



UNIVERSITY
OF OREGON

**UO Student Health Benefits Plan
Student Guide**

Group No.: G0033725

Comprehensive Medical - Domestic

Effective: 08/10/2025

With Third Party Administrative Services Provided By:



Introduction

Welcome to your Student Health Benefits Plan. The University of Oregon established the UO Student Health Benefits Plan (referred to as the “Student Plan”) to provide health coverage to help you stay well and assist you in case of illness, injury, or disease. We encourage you to familiarize yourself with the wide range of benefits and services offered by this Student Plan.

Any words or phrases used in this student guide that appear with an initial capital letter, are defined terms. All such words or phrases are defined in the Definitions Section (see the Table of Contents for exact location). The University of Oregon highly encourages you to read this student guide in its entirety and to ask any questions you may have to ensure you understand your rights, responsibilities, and the benefits available to you under the terms of this Student Plan.

Using this Student Guide

This student guide will help you understand how this Student Plan works and how to use it. Please read it carefully and thoroughly.

Within this guide you will find Member Benefit Summaries for your medical plan and any other health benefits provided under the University of Oregon’s Student Plan. The summaries work with this guide to explain this Student Plan. The guide explains the services covered by this Student Plan; the Benefit Summaries tell you how much this Student Plan pays toward expenses and the amount for which you will be responsible.

The UO Student Health Benefits Plan team is available to answer your questions about eligibility, general plan design, and enrollment/termination (call 541-346-2832 or stop by University Health Services). The customer service team at PacificSource is also available to answer questions about Providers, benefits, prior authorizations, and specific claims questions. To contact PacificSource Customer Service, call 1-855-274-9814.

Nature of this Student Plan

This Student Plan is not an employee welfare benefit plan or an employer-sponsored plan. This Student Plan is not governed by the Employee Retirement Income Security Act (“ERISA”).

This Student Plan is “self-insured,” which means benefits are paid by the University of Oregon and are not guaranteed by a separate insurance company. The University of Oregon, which is also the Plan Administrator, has contracted with the Third Party Administrator to perform certain administrative services related to this Student Plan.

PacificSource Health Plans (“PacificSource”) is the Third Party Administrator and will process Claims, manage its network of Health Care Providers, answer medical benefit and Claim questions, and generally provide administrative services to this Student Plan.

As used in this student guide, the word ‘year’ refers to the Student Plan’s Contract Year, as follows: UO Law Students – August 10, 2025 to August 9, 2026 and UO Students (Undergraduate/Non-Law Graduate Students) – September 15, 2025 to September 14, 2026. The word ‘lifetime’ as used in this student guide refers to the period of time you participate in this Student Plan or any other Student Plan offered by the University of Oregon.

Representations not warranties: In the absence of fraud, all statements made by the University of Oregon with respect to this Student Plan will be considered representations and not warranties. No statement made for the purpose of effecting coverage will void the coverage or reduce benefits unless it is contained in a written document signed by the University of Oregon and provided to a Student.

Retention of Fiduciary Duties

The University of Oregon has retained all fiduciary duties under this Student Plan, including all interpretations of this Student Plan and the eligibility, benefits, and exclusions it contains. This means that the University of Oregon is solely responsible for all final decisions regarding what benefits are or will be covered, both now and in the future. The University of Oregon is solely responsible for the design of this Student Plan. The University of Oregon is solely responsible for setting any and all criteria used to determine enrollment and eligibility.

Governing Law

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

Questions?

If you have any questions, please contact the Student Health Benefits Team or PacificSource Customer Service staff. Please give them a call, visit them on the Internet, or stop by their offices.

UO Student Health Benefits Team

General Questions on Eligibility, Enrollment, Plan Design, Premiums:
1-541-346-2832

Website

Health.uoregon.edu/insurance

PacificSource Customer Service Team

Specific Questions on Claims, Provider Network, Benefits, etc.:
1-855-274-9814

PacificSource Headquarters

555 International Way, Springfield, OR 97477
PO Box 7068, Springfield, OR 97475-0068
Phone 541-686-1242 or 888-977-9299

Website

PacificSource.com/uo

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

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MEDICAL BENEFIT SUMMARY

Comprehensive Medical Plan
Domestic Students

Benefit Year: UO Law Students: 8/10/2025 to 8/9/2026
UO Students (Undergraduate/Non-Law Graduate): 9/15/2025 to 9/14/2026

Who is eligible? University of Oregon Guidelines

Provider Network: UO Exclusive Network and Navigator Network

University Health Services (UHS):

University Health Services is considered an In-Network Provider for Covered Services.
Services provided by University Health Services (UHS) are covered per University guidelines. Note: UO Students who are eligible to receive services at Portland State University - Center for Student Health and Counseling (SHAC) will receive the same level of benefits as those received at University Health Services (UHS). To receive this benefit, these Students must print an itemized statement from the SHAC Patient Portal and mail it to PacificSource (mail to: PacificSource Health Plans, Attn: Claims, P.O. Box 7068, Springfield, OR 97475-0068) for reimbursement.

Annual Deductible	Per Person, Per Benefit Year
University Health Services	None
UO Exclusive Network & Navigator Network (In-network Providers)	\$300
Out-of-network Providers	\$1,000
Out-of-Pocket Limit	Per Person, Per Benefit Year
UHS, UO Exclusive Network, and Navigator Network (In-network Providers)	\$5,000
Out-of-network Providers	\$10,000

Please note: Your actual costs for services provided by an Out-of-network Provider may exceed this Student Plan’s out-of-pocket limit for out-of-network services. In addition, Out-of-network Providers may in certain situations bill you for the difference between the amount charged by the Provider and the amount allowed by the Student Plan (called Balance Billing), and this amount is not counted toward the out-of-network out-of-pocket limit. Even though you may have the same benefit for In-network and Out-of-network Providers, you may still be responsible for any amounts that an Out-of-network Provider charges that are over the Plan’s Allowable Fee. Please see Allowable Fee and Balance Billing in the definitions section of this student guide.

In-network Provider Deductible and out-of-pocket limit accumulates separately from the Out-of-network Provider Deductible and out-of-pocket limit.

The Member is responsible for the above Deductible and the following amounts:

Service	University Health Services:	UO Exclusive Network (In-network Providers):	Navigator Network (In-network Providers):	Out-of-network Providers:
Preventive Care				
Well child exams, ages birth - 21	Not available	No Deductible, No charge	No Deductible, No charge	Not Covered
Preventive physicals	No Deductible, No charge	No Deductible, No charge	No Deductible, No charge	Not Covered
Preventive STD screening	No Deductible, No charge	No Deductible, No charge	No Deductible, No charge	Not Covered
Well woman visits	No Deductible, No charge	No Deductible, No charge	No Deductible, No charge	Not Covered
Preventive mammograms	Not available	No Deductible, No charge	No Deductible, No charge	Not Covered
Immunizations	No Deductible, No charge	No Deductible, No charge	No Deductible, No charge	Not Covered
Preventive colonoscopy	Not available	No Deductible, No charge	No Deductible, No charge	Not Covered
Professional Services				
Office and home visits	No Deductible, No charge	First three visits, no Deductible, \$5. Subsequent visits, no Deductible, \$25 Copay/visit***	First three visits, no Deductible, \$5. Subsequent visits, no Deductible, \$40 Copay/visit***	Deductible then 50% Coinsurance
Naturopath office visits	Not available	Not available	No Deductible, \$40 Copay/visit	Deductible then 50% Coinsurance
Specialist office and home visits	No Deductible, No charge	No Deductible, \$35 Copay/visit	No Deductible, \$50 Copay/visit	Deductible then 50% Coinsurance
Telehealth	No Deductible, No charge	First three visits, no Deductible, \$5. Subsequent visits, no Deductible, \$25 Copay/visit***	First three visits, no Deductible, \$5. Subsequent visits, no Deductible, \$40 Copay/visit***	Deductible then 50% Coinsurance
Office procedures and supplies	No Deductible, No charge	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Surgery	No Deductible, No charge	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Outpatient Rehabilitation Services	No Deductible, No charge	No Deductible, \$25 Copay/visit	No Deductible, \$40 Copay/visit	Deductible then 50% Coinsurance

Service	University Health Services:	UO Exclusive Network (In-network Providers):	Navigator Network (In-network Providers):	Out-of-network Providers:
Outpatient Habilitation Services	No Deductible, No charge	No Deductible, \$25 Copay/visit	No Deductible, \$40 Copay/visit	Deductible then 50% Coinsurance
Hospital Services				
Inpatient room and board	Not available	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Inpatient Rehabilitation Services	Not available	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Inpatient Habilitation Services	Not available	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Skilled Nursing Facility care	Not available	Not available	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Outpatient Services				
Outpatient surgery/services	Not available	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Advanced Diagnostic Imaging (advanced)	No Deductible, No charge	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Diagnostic and therapeutic radiology/laboratory and dialysis – (non-advanced)	No Deductible, No charge+	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Urgent and Emergency Services				
Urgent care center visits	Not available	No Deductible, \$50 Copay/visit	No Deductible, \$75 Copay/visit	Deductible then 50% Coinsurance
Emergency room visits – medical emergency	Not available	No Deductible, \$300 Copay/visit^	No Deductible, \$300 Copay/visit^	No Deductible, \$300 Copay/visit^
Emergency room visits – non-emergency	Not available	No Deductible, \$300 Copay/visit then 10% Coinsurance^	No Deductible, \$300 Copay/visit then 20% Coinsurance^	Deductible then 50% Coinsurance

Service	University Health Services:	UO Exclusive Network (In-network Providers):	Navigator Network (In-network Providers):	Out-of-network Providers:
Ambulance, ground	Not available	No Deductible, \$300 Copay/trip then 10% Coinsurance	No Deductible, \$300 Copay/trip then 20% Coinsurance	Deductible then 50% Coinsurance
Ambulance, air	Not available	Not available	No Deductible, \$300 Copay/trip then 20% Coinsurance	Deductible then 50% Coinsurance
Maternity Services **				
Provider services (Global Charge)	Not available	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Hospital/Facility services	Not available	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Mental Health and Substance Use Disorder Services*				
Office visits	No Deductible, No charge	First three visits, no Deductible, \$5. Subsequent visits, no Deductible, \$25 Copay/visit***	First three visits, no Deductible, \$5. Subsequent visits, no Deductible, \$40 Copay/visit***	Deductible then 50% Coinsurance
Inpatient care	Not available	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Residential programs	Not available	Not available	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Other Covered Services				
Allergy injections	Not available	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Durable Medical Equipment	No Deductible, No charge+	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Home Healthcare	Not available	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Acupuncture	No Deductible, No charge	No Deductible, \$25 Copay/visit	No Deductible, \$40 Copay/visit	Deductible then 50% Coinsurance
Chiropractic manipulation/spinal manipulation	Not available	Not available	No Deductible, \$40 Copay/visit	Deductible then 50% Coinsurance
Transplants	Not available	Not available	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance

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

^ Copay applies to ER Provider and facility charges only. Copay waived if admitted into Hospital.

** Medically Necessary services, medication, and supplies to manage diabetes during pregnancy from conception through six weeks postpartum will not be subject to a Deductible, Copayment, or Coinsurance.

+ Some services at UHS are provided by a partner entity. If a Student receives a service through these external partners, the Student will receive a bill directly from that partner entity and normal Deductibles and Copays and/or Coinsurance will apply according to the tiered benefits noted above.

* This Student Plan complies with all federal laws and regulations related to the Mental Health Parity and Addiction Equity Act of 2008. Cost-sharing for Mental Health and Substance Use Disorder Services will be paid at the same cost-sharing as those Medical/Surgical benefits that fall within the same classification and sub-classification. Please contact the PacificSource Customer Service Team or the UO Student Health Benefits Team with questions.

*** First three visits per Benefit Year combined for Professional Services – Office and Home Visits, Telehealth Visits, and Mental Health and Substance Use Disorder Services – Office Visits.

Additional information

What is the annual Deductible?

This Student Plan's Deductible is the amount of money that you pay first, before this Student Plan starts to pay. You'll see that many services, especially preventive care, are covered by the Student 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.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for Covered Services during the Benefit Year. Once the out-of-pocket limit has been met, the Student Plan will pay 100 percent of allowed amounts for Covered Services for the rest of that Benefit Year.

Note that there is a separate category for In-network and Out-of-network Providers when it comes to meeting your out-of-pocket limit. Only In-network Provider expense applies to the In-network Provider out-of-pocket limit, and only Out-of-network Provider expense applies to the Out-of-network Provider out-of-pocket limit.

Payments to Providers

Payment to Providers is based on the prevailing Allowable Fee for Covered Services. In-network Providers accept the Allowable Fee as payment in full. Out-of-network Providers are allowed to Balance Bill any remaining balance that your Student Plan did not cover. Services of Out-of-network Providers could result in out-of-pocket expense in addition to the percentage indicated above.

Prior authorization

Coverage of certain medical 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 Student Plan, and if you meet the Student Plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense for In-network and Out-of-network Providers. You'll find the most current prior authorization list on our website, [PacificSource.com/uo](https://www.pacificsource.com/uo).

Discrimination is against the law

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

PHARMACY BENEFIT SUMMARY

Comprehensive Pharmacy Plan Domestic Students

Benefit Year: UO Law Students: 8/10/2025 to 8/9/2026

UO Students (Undergraduate/Non-Law Graduate): 9/15/2025 to 9/14/2026

Formulary: Oregon Drug List (ODL)

This Student Plan includes coverage for Prescription Drugs and certain other pharmaceuticals, subject to the information below. This benefit includes some drugs required by federal healthcare reform. To check which tier your prescription falls under, call PacificSource Customer Service or visit PacificSource.com/uo.

The amount you pay for covered prescriptions at in-network pharmacies applies toward this Student Plan's in-network medical out-of-pocket limit, which is shown on the Medical Benefit Summary. The Copayment and/or Coinsurance for Prescription Drugs obtained from an in-network pharmacy are waived during the remainder of the Benefit Year in which you have satisfied the medical out-of-pocket limit.

Affordable Care Act Standard Preventive No-cost Drug List

The prescription benefit includes preventive care drugs at no cost and are not subject to a Deductible or MAC penalties when filled at an in-network pharmacy. This benefit includes some drugs required by the Affordable Care Act, including tobacco cessation drugs. These drugs are identified on the Drug List as Tier 0.

PacificSource Expanded (Preventive) No-cost Drug List

The prescription benefit includes certain outpatient drugs as a preventive benefit at no charge. This includes specific drugs that are taken regularly to prevent a disease or to keep a specific disease or condition from progressing. Preventive drugs are taken to help avoid many illnesses and conditions. You can get a list of covered preventive drugs by contacting the PacificSource Customer Service team or visit PacificSource.com/uo to view the PacificSource Expanded (Preventive) No-Cost Drug List.

Contraceptives

Contraceptives approved by the Food and Drug Administration (FDA) are covered as recommended by the Health Resources and Services Administration (HRSA), U.S. Preventive Services Task Force (USPSTF), and the Centers for Disease Control and Prevention (CDC). Any Deductibles, Copayments, and/or Coinsurance amounts are waived if a Generic Drug is filled at an in-network pharmacy. When no Generic Drug exists, brand name contraceptives may be covered at no cost. If your provider prescribes a non-formulary contraceptive due to Medical Necessity, it may be subject to exception review for coverage at no charge.

If an initial three month supply is tried, then a 12 month refill of the same contraceptive is covered at an in-network pharmacy in accordance with pharmacy benefits, regardless if the initial prescription was filled under this Student Plan.

Each time a covered prescription is dispensed, you are responsible for the amounts below:

Service/Supply	Preventive Drugs:	Tier 1:	Tier 2:	Tier 3:	Tier 4:
University Health Services Pharmacy (UHS)					
Up to a 30 day supply:	No Deductible, No charge	No Deductible, \$10 Copay>*	No Deductible, \$25 Copay*	No Deductible, \$50 Copay*	Deductible then 50% Coinsurance
In-network Retail Pharmacy					
Up to a 30 day supply:	No Deductible, No charge	No Deductible, \$15 Copay*	No Deductible, \$50 Copay*	No Deductible, \$75 Copay*	Deductible then 50% Coinsurance
In-network Mail Order Pharmacy					
Up to a 30 day supply:	No Deductible, No charge	No Deductible, \$15 Copay*	No Deductible, \$50 Copay*	No Deductible, \$75 Copay*	Deductible then 50% Coinsurance
Out-of-network Pharmacy					
Regardless of tier or day(s) supply:	Not Covered				
Compound Drugs – In-network Retail or Mail Order Pharmacy**					
Up to a 30 day supply:	Deductible then 50% Coinsurance				

>Select medications available for a 90 day supply.

* Prescription insulin is not subject to a Deductible and is limited to \$35 per 30 day supply when filled at an in-network pharmacy.

**Compounded medications are subject to a prior authorization process. Compounds are generally covered only when all commercially available formulary products have been exhausted and all the ingredients in the compounded medications are on the applicable formulary.

Specialty Medications are covered for the first fill via in-network retail pharmacy and UHS. All subsequent fills must be done through the in-network Specialty Pharmacy Providers. Specialty Medications are limited to a 30 day supply.

MAC B - Unless the prescribing Provider requires the use of a brand name drug, the prescription will automatically be filled with a Generic Drug when available and permissible by state law. If you receive a brand name drug when a Generic is available, you will be responsible for the brand name drug's Copayment and/or Coinsurance plus the difference in cost between the brand name drug and its Generic equivalent. If your prescribing Provider requires the use of a brand name drug, the prescription will be filled with the brand name drug and you will be responsible for the brand name drug's Copayment and/or Coinsurance. The cost difference between the brand name and Generic Drug does not apply toward the medical out-of-pocket limit. This does not apply to formulary tobacco cessation medications or bowel prep kits covered under USPSTF guidelines.

See the student guide for important information about your Prescription Drug benefit, including which drugs are covered, limitations, and more.

PEDIATRIC VISION BENEFIT SUMMARY

Pediatric Vision

Benefit Year: UO Law Students: 8/10/2025 to 8/9/2026

UO Students (Undergraduate/Non-Law Graduate): 9/15/2025 to 9/14/2026

The following shows the vision benefit available under this Student Plan for all vision exams, lenses, and frames when performed or prescribed by a licensed ophthalmologist or licensed optometrist. Coverage for pediatric services will end on the last day of the month in which the enrolled Member turns 19. Medical Deductible, Copayment and/or Coinsurance for Covered Services apply to the medical out-of-pocket limit.

Service/Supply	In-network Providers	Out-of-network Providers:
Enrolled Members Age 18 and Younger		
Eye exam	No Deductible, No charge	Medical Deductible then 25% Coinsurance
Vision hardware or Contact Lenses	No Deductible, No charge for one pair per Benefit Year for frames or lenses	Medical Deductible then 25% Coinsurance for frames or lenses

Benefit Limitations: enrolled Members age 18 and younger

- One routine ophthalmologic exam with refraction, as well as dilation every Benefit Year.
- One pair of glasses (lenses and frames) per Benefit Year or contacts (lenses and fitting) in lieu of eyeglasses.
 - Lens coverage includes the following:
 - Glass or plastic lenses;
 - All lens powers (single vision, bifocal, trifocal, lenticular); and
 - Fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses, as well as polycarbonate lenses, anti-reflective and scratch resistant coatings.
 - Contact lens coverage includes the following:
 - Medically Necessary contact lenses for Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, Irregular Astigmatism; and
 - Low Vision services.

