dental plan and/or any endorsement attached hereto.
- Biopsies or histopathologic exams – A separate charge for a biopsy of oral tissue or histopathologic exam.
- Charges for missed appointments.
- Collection of cultures and specimens.
- Comprehensive periodontal exams.
- Connector bar or stress breaker.
- Core build-ups are not covered unless used to restore a tooth that has been treated endodontically (root canal).
- Cosmetic/reconstructive services and supplies – Procedures, appliances, restorations, or other services that are primarily for cosmetic purposes (does not apply to emergency services). This includes services or supplies rendered primarily to correct congenital or developmental malformations including, but not limited to, peg laterals, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia, veneers, and fluorosis (discoloration of teeth). However, the replacement of congenitally missing teeth is covered.
- Denture replacement made necessary by loss, theft, or breakage.
- Diagnostic casts – Diagnostic casts (study models) and occlusal appliances.
- Diagnostic casts – Gnathological recordings, occlusal equilibration procedures, or similar procedures.
- Drugs and medications that are prescribed drugs and take-home medicine or supplies distributed by a provider for any member. As well as premedication drugs, analgesics (for example, nitrous oxide or non-intravenous sedation), and any other euphoric drugs.

- Educational programs – Instructions and/or training in plaque control and oral hygiene.
- Expense incurred by a covered person; 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 procedures – Services, supplies, protocols, procedures, devices, drugs or medicines, or the use thereof that are experimental, investigational, or unproven for the diagnosis and treatment of the patient. An experimental, investigational, or unproven service is not made eligible for benefits by the fact that other treatment is considered by the member's dental care provider to be ineffective or not as effective as the service, or that the service is prescribed as the most likely to prolong life.
- Fractures of the maxilla and mandible – Surgery, services, and supplies provided in connection with the treatment of simple or compound fractures of the maxilla or mandible.
- General anesthesia except when administered by a dentist in connection with oral surgery in their office.
- Gingivectomy, gingivoplasty, or crown lengthening in conjunction with crown preparation or fixed bridge services done on the same date of service.
- Hospital charges or additional fees charged by the dentist for hospital treatment.
- Hypnosis.
- Indirect pulp caps are to be included in the restoration process, and are not a separate covered benefit.
- Infection control – A separate charge for infection control or sterilization.
- Intra and extra coronal splinting – Devices and procedures for intra and extra coronal splinting to stabilize mobile teeth.
- Mail order or Internet/web based provider are not eligible providers.
- Orthodontic services – Repair or replacement of orthodontic appliances furnished under this plan.
- Orthodontic services – Treatment of misalignment of teeth and/or jaws, or any ancillary services expressly performed because of orthodontic treatment.
- Orthognathic surgery – Surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship to the facial bones.
- Periodontal probing, charting, and re-evaluations.
- Periodontal splinting, night guards, or appliances used to increase vertical dimensions, restore the occlusion, or correct habits such as tongue thrust and grinding teeth. Periodontal splinting including crowns and bridgework used in conjunction with periodontal splinting.
- Photographic images.
- Pin retention in addition to restoration.
- Precision attachments.
- Pulpotomies on permanent teeth.
- Removal of clinically serviceable amalgam restorations to be replaced by other materials free of mercury, except with proof of allergy to mercury.
- Services covered by the member's medical plan.

- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth.
- Services or supplies provided by or payable under any plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law.
- Services or supplies with no charge, or for which the member is not legally required to pay, or for which a provider or facility is not licensed to provide even though the service or supply may otherwise be eligible. This exclusion includes any services provided by the member, or any licensed professional that is directly related to the member by blood or marriage.
- Services or supplies provided outside of the United States, except in cases of emergency.
- Sinus lift grafts to prepare sinus site for implants.
- Stress-breaking or habit-breaking appliances.
- Temporomandibular joint (TMJ) – Services or supplies for treatment of any disturbance of the temporomandibular joint.
- Third party liability, motor vehicle liability, motor vehicle insurance coverage, workers' compensation – Any services or supplies for illness or injury for which a third party is responsible or which are payable by such third party or which are payable pursuant to applicable workers' compensation laws, motor vehicle liability, uninsured motorist, underinsured motorist, and personal injury protection insurance and any other liability and voluntary medical payment insurance to the extent of any recovery received from or on behalf of such sources except in a situation where such exclusion is expressly prohibited by state law.
- Tooth transplantation – Services and supplies provided in connection with tooth transplantation, including re-implantation from one site to another, splinting, and/or stabilization. This exclusion does not relate to the re-implantation of a tooth into its original socket after it has been avulsed.
- Treatment after insurance ends – Services or supplies a member receives after the member's coverage under this plan ends. The only exception is for Class III Services ordered and fitted before enrollment ends and are placed within 31 days after enrollment ends.
- Treatment not dentally necessary, according to acceptable dental practice, or treatment not likely to have a reasonably favorable prognosis.
- Treatment of any illness, injury, or disease resulting from an illegal occupation or attempted felony, or treatment received while in the custody of any law enforcement other than with the local supervisory authority while pending disposition of charges.
- Treatment prior to enrollment – Dental services begun before you or your family member became eligible for those services under this plan.
- Unwilling to release information – Charges for services or supplies for which you are unwilling to release dental or eligibility information necessary to determine the benefits payable under this plan.
- War-related conditions – The treatment of any condition caused by or arising out of an act of war, armed invasion, or aggression, or while in the service of the armed forces unless not covered by the member's military or veterans coverage.

## EXCLUSION PERIODS

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

## CREDIT FOR PRIOR COVERAGE

You can receive credit toward the plan's exclusion period if you had qualifying dental coverage before enrolling in the plan. To qualify for this credit, there may not have been more than a 63 day gap between your last day of coverage under the previous dental coverage and your first day of coverage under this individual stand-alone dental plan.

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

## NECESSITY ACCORDING TO ACCEPTABLE DENTAL PRACTICE

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

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

## INDIVIDUAL BENEFITS MANAGEMENT

Individual benefits management addresses, as an alternative to providing covered services, PacificSource's consideration of economically justified alternative benefits. The decision to allow alternative benefits will be made by PacificSource on a case-by-case basis. PacificSource's determination to cover and pay for alternative benefits for a member shall not be deemed to waive, alter, or affect PacificSource's right to reject any other or subsequent request or recommendation. PacificSource may elect to provide alternative benefits if PacificSource and the member's attending provider concur in the request for and in the advisability of alternative benefits in lieu of specified covered services, and, in addition, PacificSource concludes that substantial future expenditures for covered services for the member could be significantly diminished by providing such alternative benefits under the individual benefit management program.

# CLAIMS PAYMENT

### *How to File a Claim*

When a PacificSource 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. It must also include your name, PacificSource member ID number or social security number, and the patient's name. If you were treated for an accidental injury, please include the date, time, place, and circumstances of the accident.

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

### *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.

All claims should be sent to:

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

### *Claims Payment Practices*

Unless additional information is needed to process your claim, we will make every effort to pay or deny your claim within 30 days of receipt. If a claim cannot be paid within 30 days of receipt because additional information is needed, we will acknowledge receipt of the claim and explain why payment is delayed. If we do not receive the necessary information within 15 days of the delay notice, we will either deny the claim or notify you every 45 days while the claim remains under investigation.

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

### *Questions about Claims*

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

### *Benefits Paid in Error*

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

In the same manner, if PacificSource applies dental expense to the plan deductibles that would not otherwise be reimbursable under the terms of this plan; we may deduct a like amount from the accumulated deductible amounts and/or recover payment of the dental expense that would have otherwise been applied to the deductibles. Examples of amounts recoverable under this provision include, but not limited to, services for an excluded dental condition. The fact that a dental expense was applied to the plan's deductibles does not in itself create an eligible expense or infer that benefits will continue to be provided for an otherwise excluded condition.

## COORDINATION OF BENEFITS

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

**Double Coverage**

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

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

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

**Primary or Secondary?**

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

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

**When This Plan is Primary**

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

**Your Own Expenses**

- The claim is for your own dental expenses.

