Pocatello Chubbuck School District No 25

Group No.: G0032790
Voyager 1700+35-50_30 S4
Effective: 09/01/2020

PacificSource HEALTH PLANS

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

Using this Handbook

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

Benefit Summaries for your medical benefits and any other health benefits provided under this employer group health plan are included in this handbook. The summaries work with this handbook to explain your plan benefits. The handbook explains the services covered by your plan; the benefit summaries tell you how much your plan pays toward expenses and how much you're responsible for.

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

Governing Law

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

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

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PacificSource HEALTH PLANS

Medical Benefit Summary
Voyager 1700+35-50_30 S4

POLICY INFORMATION
Group Name: **Pocatello Chubbuck School District No 25**
Group Number: **G0032790**
Provider Network: **Voyager**

EMPLOYEE ELIGIBILITY REQUIREMENTS
Minimum Hour Requirement: **Full Time Employees 32.5 or more hours per week**
Part Time Employees 20 to 32.5 hours per week

Waiting Period Requirement: **First of the month following date of hire**

Deductible Per Calendar Year	In-network and Out-of-network	
Individual/Family	$1,700/$5,100	
Out-of-Pocket Limit Per Calendar Year	**In-network**	**Out-of-network**
Individual/Family	$4,200/$8,400	$6,000/$12,000

Note: Your actual costs for services provided by an out-of-network provider may exceed this policy's out-of-pocket limit for out-of-network services. In addition, out-of-network providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company, and this amount is not counted toward the out-of-network out-of-pocket limit. Please see allowable fee in the Definitions section of your member handbook.

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

Service/Supply	Portneuf Medical Center In-network Member Pays	In-network Member Pays	Out-of-network Member Pays
Preventive Care			
Well baby/Well child care	No deductible, 0%	No deductible, 0%	After deductible, 50%
Preventive physicals	No deductible, 0%	No deductible, 0%	After deductible, 50%
Well woman visits	No deductible, 0%	No deductible, 0%	After deductible, 50%
Preventive mammograms	No deductible, 0%	No deductible, 0%	After deductible, 50%
Immunizations	No deductible, 0%	No deductible, 0%	After deductible, 50%
Preventive colonoscopy	No deductible, 0%	No deductible, 0%	After deductible, 50%
Prostate cancer screening	No deductible, 0%	No deductible, 0%	After deductible, 50%
Professional Services			
Office and home visits	Not available	No deductible, $35	After deductible, 50%

Service/Supply	Portneuf Medical Center In-network Member Pays	In-network Member Pays	Out-of-network Member Pays
Specialist office and home visits	Not available	No deductible, $50	After deductible, 50%
Telemedicine visits	Not available	No deductible, $10	After deductible, 50%
Office procedures and supplies	Not available	After deductible, 30%	After deductible, 50%
Surgery	Not available	After deductible, 30%	After deductible, 50%
Outpatient habilitation services (combined 30 visits per benefit year for physical, occupational, and speech therapy)	After deductible, 20%	After deductible, 30%	After deductible, 50%
Outpatient rehabilitation services (combined 30 visits per benefit year for physical, occupational, and speech therapy)	After deductible, 20%	After deductible, 30%	After deductible, 50%
Chiropractic manipulations and acupuncture (20 visits per benefit year)	Not available	No deductible, 30%	No deductible, 50%
Hospital Services			
Inpatient room and board	After deductible, 20%	After deductible, 30%	After deductible, 50%
Inpatient habilitation services	After deductible, 20%	After deductible, 30%	After deductible, 50%
Inpatient rehabilitation services	After deductible, 20%	After deductible, 30%	After deductible, 50%
Skilled nursing facility care (60 visits per benefit year)	Not available	After deductible, 30%	After deductible, 50%
Outpatient Services			
Outpatient surgery/services	After deductible, 20%	After deductible, 30%	After deductible, 50%
Advanced diagnostic imaging	After deductible, 20%	After deductible, 30%	After deductible, 50%
Diagnostic and therapeutic radiology/lab	After deductible, 20%	After deductible, 30%	After deductible, 50%
Urgent and Emergency Services			