Exclusions

- Lenses, frames, or contact lenses, for enrolled Members age 19 and older.
- Special procedures such as orthoptics or vision training.
- Special supplies such as non-prescription sunglasses and subnormal vision aids.

- Plano contact lenses.
- Replacement of lost, stolen, or broken lenses or frames.
- Duplication of spare eyeglasses or any lenses or frames.
- Non-prescription lenses.
- Visual analysis that does not include refraction.
- Services or supplies not listed as Covered Services.
- Eye exams required as a condition of employment, required by a labor agreement or government body.
- Expenses covered under any worker's compensation law.
- Services or supplies received before this plan's coverage begins or after it ends.
- Charges for services or supplies covered in whole or in part under any medical or vision benefits provided by the employer.
- Medical or surgical treatment of the eye.

Important information about the vision benefits

This Student Plan includes coverage for vision services. To make the most of those benefits, it is important to keep in mind the following:

In-network Providers

PacificSource is able to add value to the vision benefits by contracting with a network of vision Providers. Those Providers offer vision services at discounted rates, which are passed on to Members in the benefits.

Paying for Services

Members should remember to show their current PacificSource ID card whenever they use their vision benefits. The PacificSource Provider contracts require In-network Providers to bill PacificSource directly whenever Members receive Covered Services and supplies. Providers will verify Member vision benefits. In-network Providers should not ask Members to pay the full cost in advance. They may only collect the member's share of the expense up front, such as Copayments and amounts over the Student Plan's allowances. If Members are asked to pay the entire amount in advance, they should tell the Provider they understand the Provider has a contract with PacificSource and the Provider should bill PacificSource directly.

Sales and Special Promotions

Vision retailers often use coupons and promotions to bring in new business, such as free eye exams, two-for-one glasses, or free lenses with purchase of frames. Because In-network Providers already discount their services through their contract with PacificSource, this Student Plan's In-network Provider benefits cannot be combined with any other discounts or coupons. Members can use the Student Plan's In-network Provider benefits, or use their Out-of-network Provider benefits to take advantage of a sale or coupon offer.

If Members do take advantage of a special offer, the In-network Provider may treat them as an uninsured customer and require full payment in advance. Members can then send the claim to PacificSource themselves, and be reimbursed according to their Out-of-network Provider benefits.

PEDIATRIC DENTAL BENEFIT SUMMARY

Comprehensive Pediatric Dental Plan Domestic Students

Benefit Year: UO Law Students: 8/10/2025 to 8/9/2026

UO Students (Undergraduate/Non-Law Graduate): 9/15/2025 to 9/14/2026

Who is eligible? University of Oregon Guidelines

Provider Network: UO Exclusive Network

University Health Services (UHS):

University Health Services is considered an In-network Provider for Covered Services.

Services provided by University Health Services (UHS) are covered per University guidelines. This Student 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 the 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).

This Student Plan covers dental services for enrolled individuals age 18 and younger as required under the Affordable Care Act. Coverage for pediatric services will end on the last day of the month in which the enrolled individual turns 19.

Annual Deductible	Per Person, Per Benefit Year
All Providers	\$150
Out-of-Pocket Limit	
See your Medical Benefit Summary.	

The Member is responsible for any amounts shown above, in addition to the following amounts.

Service	University Health Services (UHS)	UO Exclusive Network (In-network Providers)	Out-of-network Providers
Class I Services (Covered for enrolled individuals age 18 and younger.)			
Examinations (During regular office hours)	No Deductible, No charge	No Deductible, No charge	No Deductible, No charge
Examinations (after hours)	Not available	No Deductible, 30% Coinsurance	Deductible then 40% Coinsurance
Bitewing films, full mouth X-rays, cone beam X-rays, and/or panorex	No Deductible, No charge	No Deductible, No charge	No Deductible, No charge
Dental cleaning (Prophylaxis)	No Deductible, No charge	No Deductible, No charge	No Deductible, No charge
Dental cleaning (Periodontal Maintenance)	No Deductible, No charge	No Deductible, No charge	No Deductible, No charge
Fluoride (topical and varnish applications)	No Deductible, No charge	No Deductible, No charge	No Deductible, No charge

Space maintainers	Not available	No Deductible, 50% Coinsurance	Deductible then 50% Coinsurance
Sealants	No Deductible, No charge	No Deductible, No charge	No Deductible, No charge
Class II Services (Covered for enrolled individuals age 18 and younger.)			
Fillings	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Simple extractions	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Periodontal Scaling and Root Planing	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Brush biopsies	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Crown re-cement	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Full mouth debridement	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Pulp capping	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Pulpotomy	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Palliative Care	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Anti-Microbial Agents	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Diagnostic Casts	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Denture relines	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Alveoloplasty	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Core build-up	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Tooth desensitization	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Pin retention of fillings	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Nitrous Oxide	Not available	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Class III Services (Covered for enrolled individuals age 18 and younger.)			
Crowns	Deductible then 40% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Root canal therapy	Deductible then 40% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Complicated oral surgery	Deductible then 40% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Bridges	Deductible then	Deductible then	Deductible then

	40% Coinsurance	50% Coinsurance	50% Coinsurance
Periodontal surgery	Deductible then 40% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Implants	Deductible then 40% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Replacement of existing Prosthetic Device	Deductible then 40% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Veneers	Deductible then 40% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Night guards	Deductible then 40% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Dentures	Deductible then 40% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Bone grafting	Not available	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Orthodontia for Medically Necessary reasons for enrolled individuals age 18 and younger	Not available	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance

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

Additional information

What is the annual Deductible?

This Student Plan's dental Deductible is the amount of money that Members pay first, before this Student Plan starts to pay. Members will see that some services are covered by this Student Plan without their needing to meet the Deductible.

University Health Services, UO Exclusive Network, and out-of-network expenses apply together toward the dental Deductible.

What is the out-of-pocket limit?

The out-of-pocket limit is the most a Member will pay for Covered Services during the Benefit Year. Once the out-of-pocket limit has been met, the Student Plan will pay 100 percent of allowed amounts for Covered Services for the rest of that Benefit Year. Members should be sure to check the student guide, as there are some charges, such as non-Essential Health Benefits, penalties and Balance Billed amounts that do not count toward the out-of-pocket limit.

Note that there is a separate category for In-network and Out-of-network Providers when it comes to meeting the out-of-pocket limit. Only In-network Provider expense applies to the In-network Provider out-of-pocket limit. Only Out-of-network Provider expense applies to the Out-of-network Provider out-of-pocket limit.

Payments to Providers

Payment to Providers is based on the prevailing or contracted PacificSource fee allowance for Covered Services. In-network Providers accept the fee allowance as payment in full. Out-of-network Providers are allowed to Balance Bill any remaining balance that this Student Plan did not cover.

Services of Out-of-network Providers could result in out-of-pocket expense in addition to the percentage indicated above.

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 Student Plan, and if you meet the Student Plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense for In-network and Out-of-network Providers. You'll find the most current prior authorization list on our website, [PacificSource.com/uo](https://pacificsource.com/uo).

Discrimination is against the law

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

BECOMING ELIGIBLE

Student Eligibility

The Student Plan is available to individuals who meet the following three requirements:

Admitted, meaning a Student who has gone through a formal admissions process to study at the University of Oregon in pursuit of a degree. This is verified by reference to the University of Oregon's Office of the Registrar's records indicating that the Student has a level code equal to 'UG', 'LW', or 'GR' (excluding post-doc scholars in accordance with ORS 350.370) and is not enrolled in a fully online program (e.g., PSYO).

AND

Domestic Students, meaning a Student who is Admitted to the University of Oregon and is not an International Exchange/Sponsored Student, or other Student who has a visa type of J or F, or other legal non-immigrant status that is approved by the Division of Global Engagement.

AND

Meets coverage criteria, meaning a Student who meets one or more of the following during a coverage period (listed in the section below titled "Effective Date of Coverage"):

- Enrolled in one or more University courses and remain enrolled in those courses through the Compliance Deadline, or
- Admitted to and actively enrolled in a University-approved study abroad program as designated by Global Education Oregon, or
- Approved by Office of the Dean of Students to take medical leave from the University and meet the criteria defined in the section titled "Medical Leave" below, or
- Meet standards for qualifying post-baccalaureate students, which means individuals who have been post-baccalaureate students for two years or less and who are enrolled in a minimum of 12 credits per academic term during those two years.

Notwithstanding the coverage criteria described above, individuals who are enrolled in exclusively online programs (e.g., ABAO, IMCO, PSYO, SPMO) are not eligible for coverage under the Student Plan.

The University will assess Students' eligibility on the Compliance Deadline. If the University determines that a Domestic Student is not eligible for the Student Plan on the Compliance Deadline, then coverage will be cancelled retroactively to the beginning of the non-eligible coverage period. Any incurred claims are ineligible and will be denied. Please contact the Student Health Benefits Team with questions about eligibility for the Student Plan.

Enrollment Process

Domestic Students must enroll in the Student Plan during their first eligible term each Contract Year. Domestic Students who elect to purchase the Student Plan are making an election for the remainder of the Contract Year, contingent upon continuing eligibility. This means that any Student who enrolls during the fall term must remain on the plan through the end of the annual coverage period as long as they continue to meet the eligibility requirements in subsequent terms. To enroll in the Student Plan, an enrollment form must be submitted prior to the Compliance Deadline. Timely enrollment and payment of premiums will result in retroactive coverage to the effective date of the coverage period. Although Students receive retroactive coverage from the effective date, certain benefits, including prescriptions, cannot be processed until a Student is enrolled in the Student Plan. For that reason, it is recommended that Students enroll in the Student Plan as soon as possible.

Qualifying Mid-Year Enrollments

The University will allow Domestic Students to enroll in the Student Plan after the initial enrollment period only if the Student involuntarily loses coverage from another qualifying health insurance plan due to a qualifying event. Involuntary loss of insurance coverage due to a qualifying event includes:

- Age: termination of coverage due to age. For example, termination because the Student no longer qualifies as a dependent for the parent's health plan.
- Loss of job: termination of coverage due to the termination of employment.
- Exhaustion of COBRA: termination of coverage due to expiration of COBRA eligibility.
- Marriage: termination of coverage due to marriage or divorce.
- Other involuntary termination of coverage due death in the family or family relocation.
- Termination of coverage under a government or state funded health plan. For example, no longer eligible for Oregon Health Plan.

A Student wanting to enroll due to loss of other coverage must submit a completed enrollment form and provide written documentation of each of the following requirements:

1. The student must provide proof of the previous coverage, including the termination date.
2. The other coverage must be compliant with the Affordable Care Act (certified as Minimum Essential Coverage - MEC). Short-term plans, travel plans and other non-ACA plans are not eligible.
3. The student must have experienced an involuntary loss of the other coverage. Note: Voluntarily dropping the student's other coverage (e.g., through an employer-based open enrollment period) does NOT qualify for mid-year enrollment in the UO SHBP.
4. The student must have experienced a recent loss of coverage that occurred not sooner than the end of the most recent open enrollment window for the UO SHBP period (see the section below titled "Open Enrollment Periods & Deadlines").

5. All written documentation, including the new application must be submitted prior to the close of the applicable open enrollment period (see the section below titled “Open Enrollment Periods & Deadlines”).

The Student's coverage will be effective at the start of the next coverage period; no Student will be added to the plan in the middle of a coverage period. If a Student anticipates involuntary loss of coverage in the future and can provide adequate documentation (e.g., aging out of a parent/guardian plan or loss of coverage secondary to known retirement date), the Student may enroll in the Student Plan in advance for the coverage period in which they anticipate the involuntary loss of coverage.

The University will also allow a Domestic Student to re-enroll in the Student Plan during the same Contract Year if they experienced a gap in coverage because they left the University (and lost eligibility for the Student Plan). These Students must re-enroll during the first term in which they regain eligibility. The Student's coverage will begin at the start of the coverage period in which they regain eligibility. Their coverage is not retroactive to any previous coverage periods during which they were not eligible.

Medical Leave

Domestic Students are eligible to receive coverage during a University-approved medical leave for only one term within a Contract Year. To qualify for coverage during a University-approved medical leave, the Student must have been enrolled in at least one University course during the entirety of the previous coverage period of the current Contract Year. This means that Domestic Students cannot begin the Contract Year in a Medical Leave status.

Early Termination – Other Qualifying Coverage

Domestic Students who elect to purchase the Student Plan are making an election for the remainder of the Contract Year, contingent upon continuing eligibility (as noted above in the section titled “Enrollment Process”). Any Domestic Student who becomes newly eligible for and acquires other qualifying health insurance (certified as providing minimal essential coverage) may request an exception to this rule, which would allow them to withdraw mid-year from the Student Plan as long as they meet the criteria below:

- The new coverage was not available to the Student prior to the Effective Date of the current coverage period; **and**
- The new coverage is available for the Student due to a qualifying event, including marriage; new employment (for them or a family member who claims them as a dependent); new qualification for a government or state-funded health plan.

This request must be made prior to the start of the coverage period for which they wish to terminate coverage. No Student's coverage will be terminated in the middle of a coverage period. Domestic Students must provide proof of the new coverage, including the start date of the other coverage. Domestic Students who meet these criteria will be terminated from the Student Plan at the end of the current coverage period. If a Student is allowed to withdraw from the Student Plan, they will not be eligible to rejoin the Student Plan for the remainder of the Contract Year, unless they meet the criteria listed above in the section titled “Enrollment Process”.

Graduate Students may be eligible for a late drop from the Student Plan if the University initiated an appointment of the Student to a graduate employee position on or after the Compliance Deadline and the Student enrolls in the health plan provided by the Graduate Teaching Fellows Federation (“GTFF”). If these requirements are met, the Student’s coverage will be terminated retroactively to the effective date of the coverage period for the term/semester and any claims incurred are ineligible and will be denied. Any University Health Services Pharmacy claims received by the Student Plan will be transferred to the Student’s University account for payment. The Student will be responsible for payment of those claims, as well as any claims from other pharmacies, and subsequent submission to the GTFF plan for possible reimbursement.

Leave of Absence/Early Withdrawal/Complete Withdrawal

To be eligible for coverage under the Student Plan, Domestic Students must remain enrolled in one or more University courses through the Compliance Deadline (as noted above in the section titled “Student Eligibility”). If a Domestic Student leaves the University before the Compliance Deadline their coverage will be cancelled retroactively to the beginning of the non-eligible coverage period. Any claims are ineligible and will be denied.

Any Domestic Student who leaves the University after the Compliance Deadline will not be eligible for a refund of any costs (including premiums or the UO SHBP administrative fee), and will continue to have coverage for the remainder of the term/semester in which they were previously enrolled.

Family Members

Family members of Domestic Students are not eligible for coverage under this Student Plan; only Domestic Students are eligible for coverage under the Student Plan.

Change of Status

Domestic Students are responsible for notifying the Student Health Benefits Team of any change in their University enrollment status, eligibility, other insurance coverage, or local address within 10 days of such change.

Costs of Coverage

Domestic Students are responsible for paying all costs associated with coverage (premiums include a UO SHBP administrative fee). Costs will be billed directly to the Student’s University account. Failure to pay these costs on the Compliance Deadline will result in a late payment fee of \$100 and the placement of an academic hold on the Student’s account. Students may be granted an approved late payment plan, in which case, their late payment fee will be refunded if full payment is made prior to the end of the current effective coverage period.

Refund Policy

Any Domestic Student who leaves the University prior to the effective date of coverage and notifies the UO Student Health Benefits Team about their leave will be refunded all costs (including premiums and the UO SHBP administrative fee) and terminated from the Student Plan.

EFFECTIVE DATE OF COVERAGE, OPEN ENROLLMENT PERIODS, PAYMENT DEADLINES

Coverage for each Domestic Student who enrolls is effective on the first day of the period in which you are eligible and premium has been paid. The effective date is the first day of the 'Term/Semester Coverage Periods' listed below.

Effective Date of Coverage:

	UO Students (Term-Based)	UO Law Students (Semester-Based)
Annual Coverage Period:	9/15/2025– 9/14/2026	8/10/2025 – 8/09/2026
Term/Semester Coverage Periods:		
Fall Term/Semester	9/15/2025 – 12/31/2025	8/10/2025 – 1/10/2026
Winter Term	1/01/2026– 3/28/2026	N/A
Spring Term/Semester	3/29/2026 – 9/14/2026	1/11/2026 – 8/09/2026
Summer Only	6/14/2026– 9/14/2026	N/A

Note: The Spring Term/Semester coverage period includes automatic extension of coverage through the summer term/semester, regardless of whether or not the Student meets any of the eligibility criteria for the summer term/semester.

Open Enrollment Periods & Deadlines:

Domestic Students may submit enrollment forms and meet premium payment deadlines during the timeframes noted below.

	UO Students (Term-Based)	UO Law Students (Semester-Based)
Contract Year	9/15/2025 – 9/14/2026	8/10/2025– 8/09/2026
Fall Term/Semester Dates:		
Open Enrollment Begins	8/01/2025	8/01/2025
Compliance Deadline (Payment Deadline, Open Enrollment Closes)	10/08/2025	9/08/2025
Coverage Period	9/15/2025 – 12/31/2025	8/10/2025 – 1/10/2026
Winter Term Dates:		
Open Enrollment Begins	12/01/2025	N/A

Compliance Deadline (Payment Deadline, Open Enrollment Closes)	1/14/2026	N/A
Coverage Period	1/01/2026 – 3/28/2026	N/A
Spring Term/Semester Dates:		
Open Enrollment Begins	3/01/2026	12/01/2025
Compliance Deadline (Payment Deadline, Open Enrollment Closes)	4/08/2026	1/26/2026
Coverage Period	3/29/2026 – 9/14/2026	1/11/2026 – 8/09/2026
Summer Term Dates:		
Open Enrollment Begins	6/01/2026	N/A
Compliance Deadline (Payment Deadline, Open Enrollment Closes)	7/01/2026	N/A
Coverage Period	6/14/2026 – 9/14/2026	N/A

GENERAL STUDENT PLAN PROVISIONS

HIPAA COMPLIANCE STATEMENT

UO is a hybrid entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This means that some of UO's units and departments are required to comply with HIPAA, to the extent applicable, and some parts are not. Those units and departments that are required to comply with applicable provisions of HIPAA are called covered components. This Plan and University Health Services (UHS) are covered components. While covered components are required to comply with applicable provisions of HIPAA, they are also required to comply with the Family Educational Rights and Privacy Act (FERPA) and UO policy.

Other departments, such as the Registrar's Office and the Erb Memorial Union, are not required to comply with HIPAA and therefore they are not covered components. However, the confidentiality protections afforded by FERPA still apply to education records maintained in those departments. For more information regarding the protections and rights afforded by FERPA, please visit: <https://registrar.uoregon.edu/records-privacy>.