**Other Situations**

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

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

**How We Pay Claims When We Are Primary**

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

**How We Pay Claims When We Are Secondary**

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

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An allowable expense is a dental care expense covered by one of the plans, including co-payments, co-insurance, and deductibles.

- If there is a difference between the amounts the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the primary plan, whichever is higher.
- We will determine our payment by calculating the amount we would have paid if we had been primary, and apply that calculated amount to any allowable expense that is left unpaid by the primary plan. We may limit our payment by any amount so that, when combined with the amount paid by the primary plan, the total benefits paid do not exceed the total allowable expense for your claim. We will credit any amount we would have paid in the absence of your other dental care coverage toward our own plan deductibles.

- If the primary plan covers similar kinds of dental care expenses, but allows expenses that we do not cover, we may pay for those expenses.
- We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain preauthorization, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

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

## THIRD PARTY LIABILITY

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

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

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

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 related to 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 dental expenses we have paid from the responsible party. PacificSource may also assign a representative to do so on your behalf. If there is a recovery, PacificSource will be reimbursed for any expenses or attorney's fees out of that recovery, as allowed by state law.
- If you receive a third party settlement, that money must be used to pay your related dental expenses incurred both before and after the settlement. If you have ongoing dental expenses after the settlement, PacificSource may deny your related claims until the full settlement (less reasonable attorney's fees) has been used to pay those expenses (with the exception of claims related to 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 extent permitted by law.

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

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

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

# COMPLAINTS, GRIEVANCES, AND APPEALS

### *Questions, Concerns, or Complaints*

PacificSource understands that you may have questions or concerns about your benefits, eligibility, the quality of care you receive, or how we reached a claim determination or handled a claim. We try to answer your questions promptly and give you clear, accurate answers.

*If you have a question, concern, or complaint about your PacificSource coverage, please contact our Customer Service 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.*

## GRIEVANCE PROCEDURES

If you are dissatisfied with the availability, delivery, or the quality of dental care services; or claims payment, handling or reimbursement for dental care services, you may file a grievance in writing. PacificSource will attempt to address your grievance, generally within 30 days of receipt. For more information, see How to Submit Grievances or Appeals section.

## APPEAL PROCEDURES

If you believe PacificSource has improperly reduced or terminated a dental care item or service, or failed or refused to provide or make a payment in whole or in part for a dental care item or service, that is based on any of the reasons listed below, you or your authorized representative (see Definitions section) may appeal (request a review) our decision. The request for appeal must be made in writing and within 180 days of the adverse benefit determination. For more information, see How to Submit Grievances or Appeals section. You may appeal if there is an adverse benefit determination based on a:

- Denial of eligibility for or termination of enrollment in a dental care plan;
- Rescission or cancellation of your plan;
- Imposition of a Third Party Liability, network exclusion, annual benefit limit, or other limitation on otherwise covered services or items;
- Determination that a dental care item or service is experimental, investigational, unproven, or not a dental necessity, effective or appropriate; or
- Determination that a course or plan of treatment you are undergoing is an active course of treatment for the purpose of continuity of care.

PacificSource staff involved in the initial adverse benefit determination will not be involved in the internal appeal.

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

You may receive continued coverage under the dental benefit plan for otherwise covered services pending the conclusion of the internal appeal process. If PacificSource makes payment for any service or item on your behalf that is later determined not to be a covered service or item, you will be expected to reimburse PacificSource for the non-covered service or item.

**Request for Expedited Response:** If there is a clinical urgency to do so, you or your authorized representative may request in writing or orally, an expedited response to an internal or external review of an adverse benefit determination. To qualify for an expedited response, your attending physician must attest to the fact that the time period for making a non-urgent benefit determination could seriously jeopardize your life, 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 care setting and with the appropriate level of care, you or your authorized representative may request an external review by an independent review organization. For more information, see How to Submit Grievances or Appeals section.