Service/Supply	Portneuf Medical Center In-network Member Pays	In-network Member Pays	Out-of-network Member Pays
Urgent care center visits	Not available	No deductible, $35	After deductible, 50%
Emergency room visits – medical emergency	After deductible, $200 plus 20%^	After deductible, $200 plus 20%^	After deductible, $200 plus 20%^
Emergency room visits – non-emergency	After deductible, $200 plus 20%^	After deductible, $200 plus 30%^	After deductible, $200 plus 50%^
Ambulance, ground	Not available	After deductible, 30%	After deductible, 30%
Ambulance, air	Not available	After deductible, 30%	After deductible, 30%+
Maternity Services			
Physician/Provider services (global charge)	Not available	After deductible, 30%	After deductible, 50%
Hospital/Facility services	After deductible, 20%	After deductible, 30%	After deductible, 50%
Mental Health/Chemical Dependency Services			
Office visits	Not available	No deductible, $35	After deductible, 50%
Inpatient care	After deductible, 20%	After deductible, 30%	After deductible, 50%
Residential programs	Not available	After deductible, 30%	After deductible, 50%
Other Covered Services			
Allergy injections	Not available	After deductible, 30%	After deductible, 50%
Durable medical equipment	Not available	After deductible, 30%	After deductible, 50%
Home health care	Not available	After deductible, 30%	After deductible, 50%
Certain transplant services	Not available	After deductible, 30%	After deductible, 50%
Temporomandibular Joint	Not available	After deductible, 30%	After deductible, 50%

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

^ Co-pay applies to ER physician and facility charges only. Co-pay waived if admitted into hospital.

+ Out-of-network air ambulance coverage is covered at 200 percent of the Medicare allowance. You may be held responsible for the amount billed in excess. Please see your member handbook for additional information or contact our Customer Service team with questions.

Additional information

What is the deductible?

Your plan's deductible is the amount of money that you pay first, before your plan starts to pay. You'll see that many services, especially preventive care, are covered by the plan without you needing to meet the deductible. The individual deductible applies if you enroll without dependents. If you and one or more dependents enroll, the individual deductible applies for each member only until the family deductible has been met. Deductible expense is applied to the out-of-pocket limit.

In-network provider expense and out-of-network provider expense apply together toward your deductible.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for covered medical expenses during the plan year. Once the out-of-pocket limit has been met, the plan will pay 100 percent of allowed amounts for covered services for the rest of that year. The individual out-of-pocket limit applies only if you enroll without dependents. If you and one or more dependents enroll, the individual out-of-pocket limit applies for each member only until the family out-of-pocket limit has been met. Be sure to check your member handbook, 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 your 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 your plan did not cover. Services of out-of-network providers could result in out-of-pocket expense in addition to the percentage indicated.

Preauthorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called preauthorization. Preauthorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Preauthorization does not change your out-of-pocket expense for in-network and out-of-network providers. You'll find the most current preauthorization list on our website, PacificSource.com/member/preauthorization.aspx.

Discrimination is against the law

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

Formulary Idaho Drug List (IDL)

This PacificSource health plan includes coverage for prescription drugs and certain other pharmaceuticals, subject to the information below. This plan complies with federal healthcare reform. To check which tier your prescription falls under, call our Customer Service team or visit PacificSource.com/drug-list.

The amount you pay for covered prescriptions at in-network and out-of-network pharmacies applies toward your plan's in-network medical out-of-pocket limit, which is shown on the Medical Benefit Summary. The co-payment and/or co-insurance for prescription drugs obtained from an in-network or out-of-network pharmacy are waived during the remainder of the calendar year in which you have satisfied the medical out-of-pocket limit.

Prescription Drug Deductible $250 per person

The deductible is an amount of covered pharmacy expenses the member pays for brand medications each calendar year before the following benefits begin. Co-payments, cost difference between brand and generic drugs, drugs obtained without using the PacificSource member ID card, and out-of-network pharmacy charges do not accumulate toward the deductible. The deductible does not apply to PacificSource Preventive Rx, and Tier one prescription drugs.