The below sets forth the rights and protections you have relating to your protected health information (PHI), as that term is defined by HIPAA, disclosed in relation to this Plan and as prescribed by HIPAA.

1. Only the following employees or agents of the University of Oregon will have access to PHI. Those employees who, as a part of their job duties: (i) require the information in order to resolve claims, referral, or other benefit issues on behalf of the Members; or (2) require the information to resolve enrollment and payment issues on behalf of this Student Plan;

2. This Plan and UHS have 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;
3. This Plan and UHS 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 Plan or UHS's employee or agent;
4. Neither this Plan nor UHS will disclose PHI other than as permitted or required by law or this Student Plan;
5. This Plan and the UHS will ensure that any agent agrees to the same restrictions and conditions that apply to the University with respect to such PHI;
6. This Plan and UHS will not use PHI disclosed by PacificSource for any employment-related action or in connection with any other benefit or employee benefit plan of UO;
7. This Plan and UHS have a written policy for investigating and appropriately reporting any security incidents that relate to PHI to PacificSource;
8. This Plan and UHS will make available PHI in accordance with 45 CFR § 164.524;
9. This Plan and UHS will make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;
10. This Plan and UHS will make available the information required to provide an accounting of disclosure in accordance with 45 CFR § 164.528;
11. This Plan and UHS will 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 45 CFR § 164.504.
12. This Plan and UHS will return or destroy all PHI received from this Student Plan that the UO 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
13. This Plan and UHS will 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.

As noted above, the protections described above apply to PHI disclosed by PacificSource to UO as the Plan Sponsor. For information regarding other rights relating to your education records and medical information under FERPA and UO policy, please visit:

<https://registrar.uoregon.edu/records-privacy> (FERPA);

<https://health.uoregon.edu/files/NPP-English-2018.pdf> (Notice of Privacy Practices);

<https://policies.uoregon.edu/III.05.02> (UO policy regarding confidentiality of client/patient health care and survivors' services information.)

Rescissions. This Student Plan 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.

Disclosure of PHI and PII. In compliance with state and federal law, UO policy and in accordance with the below restrictions and obligations, PacificSource may, at the request of the UO, and the University of Oregon may disclose PHI or electronic PHI ("ePHI") relating to the Members on this Student Plan to the University of Oregon to allow the University of Oregon to perform Plan Administration functions as that term is defined by 45 C.F.R. § 164.504(a), and/or personally identifiable information (PII) from your education records, as defined by the Family Educational Rights and Privacy Act (FERPA)

Only employees or agents of the University of Oregon 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 University of Oregon 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 University of Oregon's employee or agent.

The University of Oregon certifies and agrees to the following:

- The University of Oregon has sufficient administrative, physical and technical safeguards in place to protect the privacy of the PHI and PII from any unauthorized use or disclosure in compliance with all applicable state and federal laws;
- No PHI or PII 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 parties with respect to such PHI and PII;
- No PHI shall be used in employment-related actions or in connection with any other benefit or employee benefit plan of the University of Oregon;
- The University of Oregon has a written policy for investigating and appropriately reporting any security incidents that relate to PHI or PII to PacificSource;
- The University of Oregon shall make available PHI in accordance with 45 CFR § 164.524 and education records available in accordance with FERPA;
- The University of Oregon shall make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526.;
- The University of Oregon shall make available the information required to provide an accounting of disclosure in accordance with 45 CFR § 164.528 and/or FERPA;

- The University of Oregon 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 45 CFR § 164.504. The University of Oregon shall also make the same available if required for compliance review under FERPA;
- University of Oregon shall return or destroy all PHI and PII received from this Student Plan that the University of Oregon still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made; and
- The University of Oregon shall ensure that the adequate separation between employees who need access to PHI or PII to perform their assigned job functions and those who do not is established and enforced.

The provisions and restrictions described in this section relate solely to Student health information created or maintained at University Health Services or at PacificSource. For information regarding the University's practices relating to education records created or maintained by other University departments, please visit <https://registrar.uoregon.edu/records-privacy>.

TERM AND TERMINATION – COVERAGE

- **Students.** Coverage for a Student will end on the first of the following events:
 - the date this Student Plan terminates;
 - the date on which the Student withdraws from the school because of entering the armed forces of any country;
 - the date that aligns to the Student's eligibility as described in the section title, "Becoming Eligible".

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

UNDERSTANDING HOW YOUR BENEFITS ARE PAID

This section of the student guide contains information to help you understand the benefits of this Student Plan and how certain aspects of this Student Plan work, including Deductibles, Copayments, Coinsurance, out-of-pocket limits, and benefit maximums. For more information, see the Benefit Summaries for Student Plan details.

BENEFIT YEAR

Contract Year

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

separate maximum benefit (for example, not on a contract year basis) is identified in the Covered Services section for this student guide.

If this Student 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 Student Plan.

YOUR DEDUCTIBLE

Except for certain services that do not require satisfaction of the Deductible, this Student Plan 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.

Covered Services used to satisfy the Deductible also accrue to the annual or Lifetime Maximums, if any apply.

YOUR COPAYMENT

This Student 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, if any applies, this Student Plan may include a Coinsurance payment on certain services or supplies each time the Member receives a specified service or supply until the Member meets any applicable out-of-pocket limit. 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 ANNUAL OUT-OF-POCKET LIMIT

This Student Plan has an out-of-pocket limit provision. The Medical Benefit Summary shows this Student Plan's annual out-of-pocket limits. If you incur Covered Service expenses over those amounts, this Student Plan will pay 100 percent of the Allowable Fee for eligible charges for the remainder of the Benefit Year.

The allowed amounts Members pay for Covered Services will accrue toward the annual out-of-pocket limit except for the following, which will continue to be your responsibility:

- Charges over the Allowable Fee for services of Out-of-network Providers;

- Dental charges in excess of the least costly service or supply appropriate for treatment;
- Covered dental expenses age 19 and over;
- Charges over the usual, customary, and reasonable fee; or
- Incurred charges that exceed amounts allowed under this Student Plan.

Charges that do not count toward the out-of-pocket limit or that are not covered by this Student Plan will continue to be your responsibility even after the out-of-pocket limit is reached.

ESSENTIAL HEALTH BENEFITS

This Student Plan covers the Essential Health Benefits as defined by the Secretary of the U.S. Department of Health and Human Services. Annual and Lifetime Maximum dollar limits will not be applied for any service that is an Essential Health Benefit.

UNDERSTANDING MEDICAL AND DENTAL NECESSITY

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

Be careful – just because a treatment is prescribed or recommended by a Provider does not mean it is Medically/Dentally Necessary under the terms of this Student Plan. This Student 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 Medical/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 or the University of Oregon) may be required for a Medical/Dental Necessity determination.

Some Medically/Dentally Necessary services are not Covered Services. Medically/Dentally Necessary services and supplies that are specifically excluded

from coverage under this Student Plan can be found in the Benefit Exclusions section. If you ever have a question about this Student Plan, contact PacificSource's Customer Service team.

UNDERSTANDING EXPERIMENTAL, INVESTIGATIONAL, OR UNPROVEN SERVICES

This Student 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, PacificSource reviews new and emerging technologies and medications on a regular basis. PacificSource's internal committees make decisions about coverage of these methods and medications based on literature reviews, standards of care and coverage, consultations, and review of evidence-based criteria. In addition, if you seek services from a Provider outside Idaho, Montana,

Oregon, and Washington, PacificSource may delegate the development and use of evidence-based criteria to a third party for such services. You and your Provider may request information regarding PacificSource's criteria for determining these services or treatments.

ELIGIBLE PROVIDERS

This Student Plan provides benefits only for Covered Services and supplies rendered by an eligible Provider, Hospital, Specialized Treatment Facility, Durable Medical Equipment Supplier, or other licensed Providers. 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 Student 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 this Student Plan. You are responsible for all charges for services that are not a Covered Service.

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 (maximum dollar amounts do not apply to Essential Health Benefits). For an expense to be eligible for payment, you must be a Member of this Student 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 Medically/Dentally Necessary, yet not be a Covered Service. For information about exclusions, see the Benefit Exclusions section.

Subject to all the terms of this Student Plan, the following services and supplies are covered according to the Benefit Summaries.

PREVENTIVE CARE SERVICES

This Student Plan covers preventive care services in accordance with the age limits and frequency guidelines according to the recommendations of the United States Preventive Services Task Force (USPSTF) – the A and B list of preventive services, the Health Resources and Services Administration (HRSA), and by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. If one of these bodies adopts a new or revised recommendation, this Student Plan has up to one year before coverage of the related services must be available and effective under this benefit.

For a list of the services that fall within this benefit, please visit the USPSTF website, uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations or the HRSA website, hrsa.gov/womens-guidelines (note that these websites may change). For Members who do not have Internet access or have additional questions, please contact the PacificSource Customer Service team for a complete description of the preventive services lists. Below are some of the services that fall within this benefit.

Preventive care services provided out-of-network are not covered.

Colorectal Cancer Screening

This Student Plan covers colorectal cancer screening as required under ACA. Screening coverage includes a follow up colonoscopy performed after a positive non-invasive stool based screening or direct visualization. For colorectal cancer screenings not required to be covered as preventive under ACA, see the Diagnostic and Therapeutic Radiology/Laboratory and Dialysis – (non-advanced) section.

Immunizations

This Student Plan covers age-appropriate childhood and adult immunizations for primary prevention of infectious diseases as recommended and adopted by the USPSTF, Centers for Disease Control and Prevention (CDC), or similar standard-setting body. This benefit does not include immunizations that are determined to be elective or Experimental, Investigational, or Unproven.

Preventive Physicals

This Student Plan covers appropriate screening radiology and laboratory tests and other screening procedures. Screening exams and laboratory tests may include, but not limited to, depression screening for all adults including pregnant and postpartum women, blood pressure checks, weight checks, occult blood tests, urinalysis, complete blood count, prostate exams, cholesterol exams, stool guaiac screening, EKG screens, blood sugar tests, and tuberculosis skin tests. Only laboratory tests and other routine screening procedures related to the preventive physical are covered by this benefit. Diagnostic x-ray and lab work outside the scope of the preventive physical will be subject to the standard cost sharing.

- Benefits are limited as follows: Age 22 and older once per Benefit Year.

Prostate Cancer Screening

This Student Plan covers appropriate screening that includes, but not limited to, a digital rectal exam and a prostate-specific antigen test.

Tobacco Cessation Program Services

This Student Plan covers Tobacco Cessation Program services.

Weight Reduction or Control Services

This Student Plan covers medical nutritional therapy and obesity screening for children ages six and older and adults who qualify as obese, as required under the USPSTF recommendations.

Medical nutritional therapy will also be provided for women 40 to 60 years of age with normal or overweight body mass to maintain weight or limit weight gain to prevent obesity.

Well Baby/Well Child Care

This Student Plan covers well baby/well child examinations. Only laboratory tests and other routine screening procedures related to the well baby/well child exam are covered by this

benefit. Diagnostic x-ray and lab work outside the scope of the preventive physical will be subject to the standard cost sharing.

- Benefits are limited as follows:
 - Ages 3-21: One exam per Benefit Year

Well Woman Care

This Student Plan covers ACA recommended Women's Healthcare Services. Services include, but not limited to, preventive mammograms including 3D, preventive gynecological exams, pelvic exams, pap smears, and maternity related services to be covered as preventive under the ACA. For diagnostic mammograms, see the Diagnostic and Therapeutic Radiology/Laboratory and Dialysis – (non-advanced) section.

PROFESSIONAL SERVICES

Acupuncture

This Student Plan covers services for acupuncture.

- Benefits are limited as follows: Up to 12 visits per Benefit Year.

Audiological Tests

This Student Plan covers audiological (hearing) tests.

Biofeedback

This Student Plan covers biofeedback services to treat migraine headaches or urinary incontinence.

- Benefits are limited as follows: Lifetime Maximum of ten sessions.

Cardiac Rehabilitation

This Student Plan covers Cardiac Rehabilitation.

- Benefits are limited as follows:
 - Phase I (inpatient) services are covered under inpatient Hospital benefits.
 - Phase II (short term outpatient) services provided in connection with a Cardiac Rehabilitation exercise program that does not exceed a Lifetime Maximum of 36 visits.
 - Phase III (long-term outpatient) services are not covered.

Child Abuse Medical Assessments

This Student Plan covers child abuse medical assessments which includes the taking of a thorough medical history, a complete physical examination and interview by or under the direction of a Provider trained in the evaluation, diagnosis, and treatment of child abuse. Child

abuse medical assessments are covered when performed at a community assessment center. Community assessment center means a neutral, child-sensitive community-based facility or service Provider to which a child from the community may be referred to receive a thorough child abuse medical assessment for the purpose of determining whether the child has been abused or neglected.

Chiropractic Manipulation/Spinal Manipulation

This Student Plan covers services for chiropractic manipulation/spinal manipulation.

- Benefits are limited as follows: Up to 20 visits per Benefit Year.

Circumcision

This Student Plan covers circumcision regardless of age or Medical Necessity.

- Benefits are limited as follows: One circumcision per Member per lifetime.

Clinical Trials (Approved)

This Student Plan covers Routine Costs of Care associated with Approved Clinical Trials. Expenses for services or supplies that are not considered Routine Costs of Care are not covered. A qualified individual is someone who is eligible to participate in an Approved Clinical Trial and either the referring Provider is an In-network Provider and has concluded that the trial would be appropriate for the individual, or the individual provides medical or scientific information establishing that the trial would be appropriate. If an In-network Provider is participating in an Approved Clinical Trial, the qualified individual may be required to participate in the trial through that In-network Provider if the Provider will accept the qualified individual as a participant. If the Member has an adverse outcome from an Approved Clinical Trial, those Medically Necessary services are covered.

Cosmetic or Reconstructive Surgery

This Student Plan provides cosmetic or reconstructive services in the following situations:

- When necessary to correct a functional disorder or Congenital Anomaly;
- When necessary because of an Accidental Injury or Illness, or to correct a scar or defect that resulted from treatment of an Accidental Injury or Illness;
- When necessary to correct a scar or defect on the head or neck that resulted from a covered surgery; or
- When necessary for gender affirmation.

Craniofacial Anomalies

This plan covers dental and orthodontic services for the treatment of craniofacial anomalies when Medically Necessary to restore function. Coverage includes, but not limited to, physical disorders identifiable at birth that affect the bony structure of the face or head, such as a cleft palate, cleft lip, craniosynostosis, craniofacial microsomia and Treacher Collins syndrome.

Coverage is limited to the least costly clinically appropriate treatment. Cosmetic procedures and procedures to improve on the normal range of functions are not covered.

Foot Care

This Student Plan covers routine foot care for Members with diabetes mellitus.

Gender Affirmation

This Student Plan covers Medically Necessary gender affirming services and related procedures. Members under age 18 require consent from their legal guardian.

Genetic Counseling

This Student Plan covers services of a board-certified or board-eligible genetic counselor for evaluation of genetic disease.

Inborn Errors of Metabolism

This Student Plan covers treatment for inborn errors of metabolism involving amino acid, carbohydrate, and fat metabolism for which widely accepted standards of care exist for diagnosis, treatment, and monitoring, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage includes expenses for diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including, but not limited to, clinical visits, biochemical analysis, and medical foods used in the treatment of such disorders.

Injectable Drugs and Biologicals

This Student Plan covers injectable drugs and biologicals when administered by a Provider and Medically Necessary for diagnosis or treatment of an Illness or Injury. For information about drugs or biologicals that can be self-administered or are dispensed to a patient, see the Prescription Drugs section.

Injury of the Jaw or Natural Teeth

This Student Plan covers the services of a Provider to treat Injury of the jaw or natural teeth.

Intravenous Immunoglobulin Therapy

This Student Plan covers up to three monthly immunomodulatory courses of intravenous immunoglobulin therapy (IVIG) for the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS) when certain conditions are met. Certain medications to treat PANDAS/PANS may be available under your Prescription Drug benefit. For more information, contact the PacificSource Customer Service team.

Medical Nutrition Therapy

This Student Plan covers medical nutritional therapy for, diabetes, inborn errors of metabolism, eating disorders, and obesity if provided by a qualified Provider.

Office Visits and Urgent Care Visits

This Student Plan covers office visits and treatments, including associated supplies and services such as therapeutic injections and related supplies.

This Student Plan covers Urgent Care visits, including facility costs and supplies at the Urgent Care Treatment Facility. This benefit includes a visit requested by the Member for the purpose of obtaining a second opinion regarding a covered medical diagnosis or treatment plan.

All professional services performed in the office that are billed separately from the office visit or are not related to the actual visit (for example, separate laboratory services billed in conjunction with the office visit) are not considered part of the office visit and are subject to the applicable benefit for such service.

Orthognathic (Jaw) Surgery

This Student Plan covers services of a Provider for orthognathic (jaw) surgery.

- Benefits are limited as follows:
 - When Medically Necessary to repair an Accidental Injury; or
 - For removal of a malignancy, including reconstruction of the jaw.

Pediatric Dental Care Requiring General Anesthesia

This Student Plan covers facility charges of a Hospital or Ambulatory Surgical Center.

- Benefits are limited as follows: One visit per Benefit Year.

Scheduled and/or Non-emergent Medical Care Outside of the United States

This Student Plan covers scheduled and/or non-emergent medical care outside of the United States for full-time Students attending college outside the United States for three or more months.

Sleep Studies

This Student Plan covers sleep studies when ordered by a pulmonologist, neurologist, otolaryngologist, internist, family practitioner, or certified sleep medicine specialist.

Surgery

This Student Plan covers surgery and other outpatient services performed in a Providers office or an Ambulatory Surgical Center.

Telehealth

This Student Plan covers Medically Necessary Telehealth services when provided by a Provider. Telehealth cost share will be paid based upon place of service and Provider billing.

Traumatic Brain Injury

This Student Plan covers Medically Necessary therapy and services for the treatment of traumatic brain Injury.

AMBULANCE SERVICES

This Student Plan covers services of a state certified ground or air ambulance to the nearest facility capable of treating the condition when other forms of transportation will endanger your health. There is no coverage for services that are for personal or convenience purposes. Air ambulance service is only covered when ground transportation is medically or physically inappropriate.

BLOOD TRANSFUSIONS

This Student Plan covers blood, blood products, and blood storage, including services and supplies of a blood bank.

BREAST PROSTHESES

This Student Plan covers removal, repair, and/or replacement of breast prostheses due to a contracture or rupture, but only when the original prosthesis was for a Medically Necessary Mastectomy. Eligibility for benefits is subject to the following criteria:

- The contracture or rupture must be clinically evident by a Provider's physical examination, imaging studies, or findings at surgery;
- Removal, repair, and/or replacement of the prosthesis is not covered when recommended due to an autoimmune disease, connective tissue disease, arthritis, allergenic syndrome, psychiatric syndrome, fatigue, or other systemic signs or symptoms.

COCHLEAR IMPLANTS

This Student Plan covers single or bilateral cochlear implants when Medically Necessary, including programming and reprogramming. The cost of repair and replacement parts are covered if the repair or replacement parts are not under warranty.