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

PacificSource may, at its discretion and with your consent, waive the requirements of compliance with the internal appeal process and have a dispute referred directly to external review. You shall be deemed

to have exhausted the internal appeal if PacificSource fails to strictly comply with its appeal process and with state and federal requirements for an internal appeal. If PacificSource fails to comply with the decision of the independent review organization assigned under Oregon law, you have a private right of action (sue) 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 toll-free (888) 877-4984

### *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 decision in response to the appeal will be made within 30 days after receiving your request to appeal.

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

### *Information Available with Regard to an Adverse Benefit Determination*

The final adverse benefit determination will include:

- A reference to the specific internal rule or guideline PacificSource used in the adverse benefit determination; and
- An explanation of the scientific or clinical judgment for the adverse benefit determination, if the adverse benefit determination is based on dental necessity, experimental, investigational, or unproven treatment, or a similar exclusion.

Upon request, PacificSource will provide you with any additional documents, records or information that is relevant to the adverse benefit determination at no cost.

## HOW TO SUBMIT GRIEVANCES OR APPEALS

Before submitting a grievance or appeal, we suggest you contact our Customer Service team with your concerns. You can reach us by phone or email using the contact information found on the first page of this student guide. Issues can often be resolved at this level. Otherwise, you may file a grievance or appeal by contacting:

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

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

Fax (541) 225-3628

If you are unsure of what to say or how to prepare an appeal or grievance, please contact our Customer Service team. We will help you through these processes and answer any questions you have.

### *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 toll-free (888) 877-4894

Email: DFR.InsuranceHelp@oregon.gov

Website dfr.oregon.gov

# RESOURCES FOR INFORMATION AND ASSISTANCE

### *Assistance in Other Languages*

PacificSource members who do not speak English may contact our Customer Service team for assistance. We can usually arrange for a multilingual staff member or interpreter to speak with them in their native language.

### *Information Available from PacificSource*

PacificSource makes the following written information available to you free of charge. You may contact our Customer Service team to request any of the following:

- A directory of dental 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 description (consistent with risk-sharing information required by the Centers for Medicare and Medicaid Services, formerly known as Health Care Financing Administration), of any risk-sharing arrangements we have with providers;
- A description of our efforts to monitor and improve the quality of dental services;
- Information about how we check the credentials of our network providers and how you can obtain the names and qualifications of your dental providers;
- Information about our predetermination and utilization review procedures; or
- Information about any dental plan offered by PacificSource.

### *Information Available from the Division of Financial Regulation about PacificSource*

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

- The results of all publicly available accreditation surveys;
- A summary of our health promotion and disease prevention activities;
- Samples of the written summaries delivered to PacificSource policyholders;
- An annual summary of grievances and appeals against PacificSource;
- An annual summary of our utilization review policies;
- An annual summary of our quality assessment activities; and
- An annual summary of the scope of our provider network and accessibility of dental 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 toll-free (888) 877-4894

Email: DFR.InsuranceHelp@oregon.gov

Website dfr.oregon.gov

## FEEDBACK AND SUGGESTIONS

*As a PacificSource member, you are encouraged to help shape our corporate policies and practices. We welcome any suggestions you have for improving your plan or our services.*

You may send comments or feedback using the Contact Us form on our website, www.pacificsource.com/OHSU. You may also write to us at:

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

# RIGHTS AND RESPONSIBILITIES

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

### *Your Rights as a Member:*

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

### *Your Responsibilities as a Member:*

- You are responsible for reading this student guide and all other communications from PacificSource, and for understanding your plan's benefits. You are responsible for contacting our Customer Service team if anything is unclear to you.
- You are responsible for making sure your provider obtains predetermination for any services that require it before you are treated.
- You are responsible for providing PacificSource with all the information required to provide benefits under your plan.
- You are responsible for giving your dental care provider complete health information to help accurately diagnose and treat you.
- You are responsible for telling your providers you are covered by PacificSource and showing your member ID card when you receive care.
- You are responsible for being on time for appointments, and calling your provider ahead of time if you need to cancel.
- You are responsible for any fees the provider charges for late cancellations or no shows.
- You are responsible for contacting PacificSource if you believe you are not receiving adequate care.
- You are responsible for supplying information to the extent possible that PacificSource needs in order to administer your benefits or your dental providers need in order to provide care.
- You are responsible for following plans and instructions for care that you have agreed to with your doctors.
- 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 your dental records. Your personal information is only available to the PacificSource staff members who need that information to do their jobs.