PacificSource Expanded No Cost Drug List

Your prescription benefit includes certain outpatient drugs as a preventive benefit at no deductible, $0. 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 our Customer Service team or visit PacificSource.com/drug-list to view the PacificSource Expanded No Cost Drug List.

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

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays	Tier 4 Member Pays
In-network Retail Pharmacy^				
Up to a 30 day supply:	No deductible, $15	After deductible, $40	After deductible, $50	After deductible, $50
31 - 60 day supply:	No deductible, $30	After deductible, $80	After deductible, $100	After deductible, $100
61 - 90 day supply:	No deductible, $45	After deductible, $120	After deductible, $150	After deductible, $150
In-network Mail Order Pharmacy				
Up to a 30 day supply:	No deductible, $15	After deductible, $40	After deductible, $50	After deductible, $50
31 - 60 day supply:	No deductible, $30	After deductible, $80	After deductible, $100	After deductible, $100

61 - 90 day supply:	No deductible, $45	After deductible, $120	After deductible, $150	After deductible, $150
Compound Drugs**				
Up to a 30 day supply:	After deductible, $50			
31 - 60 day supply:	After deductible, $100			
61 - 90 day supply:	After deductible, $150			
Out-of-network Pharmacy				
30 day max fill, no more than three fills allowed per year:	Same as retail			

^ Remember to show your PacificSource member ID card each time you fill a prescription at a retail pharmacy. If your ID card is not used, your benefits cannot be applied and may result in higher out-of-pocket cost.

**Compounded medications are subject to a preauthorization 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 limited to a 30 day supply.

MAC A - Regardless of the reason or medical necessity, if you receive a brand name drug or if your provider prescribes a brand name drug when a generic is available, you will be responsible for the brand name drug's co-payment and/or co-insurance plus the difference in cost between the brand name and generic drug after the prescription drug deductible is met. The cost difference between the brand name and generic drug does not apply toward the prescription drug plan's deductible or medical out of pocket limit.

If your provider prescribes a brand name contraceptive due to medical necessity it may be subject to preauthorization for coverage at no charge.

See your member handbook for important information about your prescription drug benefit, including which drugs are covered, limitations, and more.

BECOMING COVERED

ELIGIBILITY

Employees

The employer decides the minimum number of hours employees must work each week to be eligible for health insurance benefits. The employer may also require new employees to satisfy a waiting period called the probationary waiting period before they are eligible for benefits. The employer's eligibility requirements, including the length of the probationary waiting period are shown in your Medical Benefit Summary. All employees who meet the requirements are eligible for coverage.

Family Members

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

- Your legal spouse or your domestic partner.
- Your, your spouse's, or your domestic partner's dependent children under age 26 regardless of the child's place of residence, marital status, or financial dependence on you.
- Your, your spouse's, or your domestic partner's unmarried child of any age who is medically certified as incapable of self-sustaining employment by reason of intellectual disability or physical disability. PacificSource requires documentation of the disability from the child's physician, within 31 days in which the individual turns 26, and will review the case before determining eligibility for coverage.

No family or household members other than those listed above are eligible to enroll under your coverage. No person can be covered both as an employee and as a dependent, or as a dependent of more than one employee.

ENROLLING DURING THE INITIAL ENROLLMENT PERIOD

Once you satisfy your employer's probationary waiting period, and meet the hours required for eligibility, you and your eligible family members become eligible for this plan. Starting on the date you become eligible, you and your family members have 60 days to enroll. We call this the initial enrollment period. To enroll, you must submit the enrollment information to your employer.

If you miss your initial enrollment period, you will not be able to enroll in the plan later in the year, unless you have a special circumstance, called a qualifying event. For more information, see Enrolling After the Initial Enrollment Period section.

Coverage for you and your enrolling family members begins after you satisfy your employer's probationary waiting period. The length of the probationary waiting period is stated in your Medical Benefit Summary. Coverage will only begin if PacificSource receives your enrollment information and your employer's premium payment for that month.

ENROLLING NEW FAMILY MEMBERS

To enroll new family members that become eligible for coverage after your effective date, complete and submit an enrollment change to PacificSource. Requests for enrollment of a new family member due to a qualifying event must be received by PacificSource within 60 days of the qualifying event.