CONTRACEPTIVES AND CONTRACEPTIVE DEVICES/FAMILY PLANNING

This Student Plan covers IUD, diaphragm, and cervical cap contraceptives and contraceptive devices along with their insertion or removal, as well as hormonal contraceptives including injections, formulary oral, patches, and rings prescribed by your Provider. Contraceptive drugs, devices, and other products approved by the Food and Drug Administration (FDA) and on the formulary are covered by your plan when prescribed.

Over-the-counter contraceptive drugs approved by the FDA, purchased without a prescription, are reimbursable by the plan.

This Student Plan covers tubal ligation, vasectomy, and abortion (termination of pregnancy) procedures.

DIABETIC EQUIPMENT, SUPPLIES, AND TRAINING

This plan covers certain diabetic equipment, supplies, and training, as follows:

- Diabetic supplies other than insulin and syringes (such as lancets, test strips, and glucostix).
- Insulin pumps.
- Diabetic insulin, syringes, and continuous glucose monitors are covered under your Prescription Drug benefit when criteria is met. Formulary lancets and test strips are also available under your Prescription Drug benefit in lieu of those covered supplies under the medical plan.
- Outpatient and self-management training and education for the treatment of diabetes and prediabetes (National Diabetes Prevention Programs). The training must be provided by a Provider with expertise in diabetes.
- Medically Necessary Telehealth, via two-way electronic communication, provided in connection with the treatment of diabetes.

DIAGNOSTIC AND THERAPEUTIC RADIOLOGY/LABORATORY AND DIALYSIS – (NON-ADVANCED)

This Student Plan covers diagnostic and therapeutic radiology/laboratory services provided in a Hospital or outpatient setting when ordered by a Provider. These services may be performed or provided by laboratories, radiology facilities, Hospitals, and Providers, including services in conjunction with office visits.

A colonoscopy that is not required to be covered as preventive under ACA, or is performed for the evaluation or treatment of a known medical condition, is paid at no cost share when provided by an In-network Provider. Non-preventive colonoscopies performed by an Out-of-network Provider will be covered under the diagnostic benefit and is subject to cost sharing.

A mammogram, MRI, and ultrasound for a Diagnostic Breast Examination or Supplemental Breast Examination are paid at no cost share when provided by an In-network Provider. If this is an HSA plan or if the services are provided by an Out-of-network Provider, the examinations will be covered under this diagnostic benefit and are subject to cost sharing.

This Student Plan covers therapeutic radiology services, Chemotherapy, and renal dialysis provided or ordered by a Provider. Covered Services include a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells.

Absent an Allowable Fee amount based on the Medicare allowable, benefits for Members who are receiving renal dialysis are limited to 125 percent of the current Medicare allowable amount for In-network and Out-of-network Providers. In all situations and settings, benefits are subject to the Deductibles, Copayments, and/or Coinsurance stated in the Medical Benefit Summary

for Outpatient Services – Diagnostic and therapeutic radiology/lab and dialysis – (non-advanced).

Please see the Medical Benefit Summary for cost sharing information on benefits that fall under this category.

DIAGNOSTIC IMAGING – ADVANCED

This Student Plan covers Medically Necessary advanced diagnostic imaging for the diagnosis of Illness or Injury. For the purposes of this benefit, advanced diagnostic imaging includes CT scans, MRIs, PET scans, CATH labs, and nuclear cardiology studies. In all situations and settings (excluding emergency room services), benefits require prior authorization and are subject to the Deductibles, Copayments, and/or Coinsurance stated in the Medical Benefit Summary for Outpatient Services – Diagnostic Imaging – Advanced. Please note that the Copayment for these services is per test. For example, if separate MRIs are performed on different regions of the back, there will be a Copayment charged for each region imaged.

DURABLE MEDICAL EQUIPMENT

This Student Plan covers services and applicable sales tax for Durable Medical Equipment. Durable Medical Equipment must be prescribed.

This Student Plan covers Prosthetic Devices and Orthotic Devices to restore or maintain the ability to complete activities of daily living or essential job-related activities and are not for comfort or convenience. Repair or replacement of a Prosthetic Device and Orthotic Device is covered when needed due to normal use. This plan covers maxillofacial prostheses to control or eliminate pain or infection or to restore functions such as speech, swallowing, or chewing.

- Benefits are limited as follows:
 - The cost of Durable Medical Equipment that is not considered an Essential Health Benefit is covered up to \$5000 per Benefit Year. Examples of Essential Health Benefits are Prosthetic Devices and Orthotic Devices, oxygen and oxygen supplies, certain diabetic supplies, wheelchairs, breast pumps, and medical foods for the treatment of inborn errors of metabolism.
 - Benefits will be paid toward either the purchase or the rental of the equipment for the period needed, whichever is less. Repair or replacement of equipment is also covered when necessary, subject to all conditions and limitations of the plan.
 - Only expenses for Durable Medical Equipment, or Prosthetic and Orthotic Devices that are provided by an In-network Provider or a Provider that satisfies the criteria of the Medicare fee schedule for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and Other Items and Services are eligible for reimbursement.
 - Medically Necessary treatment for sleep apnea and other sleeping disorders is covered. Coverage of oral devices includes charges for consultation, fitting, adjustment, follow-up care, and the appliance. The appliance must be prescribed by a Provider specializing in evaluation and treatment of sleep disorders.

- Hearing Aids: Hearing Aids, Hearing Assistive Technology Systems, and ear molds are provided in accordance with state and federal law. Contact the PacificSource Customer Service team for specific coverage requirements. The Durable Medical Equipment benefit covers one Hearing Aid per hearing impaired ear every 36 months or more frequently if modification to an existing Hearing Aid will not meet the needs of the Member.
- Wheelchairs: Purchase, rental, repair, lease, or replacement of a power-assisted wheelchair (including batteries and other accessories) is payable only in lieu of benefits for a manual wheelchair.
- Lenses: Only lenses to correct a specific vision defect resulting from a severe medical or surgical problem are covered subject to the following limitations:
 - The medical or surgical problem must cause visual impairment or disability due to loss of binocular vision or visual field defects (not merely a refractive error or astigmatism) that requires lenses to restore some normalcy to vision.
 - The maximum allowance for glasses (lenses and frames), or contact lenses in lieu of glasses, is limited to one pair per Benefit Year when surgery or treatment is performed on either eye. Other plan limitations, such as exclusions for extra lenses, other hardware, tinting of lenses, eye exercises, or vision therapy, also apply.
 - Benefits for subsequent Medically Necessary vision corrections to either eye (including an eye not previously treated) are limited to the cost of lenses only.
 - Reimbursement is subject to the Deductible, Copayment, and/or Coinsurance stated in the Medical Benefit Summary for Durable Medical Equipment and is in lieu of, and not in addition to any other vision benefit payable.
- Breast Pumps: Manual and electric breast pumps are covered at no cost share when provided by an In-network Provider, or purchased from a retail outlet, and are limited to once per pregnancy. Hospital-grade breast pump rentals are covered.
- Wigs: Wigs following Chemotherapy or Radiation Therapy are covered up to one synthetic wig per Benefit Year.

Maxillofacial Prosthetic Services

This Student Plan covers maxillofacial prosthetic services when prescribed by a Provider as necessary to restore and manage head and facial structures. Coverage is provided only when head and facial structures cannot be replaced with living tissue, and are defective because of disease, trauma, or birth and developmental deformities. To be covered, treatment must be necessary to control or eliminate pain or infection or to restore functions such as speech, swallowing, or chewing.

- Benefits are limited as follows: Coverage is limited to the least costly clinically appropriate treatment, as determined by the Provider. Cosmetic procedures and procedures to improve on the normal range of functions are not covered.

ELEMENTAL ENTERAL FORMULA

This Student Plan covers Medically Necessary non-prescription elemental enteral formula ordered by a Provider for home use to treat severe intestinal malabsorption disorder when the formula comprises a predominant or essential source of nutrition.

EMERGENCY ROOM – PROVIDER AND FACILITY

This Student Plan covers an Emergency Medical Screening Exam and Emergency Services to evaluate and treat an Emergency Medical Condition. Any referred services or treatment after discharge from the emergency room will be covered under the applicable benefit for such services and treatment. For Emergency Medical Conditions, Out-of-network Providers are paid at the In-network Provider level. If you are admitted to an out-of-network Hospital, PacificSource will coordinate your transfer to an in-network facility if necessary.

If you need immediate assistance for a medical emergency, call 911, or go to the nearest emergency room or appropriate facility.

HEALTH EDUCATION BENEFITS

This Student Plan covers Health Education Benefits with an annual maximum of \$150. Health education topics usually include matters such as maternity, fitness and education, newborn care and parenting skills, nutrition and healthy heart exercises or CPR skills.

Covered Services include health-related classes and printed materials required for the class.

After you have completed the class, please provide PacificSource with proof of payment and a completed Reimbursement Request Form for PacificSource to review for benefit payment consideration based on the Plan Sponsor's criteria. You may obtain the Reimbursement Request Form from the Plan Sponsor, or PacificSource's Customer Service team.

HOME HEALTHCARE SERVICES

This Student Plan covers Home Healthcare services, including home infusion services that cannot be self-administered, when provided by a licensed home health agency.

- Benefits are limited as follows: Private duty nursing is not covered.

HOSPICE CARE SERVICES

This Student Plan covers Hospice Care services intended to meet the physical, emotional, and spiritual needs of the patient and family during the final stages of illness and dying, while maintaining the patient in the home setting. Services are to supplement the efforts of an unpaid caregiver and include pastoral care and bereavement services.

This Student Plan covers respite care provided in a nursing facility to provide relief for the primary caregiver.

- Benefits are limited as follows:

- Hospice Care: The Student Plan does not cover services of a primary caregiver such as a relative, friend, or private duty nurse. Care is provided for a terminally ill Member when determined Medically Necessary.
- Respite care: Care is subject to a Lifetime Maximum of 30 days. The Member must be enrolled in a hospice program to be eligible for respite care benefits.

INPATIENT SERVICES

Hospital Services

This Student Plan covers Hospital inpatient services up to the Hospital's semi-private room rate, except when a private room is determined to be necessary.

This Student Plan covers hospitalization for dental procedures under limited circumstances. For more information, see Pediatric Dental Care Requiring General Anesthesia in the Professional Services section.

Inpatient Habilitation

This Student Plan covers inpatient Physical/Occupational Therapy and speech therapy services. These services must be consistent with the condition being treated, and must be part of a written treatment program prescribed by a Provider and are subject to concurrent review by PacificSource.

- Benefits are limited as follows: Up to 30 days per Benefit Year with extensions subject to Medical Necessity review. Additional treatment may be considered when criteria for individual benefits are met.

Inpatient Rehabilitation

This Student Plan covers inpatient Rehabilitation Services when Medically Necessary to keep, restore, or improve skills and function for daily living that have been lost or impaired due to Illness, Injury, or disability. Recreation therapy is only covered as part of an inpatient admission.

- Benefits are limited as follows: Up to 30 days per Benefit Year with extensions subject to Medical Necessity review. Additional treatment may be considered when criteria for individual benefits are met.

Mental Health and Substance Use Disorder Services – Inpatient

This Student Plan complies with all federal laws and regulations related to the Mental Health Parity and Addiction Equity Act of 2008. Treatment of Substance Use Disorder and related disorders is subject to placement criteria established by the American Society of Addiction Medicine, Third Edition.

This Student Plan covers crisis intervention, diagnosis, and treatment of Behavioral Health Conditions and Substance Use Disorders including withdrawal management by a Mental Health and/or Substance Use Disorder Healthcare Provider or Mental Health and/or Substance Use Disorder Healthcare Program or Mental Health and/or Substance Use Disorder

Healthcare Facility, except as otherwise excluded in this Student Plan. Services are also covered when provided by a qualified Provider for covered diagnoses when the Member is in a Skilled Nursing Facility.

Skilled Nursing Facilities and Convalescent Homes

This Student Plan covers Skilled Nursing Facilities and Convalescent Homes and are subject to admission notification and concurrent review.

- Benefits are limited as follows: Up to 60 days per Benefit Year. Confinement for Custodial Care is not covered.

MATERNITY SERVICES

This Student Plan covers services of Providers practicing within the scope of their license, for prenatal and postnatal (provided within six weeks of delivery) maternity, childbirth, and complications of pregnancy. A Hospital stay of at least 48 hours (vaginal) or 96 hours (cesarean) is covered.

Medically Necessary services, medication, and supplies to manage diabetes during pregnancy, from conception through six weeks postpartum, will not be subjected to a Deductible, Copayment, or Coinsurance.

This Student Plan covers routine nursery care of a newborn child born to a Member while the mother is hospitalized and eligible for pregnancy-related benefits under this plan if the newborn is also eligible and enrolled in this plan.

This Student Plan covers labor and delivery services at an out-of-network facility when a Member is unable to be treated by an in-network facility during a declared public health emergency. These services will be paid at the in-network cost sharing amount.

Please contact PacificSource's Customer Service team as soon as you learn of your pregnancy. Our team will explain your plan's maternity benefits and help you enroll in our prenatal care program.

OUTPATIENT SERVICES

Autism Spectrum Disorder Services and Applied Behavioral Analysis (ABA) Therapy

This Student Plan covers ABA according to PacificSource's guidelines for Medical Necessity. A treatment plan is required.

Mental Health and Substance Use Disorder Services – Outpatient

This Student Plan complies with all federal laws and regulations related to the Mental Health Parity and Addiction Equity Act of 2008. Treatment of Substance Use Disorder and related disorders is subject to placement criteria established by the American Society of Addiction Medicine, Third Edition.

This Student Plan covers crisis intervention, diagnosis, and treatment of Behavioral Health Conditions and Substance Use Disorders including withdrawal management by a Mental Health and/or Substance Use Disorder Healthcare Provider or Mental Health and/or Substance Use Disorder Healthcare Program, except as otherwise excluded in this plan.

Outpatient Habilitation

This Student Plan covers Physical/Occupational Therapy, and speech therapy services, subject to a prescription that includes site, modality, duration, and frequency of treatment.

- Benefits are limited as follows: Up to a combined maximum of 30 visits per Benefit Year with extensions subject to Medical Necessity review. Additional treatment may be considered when criteria for individual benefits are met.

Outpatient Rehabilitation

This Student Plan covers outpatient Rehabilitation Services to help a person keep, restore, or improve skills and function for daily living that have been lost or impaired due to Illness, Injury, or disability. Services must be prescribed in writing and include site, modality, duration, and frequency of treatment.

- Benefits are limited as follows: Up to a combined maximum of 30 visits per Benefit Year with extensions subject to Medical Necessity review. Additional treatment may be considered when criteria for individual benefits are met.

Outpatient pulmonary rehabilitation programs are covered for Members with severe chronic lung disease that interferes with normal daily activities despite optimal medication management.

PEDIATRIC DENTAL SERVICES

Pediatric dental services are covered for Members age 18 and younger. Coverage for pediatric services will end on the last day of the month in which the Member turns 19. Frequency limits are as required under the Affordable Care Act (ACA).

CLASS I SERVICES (COVERED FOR MEMBERS AGE 18 AND YOUNGER)

- Benefits for **dental cleaning (Prophylaxis and Periodontal Maintenance)** are limited to a combined total of two procedures per Member 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, Root Planing, and/or Curettage.
- Benefits for **examinations** (routine, problem focused, comprehensive periodontal, and other diagnostic exams) are limited to a combined total of two examinations per Member per Benefit Year. Separate charges for review of a proposed treatment plan or for diagnostic aids are not covered. Emergency examinations are covered.

- Benefits for **fluoride (topical or varnish applications)** are limited to a combined total of four applications per Benefit 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 of X-rays, cone beam X-ray, or panorex in any 36 month period and further limited to one bitewing set in a 12 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 X-rays, or panorex are available for the remainder of the year.
- Benefits for the application of **sealants** are limited to one application, per quadrant, per Benefit Year to permanent molars and bicuspid, except for visible evidence of clinical failure.
- Benefits for **space maintainers** are covered.

CLASS II SERVICES (COVERED FOR MEMBERS AGE 18 AND YOUNGER)

- **Anti-microbial agents** are covered
- Benefits for **brush biopsies** used to aid in the diagnosis of oral cancer are covered.
- Benefits for **Core build-ups** are covered.
- **Diagnostic casts** are covered.
- This Student Plan will pay for a **filling** on a tooth surface only once per Benefit Year. Three or more surface fillings are limited to one per surface per Benefit Year.
- Benefits for **full mouth debridement** are limited to once every 24 months. This procedure is only covered if the teeth have not received a Prophylaxis in the prior 24 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).
- Benefits for **general anesthesia** administered by a Provider in their office when used in conjunction with approved oral surgery procedures are covered.
- Benefits for administration of **nitrous oxide** are covered.
- Benefits for **oral pre-medication anesthesia for conscious sedation** are covered.
- **Palliative (emergency) treatment of dental pain** is covered.
- Benefits for **Periodontal Scaling, Root Planing, and/or Curettage** are limited to only one procedure per quadrant in any 24 month period. For the purpose of this limitation, eight or fewer teeth existing in one arch will be considered one quadrant.
- Benefits for **pin retention of fillings** are covered.

- 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 primary teeth.
- **Simple extractions of teeth** and other minor oral surgery procedures are covered.
- Benefits for **subsequent denture relines** are provided only once every 12 months.
- Benefits for **tooth desensitization** are covered as a separate procedure from other dental treatment.
- Benefits for **crown re-cement** are covered.

CLASS III SERVICES (COVERED FOR MEMBERS AGE 18 AND YOUNGER)

- Benefits for **Bone replacement grafts** to prepare sockets for implants after tooth extraction are covered.
- 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. Charges for denture adjustments and repairs are covered. 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 **crowns** and other cast or laboratory processed Restorations are limited to the Restoration of any one tooth every 60 months.
- Benefits for the 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.
- Benefits for an initial **fixed bridge or removable cast partial** are covered.
- The completion date for **crowns, onlays, and bridges** is the cementation date (seat date) regardless of the type of cement utilized.
- Benefits for occlusal guards (**night guards**) are covered.
- 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 **root canal therapy** are covered.

- **Complicated oral surgery procedures**, such as the removal of impacted teeth, frenulectomy, and frenulosplasty, are limited to procedures that are covered by this Student Plan and have been predetermined by PacificSource.
- Benefits for **periodontal surgery** are limited to procedures accompanied by a periodontal diagnosis and history of conservative (non-surgical) periodontal treatment.
- Benefits for **veneers** are covered for non-cosmetic purposes only. Benefits are limited to once per tooth per 60 month period.

PEDIATRIC ORTHODONTIA

- Orthodontia with a diagnosis of cleft palate and/or cleft lip is covered for Members age 18 and younger or whose treatment began and was not completed prior to turning age 19.

PEDIATRIC VISION SERVICES

This Student Plan covers the following services for individuals age 18 and younger. Coverage for pediatric services will end on the last day of the month in which the enrolled individual turns 19.

- **Preventive vision examinations** are covered on this Student Plan. Benefits are subject to the Deductible, limitations, Copayment, and/or Coinsurance stated in your Vision Benefit Summary.
- **Vision hardware** including glasses (lenses and frames) or contacts (lenses and fitting) are covered on this Student Plan. Benefits are subject to the Deductible, limitations, Copayment, and/or Coinsurance stated in your Vision Benefit Summary.