Disclosure outside PacificSource is allowed only when necessary to provide your coverage, or when otherwise allowed by law. Except when certain statutory exceptions apply, state law requires us to have written authorization from you (or your representative) before disclosing your personal information outside PacificSource. An example of one exception is that we do not need written authorization to disclose information to a designee performing utilization management, quality assurance, or peer review on our behalf. To request receipt of confidential communications in a different manner or at a different address, you will need to complete and return the form provided at PacificSource.com/member/oregon/forms-and-materials.aspx.

# PLAN ADMINISTRATION

### *Insurance Contract*

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

Our address is:

PacificSource Health Plans

PO Box 7068
Springfield, OR 97475-0068

### *Legal Procedures*

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

# DEFINITIONS

*Wherever used in this plan, the following definitions apply to the masculine and feminine, and singular and plural forms of 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.

**Adverse benefit determination** means PacificSource's denial, reduction, or termination of a dental care item or service, or PacificSource's failure or refusal to provide or to make a payment in whole or in part for a dental care item or service that is based on PacificSource's:

- Denial of eligibility for or termination of enrollment in a dental plan;
- Rescission or cancellation of a plan or coverage;
- Imposition of a Third Party Liability, network exclusion, annual benefit limit, or other limitation on otherwise covered services or items;
- Determination that a dental care item or service is experimental, investigational, unproven, or not a dental necessity, effective, or appropriate; or
- Determination that a course or plan of treatment that a member is undergoing is an active course of treatment for purposes of continuity of care.

**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 allowable fee. Depending on the service or supply and the geographical area in which it is provided, the allowable fee may be based on data collected from 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 definition allowable fee. Charges that are eligible for reimbursement, but exceed the allowable fee, are the member's responsibility. For more information, see Out-of-network Providers section.

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

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

**Appeal** means a written or verbal request from a member or, if authorized by the member, the member's representative, to change a previous decision made by PacificSource concerning:

- Access to dental care benefits, including an adverse benefit determination made pursuant to utilization management;
- Claims payment, handling or reimbursement for dental care services;
- Rescissions of member's benefit coverage by PacificSource; and
- Other matters as specifically required by law.

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

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

- Eligibility and coverage determinations (including coordination of benefits), and adjudication or subrogation of dental benefit claims;
- Review of dental care services with respect to dental necessity (including underlying criteria), coverage under the dental plan, appropriateness of care, experimental, investigational, or unproven treatment, justification of charges; and
- Utilization review activities, including precertification and predetermination of services and concurrent and retrospective review of services.

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

**Co-insurance** means a defined percentage of the allowable fee or usual, customary, and reasonable fee for covered services and supplies the member receives. It is the percentage the member is responsible for, not including co-pays and deductibles. The co-insurance amounts the member is responsible for are listed in your Schedule of Benefits.

**Complaint** means an expression of dissatisfaction directly to PacificSource that is about a specific problem encountered by a member, or about a benefit determination by PacificSource, or an agent acting on behalf of PacificSource. It includes a request for action to resolve the problem or change the benefit determination. The complaint does not include an inquiry.

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

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

**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.

**Co-payment** (also referred to as co-pay) is a fixed, up-front dollar amount the member is required to pay for certain covered services. The co-pay applicable to a specific covered service is listed under that specific benefit in your Schedule of Benefits.

**Covered expense** is an expense for which benefits are payable under this plan subject to applicable deductibles, co-payments, co-insurance, out-of-pocket limit, or other specific limitations.

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

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

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

**Deductible** means the portion of the dental expense that must be paid by the member before the benefits of this plan are applied. A plan may include more than one deductible.

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

**Dentally necessary** 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 dentist opinion published in peer-reviewed dental literature, or the results of clinical outcome trials published in peer-reviewed dental literature;
- As likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any other service or supply, both as to the disease or injury involved and the patient's overall health condition;
- Not for the convenience of the member or a provider of services or supplies; and
- The least costly of the alternative services or supplies that can be safely provided.

The fact that a dentist may recommend or approve a service or supply does not, of itself, make the charge a covered expense.

**Dental Provider or Dentist** means a licensed doctor of dental surgery (D.D.S.) or a licensed doctor of medical dentistry (D.M.D.).

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

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

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

**Experimental, investigational, or unproven procedures** 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, injury, or disease.

- 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, unproven, or clinical testing;
  - Are not of generally accepted dental practice in your plan's state of issue or as determined by dental advisors, dental associations, and/or technology resources;

  - Are not approved for reimbursement by the Centers for Medicare and Medicaid Services;
  - Are furnished in connection with dental or other research; or
  - Are considered by any governmental agency or subdivision to be experimental, investigational, unproven, not considered reasonable and necessary, or any similar finding.
- When making decisions about whether treatments are experimental, investigational, or unproven, PacificSource relies on the above resources as well as:
  - Expert opinions of specialists and other dental authorities;
  - Published articles in peer-reviewed dental literature;
  - External agencies whose role is the evaluation of new technologies and drugs; and
  - External review by an independent review organization.
- The following will be considered in making the determination whether the service is in an experimental, investigational, or unproven status:
  - Whether there is sufficient evidence to permit conclusions concerning the effect of the services on health outcomes;
  - Whether the scientific evidence demonstrates that the services improve health outcomes as much or more than established alternatives;
  - Whether the scientific evidence demonstrates that the services' beneficial effects outweigh any harmful effects; and
  - Whether any improved health outcomes from the services are attainable outside an investigational setting.

**External appeal** or review means the request by an appellant for an independent review organization to determine whether or not PacificSource's internal appeal decisions are correct.

**Grievance** means:

- A written complaint submitted by a member or an authorized representative of a member regarding:
  - The availability, delivery, or quality of a dental care service; or
  - Claims payment, handling or reimbursement for dental care services and, unless the member has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination.

**In-network provider** means a dentist, oral surgeon, endodontist, orthodontist, periodontist, pedodontist, denturist, or dental hygienist that directly or indirectly holds a provider contract or agreement with PacificSource.

**Incurred expense** means charges of a dental provider for services or supplies for which the member becomes obligated to pay. The expense of a service is incurred on the day the service is rendered, and the expense of a supply is incurred on the day the supply is delivered.

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

**Internal appeal** means a review by PacificSource of an adverse benefit determination made by PacificSource.

**Member** means an individual insured under a PacificSource dental plan.

**Out-of-network provider** is a provider of covered dental services or supplies that does not directly or indirectly hold a provider contract or agreement with PacificSource.

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

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

**Periodontal scaling and root planing** means the removal of plaque and calculus deposits from the root surface under the gum line.

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

**Prophylaxis** is a cleaning and polishing of all teeth.

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

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

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

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

**Schedule of Benefits** is a summary of the plan issued or applied for, not a contract of insurance that includes a list of principle benefits and coverages, and a statement of the limitations and exclusions contained in the plan.

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

**Usual, customary, and reasonable fee (UCR)** is the fee based on charges being made by dental providers in the same service area for similar treatment of similar dental conditions. A usual, customary, and reasonable fee is based on provider billing data gathered by PacificSource and adjusted to the 85$^{th}$ percentile. Usual, customary, and reasonable fees are reviewed by PacificSource annually.

## Contact us.

| | |
|---|---|
| Idaho: | (208) 333-1596 \| (800) 688-5008 |
| Montana: | (406) 442-6589 \| (877) 590-1596 |
| Oregon: | (541) 684-5582 \| (888) 977-9299 |
| TTY: | (800) 735-2900 |
| En Español: | (541) 684-5456 \| (800) 624-6052, ext. 1009 |
| Email: | cs@pacificsource.com |
| Web: | PacificSource.com |

### Your privacy is important to us.

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

## Discrimination Is Against the Law

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

**PacificSource:**

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

If you need these services, contact Customer Service at (888) 977-9299 or, for TTY users, (800) 735-2900, 7:00 a.m. to 5:00 p.m.