PRESCRIPTION DRUGS

This Student Plan covers certain prescription medications included on your Drug List. Please refer to the website PacificSource.com/uo for an up-to-date list of drugs and other information about your prescription benefit. If you have any questions about your coverage, please contact the PacificSource Customer Service team. See your Pharmacy Benefit Summary for your specific benefit information.

Prescription Drug List Tiers

This Student Plan's Prescription Drug List (also known as formulary) includes drugs that are used to treat all medically recognized conditions that are not otherwise excluded by your benefits. All formulary drugs are placed on a tier. Formularies are reviewed and updated

monthly, and a drug may be added, removed, or moved to a higher or lower tier. We will notify you prior to making any change that may impact your care.

- Expanded (Preventive) No-cost Drug List is comprised of certain preventive outpatient drugs. This list is a separate benefit from the preventive service drugs covered under the ACA.

- Tier 0 – Affordable Care Act Standard Preventive No-cost Drug List is comprised of preventive drugs, including tobacco cessation drugs, mandated to be covered under the ACA and are offered at no charge when provided by an In-network Provider.
- Tier 1 is comprised of medications that are mostly Generic Drugs.
- Tier 2 is comprised of preferred medications that are mostly brand name drugs.
- Tier 3 is comprised of non-preferred medications that are mostly brand name drugs. This tier can contain some Specialty Drugs.
- Tier 4 is comprised of medications that are mostly Specialty Drugs.

See the Pharmacy Benefit Summary for cost sharing information.

Drug Discount Programs

Some medications may qualify for third party Copayment assistance programs that could lower your out-of-pocket costs for those products. In addition to payments made by a Member, a Member receives credit toward cost share for coupons or other payments made on their behalf for a covered Prescription Drug that is (a) without a Generic or therapeutic equivalent on our formulary, or (b) for any drug on our formulary that the Member receives pursuant to prior authorization, Step Therapy, or through our Prescription Drug exception request process.

University Health Services Pharmacy

To use this Student Plan's pharmacy benefits at the highest benefit level, you must show the pharmacy plan number on your PacificSource ID card at the University Health Services Pharmacy. This Student Plan's pharmacy benefits can only be accessed through the pharmacy plan number printed on your PacificSource ID card. That plan number allows the pharmacy to collect the appropriate Deductibles, Copayments, and/or Coinsurance amounts from you and bill PacificSource electronically for the balance.

Retail Pharmacy Network

To use this Student Plan's pharmacy benefits at the highest benefit level, you must show the pharmacy plan number on your PacificSource ID card at the in-network pharmacy. This Student Plan's pharmacy benefits can only be accessed through the pharmacy plan number printed on your PacificSource ID card. That plan number allows the pharmacy to collect the appropriate Deductibles, Copayments, and/or Coinsurance amounts from you and bill PacificSource electronically for the balance.

Mail Order Service

This Student Plan includes an in-network mail order service for Prescription Drugs. Questions about this Student Plan's in-network mail order pharmacy may be directed to the PacificSource Customer Service team. Forms and instructions for using the mail order service are available on the website, [PacificSource.com/uo](https://www.pacificsource.com/uo).

Specialty Drug Program

PacificSource contracts with a Specialty Pharmacy provider for high-cost injectable medications. A pharmacist-led Care Team provides individual follow-up care and support to covered Members with prescriptions for Specialty Drugs by providing them strong clinical support, as well as the best overall value for these specific medications. The Care Team also provides comprehensive disease education and counseling, assesses patient health status, and offers a supportive environment for patient Inquiries.

Fills of Specialty Drugs are limited to a 30 day supply and must be filled at our exclusive network Specialty Pharmacy, University Health Services, or the UO Exclusive Network. More information is available on the website, PacificSource.com/uo. Specialty Drugs are designated with SP on the Drug List available on our website. Specialty Drugs are not available through the in-network retail pharmacy or non-contracted Specialty Pharmacies without prior authorization. All subsequent fills must be through our exclusive network Specialty Pharmacy provider.

Medication Synchronization Program

To ensure your medication is effective, it is important to take it exactly as prescribed. This can be challenging if you take multiple medications that refill at different times and require many trips to the pharmacy. Through the medication synchronization program, your ongoing prescriptions can be coordinated so refills are ready at the same time. If you wish to have your medication refills synchronized, please ask your doctor or pharmacist to contact the PacificSource Pharmacy Services team at (844) 877-4803, or email pharmacy@pacificsource.com. They will work with your Providers to evaluate your options and develop your synchronization plan.

No Duplication of Services

Medications and supplies covered under this Student Plan's pharmacy benefit are in place of, not in addition to, those same covered supplies under this Student Plan's medical benefit.

Diabetic Supplies

Refer to the applicable Drug List on the website, PacificSource.com/uo to see which diabetic supplies are covered under this Student Plan's pharmacy benefit. Some diabetic supplies may only be covered under this Student Plan's medical benefit. Diabetic testing supplies are subject to plan quantity limits. For more information, see the Diabetic Equipment, Supplies, and Training section.

Continuous glucose monitors (receivers, transmitters, and sensors) are only covered under the pharmacy benefit with a Provider prescription when criteria is met.

Contraceptives

Contraceptives approved by the Food and Drug Administration (FDA) are covered as required under state law and as recommended by the HRSA, USPSTF, and CDC. Any Deductibles, Copayments, and/or Coinsurance amounts are waived if a Generic Drug is filled at an in-network pharmacy. When no Generic Drug exists, brand name contraceptives may be covered

at no cost. If your provider prescribes a non-formulary contraceptive due to Medical Necessity, it may be subject to exception review for coverage at no charge.

If an initial three month supply is tried, then a 12 month refill of the same contraceptive is covered at an in-network pharmacy in accordance with pharmacy benefits, regardless if the initial prescription was filled under this Student Plan.

A 90 day supply of contraceptives will only be covered when filled via the University Health Services Pharmacy.

Pre-exposure and Post-exposure Prophylaxis

This Student Plan covers pre-exposure prophylaxis (PrEP) medications for the prevention of HIV infection and post-exposure prophylaxis (PEP) medications after a potential exposure to HIV.

Anticancer Medications

Orally administered and self-administered anticancer medications used to kill or slow the growth of cancerous cells are available when prescribed. All orally administered cancer medications will be covered on the same basis and at no greater cost sharing than imposed for IV or injected cancer medication. See the Pharmacy Benefit Summary for cost sharing information.

Formulary Changes

Any removal of a medication from your Drug List will be posted on the website, PacificSource.com/uo, 60 days prior to the effective date of the change, unless the change is done on an emergency basis or an equivalent Generic Drug becomes available without prior notice. In the event of an emergency change, the change will be posted as soon as practicable.

Prescription Limitations and Exclusions

This Student Plan only covers drugs prescribed by an eligible healthcare Provider prescribing within the scope of their professional license. This Student Plan does not cover the following:

- Drugs for any condition excluded under this Student Plan.
- FDA approved medications used for the purpose of weight reduction control or weight loss.
- FDA approved medications for cosmetic purposes.
- Some Specialty Drugs that are not self-administered are not covered by this Student Plan's pharmacy benefit, but may be covered under this Student Plan's medical office supply benefit.
- Some immunizations may be covered under either this Student Plan's medical or pharmacy benefit. Vaccines covered under this Student Plan's pharmacy benefit include, but not limited to: influenza, hepatitis B, herpes zoster (shingles), and

pneumococcal. Most other immunizations must be provided by your Provider under this Student Plan's medical benefit.

- Some drugs and all devices to treat erectile or sexual dysfunction unless defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.
- Drugs used as a preventive measure against hazards of travel.
- Vitamins, minerals, and dietary supplements, except for prescription formulary prenatal vitamins, fluoride products, and for drugs that have a rating of A or B from the USPSTF, some restrictions may apply.
- Drugs provided to an international covered Member in their home country.
- Certain drugs are subject to Step Therapy (ST) protocols, which means this Student Plan may require you to try a pre-requisite drug before this Student Plan will pay for the requested drug. An up-to-date list of drugs requiring Step Therapy, along with all of the requirements, is available on the website, PacificSource.com/uo.
- Certain drugs have quantity limits (QL), which means this Student Plan will generally not pay for quantities above the posted limits. An up-to-date list of drugs requiring quantity limit exceptions along with all of this Student Plan's requirements is available on the website, PacificSource.com/uo.
- This Student Plan has limitations on the quantity of medication that can be filled or refilled. This quantity depends on the type of pharmacy you are using and the days' supply of the prescription.
 - Retail pharmacies: you can get up to a 30 day supply.
 - Mail order pharmacies: you can get up to a 30 day supply.
 - Specialty Pharmacies: you can get up to a 30 day supply.
 - University Health Services Pharmacy: you can get up to a 30 day supply, with the exception of contraceptives which are available up to a 90 day supply.
- For drugs purchased at in-network pharmacies without using the PacificSource pharmacy benefits, reimbursement is limited to the in-network contracted rates. This means you may not be reimbursed the full cash price you pay to the pharmacy.
- Out-of-network pharmacy charges are not eligible for reimbursement.
- Prescription Drug benefits are subject to this Student Plan's coordination of benefits provision. (For more information, see Claims Payment – Coordination of Benefits in this student guide.)
- For most prescriptions, you may refill your prescription only after 75 percent of the previous supply has been taken. This is calculated by the number of days that have elapsed since the previous fill and the days' supply entered by the pharmacy. PacificSource will not approve early refills, except under the following circumstances:

- The request is for ophthalmic solutions or gels, refillable after 70 percent of the previous supply has been taken.
- The Member will be on vacation in a location that does not allow for reasonable access to a network pharmacy for subsequent refills. The Member will be limited to two vacation overrides per Benefit Year, not to exceed the times and criteria noted here. The Member will be allowed up to a 90 day supply if requested prior to a UO study abroad or other UO school program need, or if requested in May or June to allow for summer coverage. 90 day allowed via the University Health Services Pharmacy or mail order only, unless circumstance requires urgent fill. During all other times of year, the Member will be allowed up to a 30 day supply per vacation override.

All early refills are subject to standard cost share and are reviewed on a case by case basis. A pharmacist can approve an early refill of a prescription for eye drops as required by law.

Formulary Exception and Coverage Determination Process

Requests for formulary exceptions can be made by the Member or Provider by contacting the PacificSource Pharmacy Services team. Determinations on standard exception requests will be made no later than 72 hours, expedited requests are determined within 24 hours following receipt of the request. Formulary exceptions and coverage determinations must be based on Medical Necessity, and information must be submitted to support the Medical Necessity including all of the following:

- Documented intolerance or failure to the formulary alternatives for the submitted diagnosis;
- Formulary drugs were tried with an adequate dose and duration of therapy;
- Formulary drugs were not tolerated or were not effective;
- Formulary or preferred drugs would reasonably be expected to cause harm or not produce equivalent results as the requested drug;
- The requested drug therapy is evidence-based and generally accepted medical practice; and
- Special circumstances and individual needs, including the availability of service Providers in the Member's region.

For the complete Formulary Exception Criteria, please refer to the website.

TEMPOROMANDIBULAR JOINT SERVICES (TMJ)

This Student Plan covers treatment of temporomandibular joint syndrome (TMJ) for medical reasons only. All TMJ-related services, including but not limited to, diagnostic procedures and Surgical Procedures, must be provided by Providers practicing within the scope of their licenses. Services are only covered when Medically Necessary due to a history of advanced pathologic process (arthritic degeneration) or in the case of severe acute trauma.

TRANSPLANT SERVICES

This Student Plan covers the following Medically Necessary organ and tissue transplants including supplies, treatment, preparation, and facility fees for both donors and recipients: stem cell transplants and high-dose Chemotherapy; corneal transplants; heart; heart – lungs; intestine; kidney; kidney – pancreas; liver; lungs; and whole organ pancreas transplantation. Expenses for the acquisition of organs or tissues for transplantation are only covered when the transplantation itself is covered under this plan, and is limited to selection, removal of the organ, storage, and transportation of the organ or tissue.

- Benefits are limited as follows:
 - Transplants of human body organs and tissues.
 - Transplants of animal, artificial, or other non-human organs and tissues are not covered.
 - Limited travel and housing expenses for the Member and one caregiver are limited to \$5,000 per transplant. Travel and living expenses are not covered for the donor.
 - Testing of related or unrelated donors for a potential living related organ donation is payable at the same percentage that would apply to the same testing of an insured recipient.
 - Expense for acquisition of cadaver organs is covered, payable at the same percentage and subject to the same limitations, if any, as the transplant itself.
 - Medical services required for the removal and transportation of organs or tissues from living donors are covered. Coverage of the organ or tissue donation is payable at the same percentage as the transplant itself if the recipient is a Member on this Student Plan.
 - If the donor is not a Member on this Student Plan, only those complications of the donation that occur during the initial hospitalization are covered, and such complications are only covered to the extent that they are not covered by another health plan or government program. Coverage is payable at the same percentage as the transplant itself.
 - If the donor is a Member on this Student Plan, complications of the donation are covered as any other illness would be covered.
 - Transplant related services, including human leukocyte antigen (HLA) typing, sibling tissue typing, and evaluation costs, are considered transplant expenses and accumulate toward any transplant benefit limitations and are subject to PacificSource's Provider contractual agreements. For more information, see Payment of Transplant Benefits.

Payment of Transplant Benefits

If a transplant is performed at an in-network Center of Excellence transplantation facility, covered charges of the facility are subject to this Student Plan's in-network transplant benefit. If our contract with the facility includes the services of the medical professionals performing the

transplant, those charges are also subject to this Student Plan's in-network transplant benefit. If the professional fees are not included in our contract with the facility, then those benefits are provided according to the Medical Benefit Summary.

Transplant services that are not received at an in-network Center of Excellence and/or services of out-of-network medical professionals are paid at the Out-of-network Provider percentages stated in the Medical Benefit Summary. The maximum benefit payment for transplant services of Out-of-network Providers is 125 percent of the Medicare allowance.

WOMEN'S HEALTH AND CANCER RIGHTS

Breast Reconstruction

This Student Plan covers breast reconstruction in connection with a Medically Necessary Mastectomy, as required by the Women's Health and Cancer Rights Act of 1998. Coverage is provided in a manner determined in consultation with the attending Provider and for:

- All stages of reconstruction of the breast on which the Mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the Mastectomy, including lymphedema.

Benefits for breast reconstruction are subject to all terms and provisions of the plan, including Deductibles, Copayments, and/or Coinsurance.

Post-Mastectomy Care

This Student Plan covers post-Mastectomy care for a period of time as determined by the attending Provider and, in consultation with the Member, determined to be Medically Necessary following a Mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

WEIGHT WATCHERS

This Student Plan covers Weight Watchers benefits. You must be enrolled in this Student Plan at the time of your first and last Weight Watchers meeting to qualify for reimbursement. You must complete a minimum of ten weeks during a consecutive four month period during the Benefit Year. Participation verification is required. To be eligible for reimbursement, the Reimbursement Request Form must be submitted within two months of the last Weight Watchers class attended. You may obtain the Reimbursement Request Form from the Plan Sponsor, or PacificSource's Customer Service team.

- Benefits are limited as follows: Up to \$100 per Benefit Year.

BENEFIT EXCLUSIONS

Least Costly Setting for Services

Covered Services must be performed in the least costly setting where they can be provided safely. If a procedure can be done safely in an outpatient setting, but is performed in a Hospital inpatient setting, this Student Plan will only pay what it would have paid for the procedure on an outpatient basis.

EXCLUDED SERVICES

This Student Plan does *not* cover the following:

- Abdominoplasty for any indication.
- Academic skills training. This exclusion does not apply if the program, training, or therapy is part of a treatment plan for a pervasive developmental disorder.
- Adolescent wilderness treatment programs.
- Aesthetic (cosmetic) dental procedures – Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.
- Athletic mouth guards.
- Aversion therapy.
- Biofeedback (other than as specifically noted under the Professional Services section).
- Charges for missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims unless otherwise contracted with the Provider.
- Charges that are the responsibility of a third party who may have caused the Illness or Injury, or other insurers covering the incident (such as workers' compensation insurers, automobile insurers, and general liability insurers).
- Chelation therapy including associated infusions of vitamins and/or minerals, except as Medically Necessary for the treatment of selected medical conditions and medically significant heavy metal toxicities.
- Computer or electronic equipment for monitoring asthmatic, similar medical conditions or related data.
- Connector bar or stress breaker.
- Cosmetic/reconstructive services and supplies –Services and supplies, including drugs, rendered primarily for cosmetic/reconstructive purposes (does not apply to Emergency Services). Cosmetic/reconstructive services and supplies are those performed primarily to improve the body's appearance and not primarily to restore impaired function of the body, unless the area needing treatment is a result of a Congenital Anomaly or gender dysphoria.

- Court-ordered sex offender treatment programs.
- Day care or Custodial Care including non-skilled care and helping with activities of daily living, except as specified above in conjunction with Home Healthcare or Hospice Care.
- Dental examinations and treatment for Members age 19 and older, to prevent, diagnose, or treat diseases or conditions of the teeth and supporting tissues or structures, including treatment that restores the function of teeth.
- Denture replacement made necessary by loss, theft, or breakage, unless otherwise noted in Covered Services.
- Diabetic shoes and shoe modifications.
- Drugs and biologicals that can be self-administered (including injectables) are excluded from the medical benefit, except those provided in a Hospital, emergency room, or other institutional setting, or as outpatient Chemotherapy and dialysis, which are covered. Covered drugs and biologicals that can be self-administered are otherwise available under this Student Plan's pharmacy benefit, subject to this Student Plan's requirements.
- Educational or correctional services or sheltered living provided by a school or halfway house, except outpatient services received while temporarily living in a shelter.
- Equine/animal therapy.
- Equipment commonly used for non-medical purposes and/or marketed to the general public.
- Equipment used primarily in athletic or recreational activities. This includes exercise equipment for stretching, conditioning, strengthening, or relief of musculoskeletal problems.
- Expense incurred by a Member; not a United States citizen; for services performed within the Student's home country.
- Experimental, Investigational, or Unproven –This Student 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 the PacificSource 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.

- Eye examinations (preventive) for Members age 19 and older.
- Eye exercises and eye refraction, therapy, and procedures.
- Eye glasses/Contact lenses for Members age 19 and older – The fitting, provision, or replacement of eye glasses, lenses, frames, contact lenses, or subnormal vision aids intended to correct refractive error.
- Eye orthoptics, vision therapy, and procedures intended to correct refractive errors.
- Fitness or exercise programs and health or fitness club memberships.
- Foot care (routine) – Services and supplies for corns and calluses of the feet, conditions of the toenails other than infection, hypertrophy, or hyperplasia of the skin of the feet, and other routine foot care, except in the case of Members being treated for diabetes mellitus.
- 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.
- Growth hormone injections or treatments, except to treat documented growth hormone deficiencies.
- Homeopathic medicines or homeopathic supplies.
- Hypnotherapy.
- Immunizations when recommended for, or in anticipation of, exposure through travel or work.
- Indirect pulp caps are to be included in the Restoration process, and are not a separate Covered Service.
- Infertility – Surgery to reverse voluntary sterilization, sexual dysfunction, services, supplies for intrauterine insemination (IUI), in vitro fertilization, treatment of Infertility, and Prescription Drugs.
- Instructional or educational programs, except National Diabetes Prevention Programs, diabetes self-management programs when Medically Necessary.
- Intra and extra coronal splinting – Devices and procedures for intra and extra coronal splinting to Stabilize mobile teeth.
- Jaw – Services, medications, or supplies for developmental or degenerative abnormalities of the jaw, malocclusion, dental implants, or improving placement of dentures, and artificial larynx.
- Mail order or Internet/web based dental Providers are not eligible Providers.
- Maintenance supplies and equipment not unique to medical care.
- Massage or massage therapy, even as part of a Physical Therapy program.

- Mattresses and mattress pads are only covered when Medically Necessary to heal pressure sores.
- Mental health treatment related to the following are excluded: court-mandated psychological evaluations for child custody determinations; voluntary mutual support groups; mental examinations for the purpose of adjudication of legal rights; psychological testing and evaluations not provided as an adjunct to treatment or diagnosis of a Behavioral Health Condition; stress management, parenting skills, or family education; and assertiveness training.
- Modifications to vehicles or structures to prevent, treat, or accommodate a medical condition.
- Motion analysis, including videotaping and 3-D kinematics, dynamic surface and fine wire electromyography, including Provider review.
- Myeloablative high dose Chemotherapy, except when the related transplant is specifically covered under the transplantation provisions of this plan.
- Naturopathic supplies.
- Nicotine related disorder treatment, other than those covered through Tobacco Cessation Program services.
- Obesity services and bariatric surgery – Except those outlined under weight reduction or control services in the Preventive Services section, all services, medications, supplies, food supplementation, self-help programs provided for obesity, weight reduction control, weight loss, or cosmetic purposes, regardless of the medical conditions that may be caused or exacerbated by excess weight, including food supplementation, and self-help programs. Bariatric surgery and other gastric restrictive procedures, or the revision of these procedures.
- Oral/facial motor therapy for strengthening and coordination of speech-producing musculature and structures, except as Medically Necessary in the restoration or improvement of speech following a traumatic brain Injury or for Members diagnosed with a pervasive developmental disorder.
- Orthodontic services – Repair or replacement of orthodontic appliances.
- Orthodontic services – Treatment of misalignment of teeth and/or jaws, or any ancillary services expressly performed because of orthodontic treatment, except as may be provided for treatment of cleft palate/cleft lip whose treatment began prior to turning age 19, and was not completed prior to turning age 19.
- Orthognathic surgery – Services and supplies to augment or reduce the upper or lower jaw, except to repair an Accidental Injury or for removal of a malignancy, including reconstruction of the jaw.
- Orthopedic shoes and shoe modifications.
- Over-the-counter non-Prescription Drugs, unless included on your Drug List or otherwise listed as a Covered Service in this student guide. Does not apply to tobacco cessation

medications covered under USPSTF guidelines or to over-the-counter preventive care services that are prescribed by the Member's Provider.

- Panniculectomy (removal of panniculus, or excess skin, from lower abdomen) for any indication.
- Periodontal probing, charting, and re-evaluations.
- Personal items such as telephones, televisions, and guest meals during a stay at a Hospital or other inpatient facility.
- Photographic images.
- Physical or eye examinations required for administrative purposes such as participation in athletics, admission to school, or by an employer.
- Precision attachments.
- Private nursing service.
- Programs that teach a person to use medical equipment, care for family members, or self-administer drugs or nutrition, except for diabetic education benefit.
- Psychoanalysis.
- Psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present.
- Pulpotomies on permanent teeth.
- Recreation therapy – outpatient.
- Rehabilitation – Functional capacity evaluations, work hardening programs, vocational rehabilitation, community reintegration services, and driving evaluations and driving training programs
- Removal of clinically serviceable Amalgam Restorations to be replaced by other materials free of mercury, except with proof of allergy to mercury.
- Replacement costs for worn or damaged Durable Medical Equipment that would otherwise be replaceable without charges under warranty or other agreement.
- Scheduled and/or non-emergent medical care outside of the United States (if received in country of citizenship).
- Screening tests – Services and supplies, including imaging and screening exams performed for the sole purpose of screening and not associated with specific diagnoses and/or signs and symptoms of disease or of abnormalities on prior testing (including but not limited to total body CT imaging, CT colonography and bone density testing). This does not include preventive care screenings listed in the Preventive Care Services section.
- Self-help health or instruction or training programs.

- Sensory integration training. This exclusion does not apply if the program, training, or therapy is part of a treatment plan for a pervasive developmental disorder.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth (other than as specifically noted under the Covered Services section).
- 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 required by state law as a condition of maintaining a valid driver license or commercial driver license.
- Services, supplies, and equipment not involved in diagnosis or treatment but provided primarily for the comfort, convenience, alteration of the physical environment, or education of a patient. This includes appliances like adjustable power beds sold as furniture, air conditioners, air purifiers, room humidifiers, heating and cooling pads, home blood pressure monitoring equipment, light boxes, conveyances other than conventional wheelchairs, whirlpool baths, spas, saunas, heat lamps, tanning lights, and pillows.
- Sexual disorders – Services or supplies for the treatment of erectile or sexual dysfunction unless defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.
- Sinus lift grafts to prepare sinus site for implants.
- Skin and tissue removal related to cosmetic body contouring procedures.
- Snoring – Services or supplies for the diagnosis or treatment of snoring , except when attributed to the diagnosis of sleep apnea.
- Social skills training. This exclusion does not apply if the program, training, or therapy is part of a treatment plan for a pervasive developmental disorder.
- Stress-breaking or habit-breaking appliances.
- Support groups.
- Surgery to reverse voluntary sterilization.
- 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 (lost).

- Transplants – Any services, treatments, or supplies for the transplantation of stem cells or any human body organ or tissue, except as expressly provided under the provisions of this Student Plan for covered transplantation expenses.
- Treatment after coverage ends – Services or supplies a Member receives after the Member's coverage under this Student Plan ends.
- Treatment not Dentally Necessary, according to acceptable dental practice, or treatment not likely to have a reasonably favorable prognosis.
- Treatment not Medically Necessary – Services or supplies that are not Medically Necessary for the diagnosis or treatment of an Illness or Injury.
- Treatment of any Illness or Injury resulting from an illegal occupation or attempted felony, or treatment received while in the custody of any law enforcement other than with the local supervisory authority while pending disposition of charges.
- Treatment of any work-related Illness or Injury except as described in the On-the-Job Illness or Injury and Workers' Compensation section.
- Treatment prior to enrollment.
- Unwilling to release information – Charges for services or supplies for which a Member is unwilling to release medical, dental, or eligibility information necessary to determine the benefits covered under this Student 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.

UTILIZATION REVIEW

PacificSource has a utilization review program to determine coverage. This program is administered by the PacificSource Health Services team for prior authorization, concurrent reviews, and post-service reviews. PacificSource may delegate certain utilization review functions to third parties, including utilization review for services rendered by Providers outside of Idaho, Montana, Oregon, and Washington.

Questions regarding Medical/Dental Necessity, possible Experimental, Investigational, or Unproven services, appropriate setting, and appropriate treatment are forwarded to the PacificSource Medical Director for review and Benefit Determination, where applicable.

If you would like information on how PacificSource reached a particular utilization review Benefit Determination, please contact the PacificSource 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, supplies, and Prescription Drugs are covered under this Student, and if you meet this Student Plan's eligibility requirements.

Your Provider can request prior authorization from the PacificSource Health Services team. If your Provider will not request prior authorization for you, you may contact PacificSource yourself. In some cases, PacificSource may ask for more information or require a second opinion before authorizing coverage. You and/or your Provider are responsible for providing PacificSource with all information necessary to make a Benefit Determination.

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 the website, Authgrid.PacificSource.com (select Commercial for the line of business).

You can search for information about Prescription Drug prior authorization requirements on the website, PacificSource.com/find-a-drug. The prior authorization search tool is not intended to suggest that all the items listed are covered by the benefits of this Student Plan.

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

If your treatment does not receive prior authorization, you can still seek treatment, but your 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 Student Plan or were not Medically/Dentally Necessary, you will be held responsible for the expense. Remember, any time you are unsure if an expense will be covered, contact the PacificSource Customer Service team.

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

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

In a medical emergency, services and supplies necessary to determine the nature and extent of an Emergency Medical Condition and to Stabilize the Member are covered without prior authorization requirements. A Hospital or other healthcare facility must notify PacificSource of an emergency admission within two business days.

If your Provider's prior authorization request is denied as not Medically/Dentally Necessary or as Experimental, Investigational, or Unproven, your Provider may Appeal the Benefit Determination. You retain the right to Appeal the Benefit Determination independent from your Provider.

CASE MANAGEMENT

Case management is a program designed to provide early detection and intervention in serious cases of Illness or Injury that have the potential for ongoing major or complex resource use. Case management services may be initiated by PacificSource when there is a high utilization of health services or multiple Providers, or for health problems such as, but not limited to, transplantation, high risk obstetric or neonatal care, spinal cord Injury, trauma or traumatic Injury, or any acute or chronic condition that may necessitate specialized treatment or care coordination.

Case managers are experienced licensed healthcare professionals with specialized skills to respond to the complexity of a Member's healthcare needs. When case management services are implemented, the Case Manager will work in collaboration with the Member's Provider and the PacificSource Medical Director to enhance the quality of care, maximize available benefits, and propose individual supplemental benefits.

PacificSource reserves the right to employ a third party to assist with or perform the function of case management.

INDIVIDUAL/SUPPLEMENTAL BENEFITS

An individual/supplemental benefit may be available if PacificSource, on behalf of the University of Oregon, approves coverage for services or supplies that are not a Covered Service under this Student Plan (for example, continuation of home health physical therapy beyond the benefit limit, if Medical Necessity determines that continuation would result in both improved health of Member and overall reduction of costs). This Student Plan may cover these supplemental benefits through case management if PacificSource determines that supplemental benefits are Medically Necessary and will result in an overall reduction in covered costs and improved quality of care. 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, on behalf of the University of Oregon, 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 Member.

USING THE PROVIDER NETWORK

This section explains how this Student Plan's benefits differ when you use the University Health Services, 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. This Student Plan's networks are listed on your Member ID card.

All Providers are independent contractors. The University of Oregon or PacificSource cannot be held liable for any claim for damages or Injuries you experience while receiving care. Members have the right to choose their Providers.

Under this Student Plan, you are free to seek care, including Women's Healthcare Services, 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.

Nothing in this Student Plan is designed to restrict Members from contracting to obtain any healthcare services outside the Student Plan on any terms Members choose.

UNIVERSITY HEALTH SERVICES (UHS)

The Student Plan covers 100% of most Medically Necessary, eligible services received at University Health Services.

Some services at UHS are not covered benefits (e.g., massage therapy, etc.). If a service is deemed as not medically necessary, it will not be covered by the plan (e.g., a student needs a blood test as part of an employment or study abroad requirement; not because of a medical diagnosis). Some services at UHS are provided by a partner entity, such as Quest Diagnostics or DonJoy Global. If a student receives a service through these partners, the student will receive a bill directly from that partner entity and normal deductibles and co-pays and/or co-insurance will apply. Students are encouraged to ask questions about services they plan to receive ahead of time (at UHS and any other provider) to help them make an informed decision about their care.

IN-NETWORK PROVIDERS (UO EXCLUSIVE & NAVIGATOR NETWORKS)

In-network Providers contract with PacificSource or the University of Oregon to provide services and supplies for an Allowable Fee. In-network Providers agree not to collect more than the Allowable Fee. In-network Providers bill PacificSource directly, and they 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. To ensure the highest level of benefits, access care from an In-network Provider, including specialists and Hospitals.

PacificSource contracts directly and/or indirectly with In-network Providers throughout their networks' Service Area. PacificSource also has agreements with nationwide Provider networks. These Providers outside Idaho, Montana, Oregon, and Washington are also considered PacificSource In-network Providers under this Student Plan.

It is not safe to assume that when you are treated at an in-network facility, all services are performed by In-network Providers. Whenever possible, you should arrange for professional services, such as surgery and anesthesiology to be provided by an In-network Provider. Doing so will help you maximize your benefits and limit your out-of-pocket expenses.

Risk-sharing Arrangements

By agreement, an In-network Provider may not bill a Member for any amount in excess of the Allowable Fee. However, the agreement does not prohibit the Provider from collecting Copayments, Deductibles, Coinsurance, and amounts for non-Covered Services from the Member.

SHARED DECISION MAKING

Shared decision making (SDM) is a collaborative process that allows Members and their

Providers to make healthcare decisions together, taking into account the best scientific evidence available, as well as the Member's values and preferences. SDM honors both the Provider's expert knowledge and the Member's right to be fully informed of all care options and the potential harms and benefits. This process provides Members with the support they need to make the best decisions about their care, while allowing Providers to feel confident in the care they prescribe. For certain procedures, Members may be required to complete SDM tools for review with their Providers in order to receive the highest level of benefits.

Under this Student Plan, you are free to seek care from Providers other than your PCP without a referral.

In addition to the In-network Providers for this Student Plan, PacificSource has agreements with a number of medical centers and specialized treatment programs. If you need services for which PacificSource has Provider contracts, you will be required to use the In-network Providers for your treatment to be covered at the Student Plan's highest benefit level.

FINDING AN IN-NETWORK PROVIDER

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

- On the website, [PacificSource.com/uo](https://www.pacificsource.com/uo), go to Find a Doctor to easily look up In-network Providers, specialists, behavioral health Providers, and Hospitals. You can also print your own customized directory.
- Contact the PacificSource Customer Service team. Their staff can answer your questions about specific Providers.

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 Deductible, Copayment, and/or Coinsurance amounts stated in your Benefit Summaries.

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 the payment to Out-of-network Providers, PacificSource determines the

Allowable Fee, then subtracts the Out-of-network Provider benefits.

Your Rights and Protections Against Surprise Medical Bills and Balance Billing

When you get emergency care or get treated by an Out-of-network Provider at an in-network Hospital or Ambulatory Surgical Center, you are protected from Balance Billing. In these cases, you shouldn't be charged more than your Student Plan's Copayments, Coinsurance, and/or Deductible.

What is Balance Billing (sometimes called 'surprise billing')?

When you see a doctor or other healthcare Provider, you may owe certain out-of-pocket costs, like a Copayment, Coinsurance, or Deductible. You may have additional costs or have to pay the entire bill if you see a Provider or visit a healthcare facility that isn't in your health plan's network.

Out-of-network means Providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network Providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called 'Balance Billing'. This amount is likely more than in-network costs for the same service and might not count toward your plan's Deductible or annual out-of-pocket limit.

'Surprise billing' is an unexpected Balance Bill. This can happen when you can't control who is involved in your care - like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an Out-of-network Provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are Protected from Balance Billing for:

- **Emergency Services:**

If you have an Emergency Medical Condition and get Emergency Services from an Out-of-network Provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as Copayments, Coinsurance, and Deductibles). You can't be Balance Billed for these Emergency Services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be Balance Billed for these post-stabilization services.

- **Certain Services at an in-network Hospital or Ambulatory Surgical Center:**

When you get services from an in-network Hospital or Ambulatory Surgical Center, certain Providers there may be out-of-network. In these cases, the most those Providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeons, hospitalists, or intensivist services. These Providers can't Balance Bill you and may not ask you to give up your protections not to be Balance Billed.

If you get other types of services at these in-network facilities, Out-of-network Providers can't Balance Bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from Balance Billing. You also aren't required to get out-of-network care. You can choose a Provider or facility in your plan's network.

When Balance Billing Isn't Allowed, You also have the Following Protections:

You are only responsible for paying your share of the cost (like the Copayments, Coinsurance, and Deductibles) that you would pay if the Provider or facility was in-network. Your health plan will pay any additional costs to Out-of-network Providers and facilities directly.

Generally, your health plan must:

- Cover Emergency Services without requiring you to get approval for services in advance (also known as ‘prior authorization’);
- Cover Emergency Services by Out-of-network Providers;
- Base what you owe the Provider or facility (cost-sharing) on what it would pay an In-network Provider or facility and show that amount in your explanation of benefits; and
- Count any amount you pay for Emergency Services or out-of-network services toward your in-network Deductible and out-of-pocket limit.

If you think you’ve been wrongly billed, you may file a Complaint with the federal government at cms.gov/nosurprises/consumers or by calling **1-800-985-3059**.

Visit cms.gov/nosurprises/consumers for more information about your rights under federal law.

Example of Provider Payment

The following provides an example of how a payment could be made for In-network or Out-of-network Providers.

This Student Plan will pay 80 percent of the Allowable Fee for In-network Providers and 60 percent of the Allowable Fee for Out-of-network Providers. The benefits would appear as follows:

In-network Provider	Out-of-network Provider
Payment: After Deductible, Member pays 20% of the Allowable Fee.	Payment: After Deductible, Member pays 40% of the Allowable Fee and the balance of billed charges unless the service qualifies for Balance Billing protection (see Your Rights and Protections Against Surprise Medical Bills and Balance Billing).

In this example, the Provider’s charge for a service is \$5,000 and the Allowable Fee for an In-network Provider is \$4,000. This example assumes that the Member has met this Student Plan’s Deductible during the Benefit Year, but has not yet met the out-of-pocket limit for the Benefit Year:

In-network Provider:

This Student Plan would pay 80 percent of the Allowable Fee and the Member would pay 20 percent of the Allowable Fee, as follows:

Amount the In-Network Provider must discount (Allowable Fee):	\$1,000
Amount this Student Plan pays (80% of the \$4,000 Allowable Fee):	\$3,200
Amount the Member pays (20% of the \$4,000 Allowable Fee):	\$800
Total:	\$5,000

Out-of-network Provider:

This Student Plan would pay 60 percent of the Allowable Fee. (For this example, \$4,000 is also the charge upon which the Out-of-Network Provider's Allowable Fee is established.) Because the Out-of-Network Provider does not accept the Allowable Fee and may charge more, the Member would pay 40 percent of the Allowable Fee, plus the \$1,000 difference between the Out-of-Network Provider's billed charges and the Allowable Fee, as follows:

Amount this Student Plan pays (60% of the \$4,000 Allowable Fee):	\$2,400
Amount the Member pays (40% of the \$4,000 Allowable Fee and the \$1,000 difference between the billed charges and the Allowable Fee):	\$2,600
Total:	\$5,000

This Student Plan's actual benefits may vary, so please review the Benefit Summaries and Covered Services section to determine how your benefits are paid. Please remember that the Allowable Fee may vary for a Covered Service depending upon the selected Provider.

COVERAGE WHILE TRAVELING

Finding an In-network Provider

If you are away from home, but within the Service Area, you may find an In-network Provider by using the website PacificSource.com/uo or by contacting the PacificSource Customer Service team.