If you believe that PacificSource has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Civil Rights Coordinator, PO Box 7068, Springfield, OR 97475-0068, (888) 977-9299, TTY 711, fax (541) 684-5264, or email crc@pacificsource.com. Please indicate you wish to file a civil rights grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the PacificSource Customer Service Department is available to help you.

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

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

Complaint forms are available at HHS.gov/ocr/office/file/index.html.

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| Arabic | اتموﻟﻌﻤﻟا وﺔﻋاﺴﻤﻟا ىﻠﻋ لوﺼﺤﻟا يﻓ قﺤﻟا كﻴدﻠﻟ ، PacificSource Health Plans صوﺼﺨﺑ ﺔﻠﺋأﺴﻟ ﺔﻋاﺴﺘﻟ ﺺﺨﺷ ىدﻟ وأ كﻴدﻠﻟ نﺎﻛ نإ. (888) 977-9299 ﺑ ﻞﺼﺗا ﻢﺟرﺘﻤﻟ ﻊﻣ ثدﺤﺘﻠﻟ ﺔﻔﻠﻜﺘﻟا. ﺔﻳاﻮﻏ نود ﻦﻣ ﻚﺘﻐﻠﺑ ﺔﻳرورﻀﻟا |
| Cambodian-Mon-Khmer | ប្រសិនបើអ្នក ឬនរណាម្នាក់ ដែលអ្នកកំពុងជជែក ជាមួយ PacificSource Health Plans បាន, អ្នកមានសិទ្ធិស្នើសុំជំនួយនិងព័ត៌មាន បានៅក្នុងភាសា ដែលអ្នក បានិយាយមិនអស់ហ្មត់ ។ បើមិនបានិយាយជាមួយអ្នកតាងប្រ សូម (888) 977-9299. |
| Chinese | 如果您，或是您正在協助的對象，有關於[插入 SBM 項目的名稱 PacificSource Health Plans 方面的問題，您 有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入数字 (888) 977-9299. |
| Cushite-Oromo | Isin yookan namni biraa isin deeggartan PacificSource Health Plans irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa (888) 977-9299 tiin bilbilaa. |

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| French | Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de PacificSource Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez (888) 977-9299. |
| German | Falls Sie oder jemand, dem Sie helfen, Fragen zum PacificSource Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer (888) 977-9299 an. |
| Japanese | ご本人様、またはお客様の身の回りの方でもPacificSource Health Plans についてご質問がございました ら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。 通訳とお話される場合、(888) 977-9299までお電話ください。 |
| Korean | 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 PacificSource Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 (888) 977-9299로 전화하십시오. |
| Persian-Farsi | مي‌کني‌د ، سوال در مورد PacificSource Health Plans ، داشته‌باشي‌د حق اين را داري‌د که کمک دريافت نمايي‌د.(888) 977-9299 تماس حاصل نمايي‌د. اگر شما، يا کسی که شما به او کمک و اطلاعات به زبان خود را به طور رايگان |
| Romanian | Dacă dumneavoastră sau persoana pe care o asistați aveți întrebări privind PacificSource Health Plans, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la (888) 977-9299. |
| Russian | 1Если у вас или лица, которому вы помогаете, имеются вопросы по поводу PacificSource Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону (888) 977-9299. |
| Spanish | Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de PacificSource Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al (888) 977-9299. |
| Thai | หากคณุ หรือคนทีคณก าลงช่วยเหลือมีค าถามเกียวกบั PacificSource Health Plans คณมีสิทธิทีจะได้รับความช่วยเหลือและข้อมลในภาษาของคณได้โดยไม่มีค่าใช้จ่าย พดคยุ กบลาม โทร (888) 977-9299. |
| Ukrainian | Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про PacificSource Health Plans, у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть на (888) 977-9299. |
| Vietnamese | Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về PacificSource Health Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi (888) 977-9299. |