If you are outside of the Service Area, go to PacificSource.com/uo and follow the instructions to find In-network Providers outside the Service Area. The listed Providers are part of nationwide Provider networks with whom PacificSource has agreements with. Providers on these networks are considered in-network when and only when you are outside your Service Area.

Non-emergency Care While Traveling

To find an In-network Provider outside the regions covered by your network, go to the PacificSource.com/uo website.

Non-emergency care outside the United States is covered for full-time Students attending college outside the United States for three or more months.

- If you access care through an In-network Provider, this Student Plan's In-network Provider benefits will apply.
- If an In-network Provider is available but you choose to use an Out-of-network Provider, this Student Plan's Out-of-network Provider benefits will apply.
- When abroad, this Student Plan's In-network Provider benefits will apply for Covered Services.

Out-of-network Provider for Emergency Services

If you use an Out-of-network Provider for emergency Covered Services, this Student Plan will pay benefits at the In-network Provider level.

If you are admitted to an out-of-network Hospital and require additional service to further Stabilize your Emergency Medical Condition, your Provider or Hospital should contact the PacificSource Health Services team at (888) 691-8209 as soon as possible. PacificSource may coordinate your transfer to an in-network facility.

Emergency care outside of the United States is covered. Members will need to pay for these services upfront and submit a claim for reimbursement. Your claim for reimbursement must include a detailed invoice from the treating facility.

EPIDEMIC

PacificSource will work in conjunction with local authorities and health systems to coordinate in the communication of health services to assist you with accessing care in the event of an epidemic. Critical care and Emergency Services are given the highest priority.

TERMINATION OF PROVIDER CONTRACTS

PacificSource will attempt to notify you within 30 days of learning about the termination of a PacificSource 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.

You are entitled to continue care with an individual Provider or facility, whose contract was terminated without cause, for a limited period of time at the in-network cost share. Continuation of care will not be available if you are no longer covered under this Student Plan, the Provider will not accept the Allowable Fee under the terms of their terminated agreement,

the Provider no longer holds an active license, or the Provider is otherwise unavailable to continue the care. Contact the PacificSource Customer Service team for additional information.

If you do not qualify for continuation of care, 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 Summaries. To avoid unexpected costs, be sure to verify each time you see your Provider that they are still participating in the network.

Active Course of Treatment

If the contract of a Provider who is providing to you an active course of treatment, as defined in Consolidated Appropriations Act of 2021 (CAA), is terminated without cause, you may be able to continue to receive services from the Provider at the in-network benefit level for a limited period of time. The services may be paid at in-network cost sharing until the earliest of the following:

- Treatment is complete; or
- 90 days after you were notified that the contract ended.

BENEFIT DETERMINATIONS AND CLAIMS PAYMENT

How to File a Claim

When an 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 PacificSource 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 Student 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, PacificSource 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, they 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 for the specific type of review. This does not apply to Emergency Services or Urgent Care services. No extension is permitted for Urgent Care Reviews.

Benefit Determination	Pre-service Review	Concurrent Care Review	Urgent Care Review
Initial determination by PacificSource	2 business days	24 hours	72 hours
If PacificSource requires additional information, PacificSource will make request within	2 business days	24 hours	24 hours
Provider or Member must provide requested additional information within	15 business days	24 hours	48 hours
Once PacificSource receives the information, decision will be made and written notice sent within	2 business days	24 hours	48 hours

Claim Determination – PacificSource, on behalf of the University of Oregon, 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, PacificSource will send you notice that the claim was received and explain what additional information is necessary to process the claim. If PacificSource does not receive the necessary information within 15 days of the delay notice, they 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, post-service, or concurrent care basis may be Appealed in accordance with this Student Plan's Appeals procedures. For more information, see the Complaints, Grievances, and Appeals section.

Payment of Claims

PacificSource, on behalf of the University of Oregon, may pay benefits to the Member, the Provider, or both jointly. Neither the benefits of this Student Plan nor a claim for payment of benefits under this Student 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 the PacificSource Customer Service team or go online to view the information via the website, **PacificSource.com/uo**.

Benefits Paid in Error

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

In the same manner, if PacificSource applies healthcare expense to this Student Plan's Deductibles that would not otherwise be reimbursable under the terms of this Student Plan; PacificSource may deduct a like amount from the accumulated Deductible amounts and/or recover payment of the healthcare expense that would have otherwise been applied to the Deductibles.

Legal Procedures

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

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

COORDINATION OF BENEFITS

The Student Plan serves as secondary coverage in coordination of benefits situations. However, this Plan serves as primary coverage when the Member also has coverage through the Oregon Health Plan, other state Medicaid plans, federal health plans, or tribal plans. The Plan is formed under the authority granted by ORS 352.087 and therefore is not subject to the

insurance code, including the Coordination of Benefits rules as outline by the Division of Financial Regulation.

Special Provision for National Collegiate Athletic Association (NCAA)-Sanctioned Intercollegiate Sports

Benefits for services related to participation in UO's NCAA-sanctioned intercollegiate sports are only provided by the Student Plan on a secondary payor basis. This provision does not apply to expenses incurred from the practice or play of intramural or club sports, as such expenses are covered on the same basis as any other Injury.

The Student Plan provides benefits for Injury or Illness resulting from the practice or play of NCAA-Sanctioned Intercollegiate Sports when:

1. The maximum per-Injury limits of insurance coverage provided by the NCAA are reached; or
2. A specific limitation or exclusion in NCAA coverage, or any other coverage provided by the UO Athletic Department for medical expenses incurred from practice or play of intercollegiate sports is applied to an expense that is otherwise eligible under the Student Plan.

In combination with insurance/benefits provided by the UO Athletic Department, this provision assures that intercollegiate athletes do not incur any out-of-pocket expense resulting from the practice or play of NCAA-sanctioned intercollegiate sports.

THIRD PARTY LIABILITY

Third party liability means claims that are the responsibility of someone other than this Student Plan. 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.

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

When PacificSource receives a claim that might involve a third party, they may send you a questionnaire to help determine responsibility.

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

- If this Student Plan 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 this Student Plan.
- This Student Plan 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 this Student Plan to the Injury caused by the third party. This Student Plan 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).
- This Student Plan may subtract a proportionate share of the reasonable attorney's fees you incurred from the money you are to pay back to this Student Plan.
- This Student Plan may ask you to take action to recover expenses we have paid from the responsible party. This Student Plan may also assign a representative to do so on your behalf. If there is a recovery, this Student Plan will be reimbursed for any expenses or attorney's fees out of that recovery.
- 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 healthcare expenses after the settlement, this Student Plan 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 this Student Plan's right of reimbursement or subrogation, until that right is satisfied or released.
- If any of these conditions are not met, then this Student Plan may recover any such benefits paid or advanced for any Illness or Injury through legal action, as well as reasonable attorney fees incurred by this Student Plan.
- Unless Federal Law is found to apply.
- Unless expressly prohibited by state law, this Student Plan's right to reimbursement overrides the made whole doctrine and this Student 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, on behalf of this Student Plan, 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, on behalf of this Student Plan.

PacificSource must request reimbursement within 12 months of the claim payment except under the following circumstance:

- In the case where this Student Plan and/or 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 this Student Plan and/or PacificSource has actual knowledge of the invalid claim, claim overpayment, or other incorrect payment. Regardless of the date upon which this Student Plan and/or PacificSource obtains actual knowledge of an invalid claim, claim overpayment, or other incorrect payment, PacificSource, on behalf of this Student Plan, 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, on behalf of this Student Plan, 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, on behalf of this Student Plan, 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 expenses are not covered by this Student Plan if they are covered by any other type of insurance policy.

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

By enrolling in this Student Plan, you agree to the terms in the previous section regarding third party liability.

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

This Student 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 the 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 with 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 the PacificSource Third Party Claims team for complete details.

Surrogacy Health Services

A Member who enters into a Surrogacy Agreement and receives compensation under such Surrogacy Agreement, must reimburse this Student Plan for claims paid for Covered Services related to conception, fertility treatments, pregnancy, delivery, or postpartum care that are received in connection with the Surrogacy Agreement. This Student Plan is entitled to reimbursement for any paid claims out of the compensation a Member receives or is entitled to receive under a Surrogacy Agreement. A Member who enters into a Surrogacy Agreement must inform this Student Plan of that agreement within 30 days of entering that agreement or becoming a Member of this Student Plan, and provide a copy of the agreement to this Student Plan.

COMPLAINTS, GRIEVANCES, AND APPEALS

Questions, Concerns, or Complaints

The University of Oregon understands that you may have questions or concerns about your benefits, eligibility, the quality of care you receive, or about a claim determination. PacificSource will try to answer your questions promptly and give you clear, accurate answers based on the criteria adopted by the University of Oregon.

If you have a question, concern, or Complaint about your coverage, please contact the PacificSource Customer Service team. Many times, their 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.

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

GRIEVANCE PROCEDURES

If you or your Authorized Representative are dissatisfied with the availability, delivery, or the quality of healthcare services; or claims payment, handling, or reimbursement for healthcare services, or matters pertaining to the relationship between you and this Student Plan, 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. (See How to Submit Grievances or Appeals below.)

APPEAL PROCEDURES

If you believe the University of Oregon, or PacificSource acting on behalf of the University of Oregon, has improperly reduced or terminated a healthcare item or service, or failed or refused

to provide or make a payment in whole or in part for a healthcare item or service, that is based on any of the reasons listed below, you or your Authorized Representative (see Definition section) may Appeal (request a review) of that decision. The request for Appeal must be made in writing and within 180 days of the receipt of notification of an Adverse Benefit Determination (see How to Submit Grievances or Appeals below). 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 coverage, 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 healthcare item or service is Experimental, Investigational, Unproven, or not a Dental Necessity, or Medically Necessary, 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.

Any 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, your Appeal is not considered to be filed until such time as PacificSource has received the 'Authorization to Use or Disclose PHI' and the 'Designation of Authorized Representative' forms.

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 healthcare 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 below) you may request that the internal and External Reviews be performed at the same time.

External Independent Review: If your dispute with this Student Plan relates to an Adverse Benefit Determination that a course or plan of treatment is not a Medical 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 healthcare setting and with the appropriate level of care, **you or your Authorized Representative may request an External Review by an independent review organization.** PacificSource must receive a signed Authorization to Use/Disclose Protected Health Information form within five business days of your external independent review request. This form must be signed to grant the review organization access to health records relevant to the decision. This form is located on the

website [PacificSource.com/resources/documents-and-forms](https://www.pacificsource.com/resources/documents-and-forms). For more information, see the How to Submit Grievances or Appeals section.

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

This Student Plan 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 this Student Plan fails to strictly comply with its Appeals process and with state and federal requirements for Internal Appeals.

If the independent review organization reverses the Student Plan's decision, PacificSource will apply their decision quickly. However, if the independent review organization stands by this Student Plan's decision, there is no further Appeal available to you.

Timelines for Responding to Appeals

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

The above time frames do not apply if the period is too long to accommodate the clinical urgency of a situation, or if you do not reasonably cooperate, or if circumstances beyond your or PacificSource's 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 medical or 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.

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 PacificSource's 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

Emailing studenthealth@pacificsource.com, with 'Grievance' or 'Appeal' as the subject

Faxing (541) 225-3628

RESOURCES FOR INFORMATION AND ASSISTANCE

Assistance in Other Languages

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

Information Available from the University of Oregon and PacificSource

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

- A directory of In-network Providers under this Student Plan;
- Information about the Drug List (also known as a formulary);
- A copy of the annual report on Complaints and Appeals;
- A summary of Adverse Benefit Determinations and Grievance processes;
- Information about PacificSource's policy for protecting confidentiality or your information;
- 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 this Student Plan or PacificSource has with Providers;
- A description of this Student Plan and/or PacificSource's efforts to monitor and improve the quality of health services;
- Information about how PacificSource checks the credentials of their network Providers, and how you can obtain the names and qualifications of your healthcare Providers;
- Information about PacificSource's prior authorization and utilization review procedures;
- Information about any healthcare plan offered by PacificSource; and

- Information about PacificSource's price transparency for all Covered Services, items, and Prescription Drugs is available on the PacificSource 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.

RIGHTS AND RESPONSIBILITIES

This Student Plan and PacificSource are committed to providing you with the highest level of service in the industry. By respecting your rights and clearly explaining your responsibilities under this Student Plan, we will promote effective healthcare.

Your Rights as a Member:

- You have a right to receive information about this Student Plan and PacificSource, our services, our Providers, and your rights and responsibilities.
- You have a right to expect clear explanations of this Student Plan benefits and exclusions.
- You have a right to be treated with respect and dignity.
- You have a right to impartial access to healthcare without regard to race, religion, gender, national origin, or disability.
- You have a right to honest discussion of appropriate or Medically/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 Student Plan.
- You have a right to the confidential protection of your records and personal information.
- You have a right to voice Complaints about this Student Plan 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.

Your Responsibilities as a Member:

- You are responsible for reading this student guide and all other communications from this Student Plan and PacificSource, and for understanding this Student Plan's benefits. You are responsible for contacting PacificSource Customer Service 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 the University of Oregon and PacificSource with all the information required to provide benefits under this Student Plan.
- You are responsible for giving your Provider complete health information to help accurately diagnose and treat you.
- You are responsible for telling your Providers you are covered by this Student Plan and showing your 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 the University of Oregon or PacificSource if you believe you are not receiving adequate care.
- You are responsible for supplying information to the extent possible that this Student Plan or PacificSource needs in order to administer your benefits or your medical 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 problems and participating in developing mutually agreed upon goals, to the degree possible.

PRIVACY AND CONFIDENTIALITY

This Student Plan and PacificSource have strict policies in place to protect the confidentiality of your personal information, including your healthcare records. Your personal information is only available to the University of Oregon and PacificSource staff members who need that information to do their jobs.

Disclosure outside this Student Plan or 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 this Student Plan or PacificSource. An example of one exception is that PacificSource does not need written authorization to disclose information to a designee performing utilization management, quality assurance, or peer review on their behalf. To request receipt of confidential communications in a different manner or at a different address, you will need to complete and return the form provided at [PacificSource.com/resources/documents-and-forms](https://www.pacificsource.com/resources/documents-and-forms).

PLAN ADMINISTRATION

Name of Plan:

University of Oregon Student Health Benefits Plan

Name and Address:

University of Oregon
1232 University of Oregon
Eugene, OR 97403

University of Oregon's Employer Identification / Tax Identification Number:

46-4727800

Plan Identification Number:

501

Contract Year:

UO Law Students: 8/10/2025 to 8/9/2026

UO Students (Undergraduate/Non-Law Graduate): 9/15/2025 to 9/14/2026

Type of Plan:

Student Health Plan (self-insured)

Type of Administration:

This Student Plan is administered by the employees of the University of Oregon and under an administrative services agreement with a Third Party Administrator.

Name and Address of Third Party Administrator:

PacificSource Health Plans
P.O. Box 7068
Springfield, OR 97475-0068
Phone: (888) 977-9299
Fax: (541) 684-5264

Name and Address of Designated Agent for Service of Legal Process:

Office of General Counsel
219 Johnson Hall
1226 University of Oregon

Funding Method and Contributions:

This Student Plan is self-insured, meaning that benefits are paid from the general assets and/or trust funds of the University of Oregon and are not guaranteed under an insurance policy or contract. The cost of this Student Plan is paid with contributions by the University of Oregon and participating Students. The University of Oregon determines the amount of contributions to this Student Plan, based on estimates of claims and administration costs. The University of Oregon may purchase insurance coverage to guard against excess loss incurred by allowed claims under this Student Plan, but such coverage is not included as part of this Student Plan.

Student Plan Changes

The terms, conditions, and benefits of this Student Plan may be changed from time to time. The following people have the authority to accept or approve changes or terminate this Student Plan:

- The University of Oregon's Student Health Benefits Plan Advisory Group or other governing body; or
- Anyone authorized by the above people to take such action.

These persons are authorized to make changes to the Student Plan on behalf of the University of Oregon.

If this Student Plan terminates and the University of Oregon does not replace the coverage with another plan, the University of Oregon is required by law to advise you in writing of the termination.

DEFINITIONS

Wherever used in this Student Plan, the following definitions apply to the terms listed below, and the masculine includes the feminine and the singular includes the plural. 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.

Admitted means any Student who has gone through a formal admissions process to study at the University of Oregon in pursuit of a degree. This is verified by reference to the University of Oregon's Office of the Registrar's records indicating that the Student has a level code equal to 'UG', 'LW', or 'GR' (excluding post-doc scholars, in accordance with ORS 350.370).

Adverse Benefit Determination means the University of Oregon's denial, reduction, or termination of, or PacificSource's, on half of the University of Oregon, failure to provide or to make a payment in whole or in part, for a benefit that is based on this Student Plan'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 healthcare item or service is Experimental, Investigational, Unproven, or not Dental Necessity or Medically Necessary, 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 this Student Plan 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 this Student Plan 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 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.

Ambulatory Surgical Center means a facility licensed by the appropriate state or federal agency to perform Surgical Procedures on an outpatient basis.

Appeal means a written request from a Member or, if authorized by the Member, the Member's Authorized Representative, to change a previous decision made by University of Oregon concerning:

- Access to healthcare benefits, including an Adverse Benefit Determination made pursuant to utilization management;
- Claims payment, handling, or reimbursement for healthcare services;

- Rescission of the Member's benefit coverage by University of Oregon; and
- Other matters as specifically required by law.

Approved Clinical Trials means Phase I, II, III, or IV clinical trials for the prevention, detection, or treatment of cancer or another life-threatening condition or disease. Life threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. The trial must be:

- Funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense, or the United States Department of Veterans Affairs, or the Department of Energy;
- Supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense, or the United States Department of Veterans Affairs;
- Conducted as an investigational new drug application, an investigational device exemption or a biologics license application subject to approval by the United States Food and Drug Administration; or
- Exempt by federal law from the requirement to submit an investigational new drug application to the United States Food and Drug Administration.

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/uo**, 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 out-of-network Allowable Fee and the Provider's billed charge. Out-of-network Providers may bill the Member this amount, unless the service qualifies for protection rights under federal law. For more information, see the Your Rights and Protections Against Surprise Medical Bills and Balance Billing section.

Behavioral Health Assessment means an evaluation by a behavioral health clinician, in person or using Telehealth, to determine a patient's need for immediate crisis stabilization.

Behavioral Health Condition means any mental or Substance Use Disorder covered by diagnostic categories listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), the International Classification of Diseases, 10th Revision (ICD-10), or the International Classification of Diseases, 11th Revision (ICD-11).

Behavioral Health Crisis means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a Hospital to prevent a serious deterioration in the individual's mental or physical health.

Benefit Determination means the activity taken to determine or fulfill the responsibility for provisions under this Student Plan and provide reimbursement for healthcare 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 healthcare services with respect to Medical/Dental Necessity (including underlying criteria), coverage under this Student 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 Summary is a summary of this Student Plan issued or applied for, not a contract of coverage that includes a list of principle benefits and coverages, and a statement of the limitations and exclusions contained in this Student Plan.

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

Cardiac Rehabilitation refers to a comprehensive program that generally involves medical evaluation, prescribed exercise, and cardiac risk factor modification. Education, counseling, and behavioral interventions are sometimes used as well. Phase I refers to inpatient services that typically occur during hospitalization for heart attack or heart surgery. Phase II refers to a short-term outpatient program, usually involving ECG-monitored exercise. Phase III refers to a long-term program, usually at home or in a community-based facility, with little or no ECG monitoring.

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.

Chemotherapy means the use of drugs approved for use in humans by the FDA and ordered by the Provider for the treatment of disease.

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 Copays and Deductibles. The Coinsurance amounts the Member is responsible for are listed in the Benefit Summaries.

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

Compliance Deadline means those dates identified as a "Compliance Deadline" in the tables included in the 'Becoming Eligible' section of this document.

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

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

Congenital Anomaly means a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. The term significant deviation is defined to be a deviation which impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be Congenital Anomalies.

Contract Year means a 12 month period beginning on the date this Student Plan is issued or the anniversary of the date this Student Plan was issued. If changes are made to this Student Plan 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 University of Oregon. A Contract Year may or may not coincide with a calendar year.

Copayment (also referred to as 'Copay') is a fixed, up-front dollar amount the Member is required to pay for certain Covered Services. The Copay applicable to a specific Covered Service is listed under that specific benefit in the Benefit Summary.

Covered Service means a service or supply for which benefits are payable under this Student 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 Student 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.

Custodial Care means care that is for the purpose of watching and protecting a patient. Custodial Care includes care that helps the patient conduct activities of daily living that can be provided by a person without medical or paramedical skills and/or is primarily for the purpose of separating the patient from others or preventing self-harm.

Deductible means the portion of the expense for a Covered Service that must be paid by the Member before the benefits of this Student 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.

Diagnostic Breast Examination means a Medically Necessary and clinically appropriate examination of the breast that is used to evaluate an abnormality seen or suspected from a screening examination for breast cancer or detected by another means of examination.

Domestic Student means any Student who is Admitted to the University of Oregon and is not an International Exchange/Sponsored Student, or other Student who has a visa type of J or F, or other legal non-immigrant status that is approved by the Division of Global Engagement.

Drug List (also known as a formulary) is a list of covered medications used to treat various medical conditions. Please refer to PacificSource.com/uo to determine which Drug List applies to your coverage. The Drug Lists are developed and maintained by a committee of regional Providers, including doctors, who are not employed by PacificSource.

Durable Medical Equipment means equipment that can withstand repeated use; is primarily and customarily used to serve a medical purpose rather than convenience or comfort; is generally not useful to a person in the absence of an Illness or Injury; is appropriate for use in the home; and is prescribed by a Provider. Examples of Durable Medical Equipment include but are not limited to Hospital beds, wheelchairs, crutches, canes, walkers, nebulizers, commodes, suction machines, traction equipment, respirators, and TENS units.

Durable Medical Equipment Supplier means a PacificSource In-network Provider or a Provider that satisfies the criteria in the Medicare Quality Standards for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and Other Items and Services section.

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.

Emergency Medical Condition means a medical, mental health, or Substance Use Disorder condition:

- Manifesting itself by acute symptoms of sufficient severity, including severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition:
 - 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.
- With respect to a pregnant woman who is having contractions, for which there is inadequate time to affect a safe transfer to another Hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child.
- That is a Behavioral Health Crisis.

Emergency Medical Screening Exam means the medical history, examination, ancillary tests, and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

Emergency Services means:

- An Emergency Medical Screening Exam or Behavioral Health Assessment that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
- Further medical examination and treatment as are required under 42 U.S.C. 1395dd to Stabilize the patient to the extent the examination and treatment are within the capability of the staff and facilities available at a Hospital.

Essential Health Benefits are services defined as such by the Secretary of the U.S. Department of Health and Human Services. Essential Health Benefits fall into the following categories:

- Ambulatory patient services;
- Emergency Services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and Substance Use Disorder services, including behavioral health treatment;
- Prescription Drugs;
- Rehabilitation and Habilitation Services and Devices;

- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

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 are 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 medical practice in this Student Plan's state of issue or as determined by medical advisors, medical associations, and/or technology resources;
 - Are not approved for reimbursement by the Centers for Medicare and Medicaid Services;
 - Are furnished in connection with medical 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.
- Chemotherapy is considered Experimental, Investigational, or Unproven when its use is not recommended by National Comprehensive Cancer Network with at least a 2A level of evidence.
- When making decisions about whether treatments are Experimental, Investigational, or Unproven, the University of Oregon and PacificSource relies on the above resources as well as:
 - Expert opinions of specialists and other medical authorities;
 - Published articles in peer-reviewed medical 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.

PacificSource may delegate the determination whether a service is Experimental, Investigational, or Unproven to a third party for services received outside Idaho, Montana, Oregon, and Washington. Such determinations shall be based upon evidence-based criteria and may vary from PacificSource's determinations within Idaho, Montana, Oregon, and Washington.

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

Generic Drugs are drugs that, under federal law, require a prescription by a Provider, and are not a brand name medication. By law, Generic Drugs must have the same active ingredients as the brand name medication and are subject to the same standards of their brand name counterpart. Generic Drugs must be approved by the FDA through an Abbreviated New Drug Application and generally cannot be limited to a single manufacturer.

Global Charge means a lump sum charge for maternity care that includes prenatal care, labor and delivery, and post-delivery care. Ante partum services such as amniocentesis, cordocentesis, chorionic villus sampling, fetal stress test, fetal non-stress test, lab, radiology, maternal, and fetal echography are not considered part of global maternity services and are reimbursed separately.

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.

Habilitation Services and Devices are healthcare services and devices that help a person keep, learn, or improve skills and functioning for daily living. These services and devices may include Physical/ Occupational Therapy, speech-language pathology, and other services and devices for people with disabilities in a variety of inpatient and/or outpatient settings.

Hearing Aid means any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments, or accessory for the instrument or device, except batteries and cords.

Hearing Assistive Technology Systems means devices used with or without Hearing Aids or cochlear implants to improve the ability of a user with hearing loss to hear in various listening situations, such as being located a distance from a speaker, in an environment with competing background noise or in a room with poor acoustics or reverberation.

Home Healthcare means services provided by a licensed home health agency in the Member's place of residence that is prescribed by the Member's attending Provider as part of a written plan of care. Services provided by Home Healthcare include:

- Nursing;
- Home health aide services;
- Physical Therapy;
- Occupational Therapy;
- Speech therapy;
- Hospice therapy;
- Medical Supplies and equipment suitable for use in the home; and
- Medically Necessary personal hygiene, grooming, and dietary assistance.

Hospice Care means care designed to give supportive care to a Member in the final phase of a terminal illness and focuses on comfort and quality of life, rather than curing a disease. A Member's Provider must certify that the Member is terminally ill with a life expectancy of less than six months, and the Member must not be undergoing treatment of the terminal illness other than for direct control of adverse symptoms.

Hospital means an institution licensed as a 'general Hospital' or 'intermediate general Hospital' by the appropriate state agency in the state in which it is located.

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.

Infertility means disease of the male or female reproductive system defined by the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse.

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 this Student Plan.

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

International Exchange/Sponsored Student means any Student, degree or non-degree seeking, who is approved by the Division of Global Engagement as an exchange or sponsored Student to engage in an approved academic program at the University of Oregon.

Lifetime Maximum or Lifetime Benefit means the maximum benefit that will be provided toward the expenses incurred by any one Member while the Member is covered by this Student Plan. If any Covered Service is deemed to be an 'Essential Health Benefit' as determined by the Secretary of the U.S. Department of Health and Human Services the Lifetime Maximum dollar limits will not apply to that Covered Service in accordance with the standards established by the Secretary.

Mastectomy is the surgical removal of all or part of a breast or a breast tumor suspected to be malignant.

Medical Supplies means items of a disposable nature that may be essential to effectively carry out the care a Provider has ordered for the treatment or diagnosis of an Illness or Injury. Examples of Medical Supplies include but are not limited to syringes and needles, splints and slings, ostomy supplies, sterile dressings, elastic stockings, enteral foods, drugs, or biologicals that must be put directly into the equipment in order to achieve the therapeutic benefit of the Durable Medical Equipment or to assure the proper functioning of this equipment.

Medically Necessary or Medical Necessity means those services and supplies that are required for diagnosis or treatment of Illness, Injury, or disease and that are:

- Consistent with the symptoms or diagnosis and treatment of the condition;
- Consistent with generally accepted standards of good medical practice in this Student Plan's state of issuance, or expert consensus Provider opinion published in peer-reviewed medical literature, or the results of clinical outcome trials published in peer-reviewed medical 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;
- The least costly of the alternative services or supplies that can be safely provided;
- When referring specifically infused medications, it further means that they may require administration at a designated location or preferred site of care as outlined in the infusion therapy site of care policy and Drug List;
- When specifically applied to a Hospital inpatient, it further means that the services or supplies cannot be safely provided in other than a Hospital inpatient setting without adversely affecting the patient's condition or the quality of medical care rendered: and
- When applied to Hospital outpatient services (imaging, infusion, surgery), it further means that the services or supplies can be safely provided in other than a Hospital outpatient setting without adversely affecting the patient's condition or the quality of medical care rendered.

PacificSource may delegate determinations of Medical Necessity to third parties for services outside Idaho, Montana, Oregon, and Washington, and such third parties may utilize evidence-based criteria for determining Medical Necessity consistent with the above. Services and supplies intended to diagnose or screen for a medical condition in the absence of signs or symptoms, or of abnormalities on prior testing, including exposure to infectious or toxic materials or family history of genetic disease, are not considered Medically Necessary under this definition. For more information, see screening tests in the Benefit Exclusions section.

Member means a Student or individual covered under this Student Plan. In this Student Plan, Member is also referred to as 'patient', 'Member', or 'you'.

Mental Health and/or Substance Use Disorder Healthcare Facility means a corporate or governmental entity or other Provider of services for the care and treatment of Substance Use Disorders and/or Behavioral Health Conditions which is licensed by the state and accredited by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities for the level of care which the facility provides.

Mental Health and/or Substance Use Disorder Healthcare Program means a particular type or level of service that is organizationally distinct within a Mental Health and/or Substance Use Disorder Healthcare Facility.

Mental Health and/or Substance Use Disorder Healthcare Provider means a person that has met the applicable credentialing requirements, is otherwise eligible to receive reimbursement under this Student Plan, and is:

- A Mental Health and/or Substance Use Disorder Healthcare Facility;
- A residential Mental Health and/or Substance Use Disorder Healthcare Program or Facility;
- A day or partial hospitalization program;
- An outpatient service; or
- An individual behavioral health or medical professional duly licensed and authorized for reimbursement under state law.

Orthotic Devices means rigid or semi-rigid devices supporting a weak or deformed leg, foot, arm, hand, back, neck, or restricting or eliminating motion in a diseased or Injured leg, foot, arm, hand, back, or neck. It includes orthopedic appliances or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body. Orthotic Devices are usually customized for an individual's use and are not appropriate for anyone else. Examples of Orthotic Devices include but not limited to Ankle Foot Orthosis (AFO), Knee Ankle Foot Orthosis (KAFO), Lumbosacral Orthosis (LSO), and foot orthotics.

Out-of-network Provider is a Provider that does not directly or indirectly hold a Provider contract or agreement with PacificSource or the University of Oregon.

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.

Physical/Occupational Therapy is comprised of the services provided by (or under the direction and supervision of) a licensed physical or occupational therapist.

Physical/Occupational Therapy includes emphasis on examination, evaluation, and intervention to alleviate impairment and functional limitation and to prevent further impairment or disability.

Plan Amendment is a written attachment that amends, alters or supersedes any of the terms or conditions set forth in this student guide.

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 this Student Plan will pay, the amount for which you will be responsible, and any alternate treatment options covered by this Student Plan. A Predetermination is not a guarantee of payment and is based on benefits available at the time requested.

Prescription Drugs are drugs that, under federal law, require a prescription by Providers practicing within the scope of their licenses.

Prophylaxis is a cleaning and polishing of all teeth.

Prosthetic Devices (excluding dental) means artificial limb devices or appliances designed to replace, in whole or in part, an arm or a leg. It includes devices that replace all or part of an internal or external body organ, or replace all or part of the function of a permanently inoperative or malfunctioning internal or external organ. Examples of Prosthetic Devices include, but not limited to artificial limbs, cardiac pacemakers, prosthetic lenses, breast prosthesis (including Mastectomy bras), and maxillofacial devices.

Provider means a healthcare professional, Hospital/other institution, or medical supplier that is state licensed or state certified to provide a Covered Service or supply. Healthcare professionals eligible to provide care include, but not limited to: chiropractors, dental Providers, massage therapists, mental health counselors, nurses, nurse midwives, nurse practitioners, pharmacists, physical therapists, physicians, podiatrists, and psychologists.

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.

Radiation Therapy is the treatment of disease using x-rays or similar forms of radiation.

Rehabilitation Services are those Medically Necessary services and devices that help a person keep, restore, or improve skills and function for daily living that have been lost or impaired because a person was sick, hurt, or disabled.

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

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

Routine Costs of Care mean costs for Medically Necessary services or supplies covered by this Student Plan in the absence of a clinical trial. Routine Costs of Care do not include:

- The drug, device, or service being tested in the clinical trial unless the drug, device, or service would be covered for that indication by this Student Plan if provided outside of a clinical trial. If a Member participating in an Approved Clinical Trial has a consequential health condition directly caused by an Approved Clinical Trial, services and associated costs are covered under this Student Plan as comparable services;
- Items or services required solely for the provisions of the drug, device, or service being tested in the clinical trial;
- Items or services required solely for the clinically appropriate monitoring of the drug, device, or service being tested in the clinical trial;
- Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- Items or services customarily provided by a clinical trial sponsor free of charge to any participant in the clinical trial; or
- Items or services that are not covered by this Student Plan if provided outside of the clinical trial.

Service Area is Oregon, Idaho, Montana, and Washington.

Skilled Nursing Facility or Convalescent Home means an institution that provides skilled nursing care under the supervision of a Provider, provides 24 hour nursing service by or under the supervision of a registered nurse (RN), and maintains a daily record of each patient. Skilled Nursing Facilities must be licensed by an appropriate state agency and approved for payment of Medicare benefits to be eligible for reimbursement.

Specialized Treatment Facility means a facility that provides specialized short-term or long-term care. The term Specialized Treatment Facility includes Ambulatory Surgical Centers, birthing centers, hospice facilities, inpatient rehabilitation facilities, Mental Health and/or Substance Use Disorder Healthcare Facilities, organ transplant facilities, psychiatric day treatment facilities, residential treatment facilities, Skilled Nursing Facilities, Substance Use Disorder Treatment Facilities, Substance Use Disorder day treatment facilities, and Urgent Care Treatment Facilities.

Specialty Drugs are high dollar oral, injectable, infused, or inhaled biotech medications prescribed for the treatment of chronic and/or genetic disorders with complex care issues that have to be managed. The major conditions these drugs treat include but are not limited to: cancer, HIV/AIDS, hemophilia, hepatitis C, multiple sclerosis, Crohn's disease, rheumatoid arthritis, and growth hormone deficiency.

Specialty Pharmacies specialize in the distribution of Specialty Drugs and providing pharmacy care management services designed to assist patients in effectively managing their condition.

Stabilize means to provide medical treatment as necessary to ensure that, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during or to result from the transfer of the patient from a facility; and with respect to a pregnant woman who is in active labor, to perform the delivery, including the delivery of the placenta.

Step Therapy means a program that requires the Member to try lower-cost alternative medications (Step 1 drugs) before using more expensive medications (Step 2 or 3 drugs). The program will not cover a brand name, or second-line medication, until less expensive, first-line/Generic Drugs have been tried first.

Student means an individual that meets University of Oregon eligibility guidelines.

Student Plan means the University of Oregon Student Health Benefits Plan explained in this student guide.

Substance Use Disorder means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the individual's social, psychological, or physical adjustment to common problems on a recurring basis. Substance Use Disorder does not include addiction to, or dependency on, tobacco products or foods.

Substance Use Disorder Treatment Facility means a treatment facility that provides a program for the treatment of Substance Use Disorders pursuant to a written treatment plan approved and monitored by a Provider or addiction counselor licensed by the state; is licensed or approved as a treatment center by the department of public health and human services, and is licensed by the state where the facility is located.

Supplemental Breast Examination means a Medically Necessary and appropriate examination of the breast that is used to screen for breast cancer when there is no abnormality seen or suspected and is based on personal or family medical history or other factors that may increase a person's risk of breast cancer.

Surgical Procedure means any of the following listed operative procedures:

- Procedures accomplished by cutting or incision;
- Suturing of wounds;
- Treatment of fractures, dislocations, and burns;
- Manipulations under general anesthesia;
- Visual examination of the hollow organs of the body including biopsy, or removal of tumors or foreign body;
- Procedures accomplished by the use of cannulas, needling, or endoscopic instruments; or
- Destruction of tissue by thermal, chemical, electrical, laser, or ultrasound means.

Surrogacy Agreement means an agreement between one or more intended parents and a woman who is not an intended parent in which the woman agrees to become pregnant through assisted reproduction and which provides that each intended parent is a parent of a child conceived under the agreement.

Telehealth means the use of audio, video, or other telecommunications technology or media, including audio-only communication, that is used by a Provider or facility to deliver services, and delivered over a secure connection that complies with state and federal privacy laws.

Third Party Administrator means an organization that processes claims and performs administrative functions on behalf of the Plan Sponsor pursuant to the terms of a contract or agreement. In the case of this Student Plan, the term Third Party Administrator refers solely to PacificSource.

Tobacco Cessation Program means a program recommended by a Provider that follows the United States Public Health Services guidelines for tobacco cessation. Tobacco Cessation Program includes education and medical treatment components designed to assist a person in ceasing the use of tobacco products.

Tobacco Use means use of tobacco on average four or more times per week within the past six months. This includes all tobacco products. Tobacco Use does not include religious or ceremonial use of tobacco by American Indians and/or Alaska Natives.

University means the University of Oregon (UO).

University Health Services means the health services clinic on campus that provides services to Students/Members.

Urgent Care means services for an unforeseen illness or injury that requires treatment within 24 hours to prevent serious deterioration of a patient's health. Urgent conditions are normally less severe than medical emergencies. Examples of conditions that could need Urgent Care are sprains and strains, vomiting, cuts, and headaches.

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

Urgent Care Treatment Facility means a healthcare facility whose primary purpose is the provision of immediate, short-term medical care for minor, but urgent, medical conditions.

Women's Healthcare Provider means an obstetrician, gynecologist, physician assistant, naturopathic physician, or nurse practitioner specializing in women's health, physician, or other Provider practicing within the scope of their license.

Women's Healthcare Services means organized services to provide healthcare to women, inclusive of the women's preventive services required by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. The services include, but not limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. Women's Healthcare Services also include any appropriate

healthcare service for other health problems, discovered and treated during the course of a visit to a Women's Healthcare Provider for a Women's Healthcare Service, which is within the Provider's scope of practice. For purposes of determining a woman's right to directly access health services covered by the plan, maternity care, reproductive health, and preventive services include: Contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breastfeeding, and complications of pregnancy.

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.