A newborn child of any covered member is eligible from the moment of birth for 60 days. A claim for maternity care is not considered notification for the purpose of enrolling a newborn child.

Premium for the first 60 days of coverage and any additional premium is due 31 days from the date billing for the required premium is received by you from the employer. If family member is eligible the 1st through the 15th of the month, full premium is due. If family member is eligible the 16th of the

month through the last day of the month, no premium is charged for that month. PacificSource may ask for legal documentation to confirm the status of the dependent.

Qualifying Events

Coverage for newly eligible family members due to the following events will begin on the date of the event:

- Birth of a newborn dependent child; or
- Placement of an adopted or foster child. Placement means physical placement in the care of the adoptive member, or in those circumstances in which such physical placement is prevented due to medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive member signs an agreement assuming financial responsibility for such child.

Coverage for newly eligible family members due to the following events will begin on the first day of the month after the event:

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

This health plan complies with a QMCSO issued by a state court or state child support agency. A QMCSO is a judgment, decree, or order, including approval of a settlement agreement, which provides for health benefit coverage for the child of a member.

ENROLLING AFTER THE INITIAL ENROLLMENT PERIOD

Returning to Work after a Layoff

If you are laid off and then rehired by your employer within six months, you will not have to satisfy another probationary waiting period.

Your health coverage will resume the day you return to work and again meet your employer's minimum hour requirement. If your family members were covered before your layoff, they can resume coverage at that time as well. You must re-enroll your family members by submitting an enrollment change within the 60 day enrollment period following your return to work.

Returning to Work after a Leave of Absence

If you return to work after an employer-approved leave of absence of six months or less, you will not have to satisfy another probationary waiting period.

Your health coverage will resume the day you return to work and again meet your employer's minimum hour requirement. If your family members were covered before your leave of absence, they can resume coverage at that time as well. You must re-enroll your family members by submitting an enrollment change within the 60 day enrollment period following your return to work.

Returning to Work after Family Medical Leave

If you work for a company that employs 50 or more people, your employer is probably subject to the Family Medical Leave Act (FMLA). To find out if you have rights under FMLA, ask your health plan administrator. Under FMLA, if you return to work after a qualifying FMLA medical leave, you will not have to satisfy another probationary waiting period under this plan. Your health coverage will resume the day you return to work and meet your employer's minimum hour requirement. If your family members were covered before your leave, they can resume coverage at that time as well. You must

re-enroll your family members by submitting an enrollment change within the 60 day enrollment period following your return to work.

Special Enrollment Periods

You and/or your family members may decline coverage during your initial enrollment period. To do so, you must submit a Waiver of Coverage to PacificSource through your employer. You and your family members may enroll in this plan later if you qualify under the Special Enrollment Rules below. To do so, you must submit an enrollment change within 60 days of the qualifying event. For more information, see Enrolling New Family Members section.

All special enrollment provisions assume that the employee has satisfied any probationary periods required and each individual is eligible as stated in the group policy.

- Special Enrollment Rule #1

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

- Special Enrollment Rule #2

  If you acquire new family members due to a qualifying event, you may be able to enroll yourself and/or your eligible family members at that time.

- Special Enrollment Rule #3

  If you or your family members become eligible for a premium assistance subsidy under Medicaid or a state Children's Health Insurance Program (CHIP), you may be able to enroll yourself and/or your family members at that time. Coverage will begin on the first day of the month after becoming eligible for such assistance.

Late Enrollment

If you did not enroll during your initial enrollment period and you do not qualify for a special enrollment period, your enrollment will be delayed until the plan's next designated open enrollment period.

A late enrollee is an otherwise eligible employee or family member who does not qualify for a special enrollment period explained above, and who:

- Did not enroll during the initial enrollment period; or
- Enrolled during the initial enrollment period but discontinued coverage later.

A late enrollee may enroll by submitting an enrollment application to your employer during the open enrollment period. When you or your family members enroll during the open enrollment period, plan coverage becomes effective the first day of the plan year.

PLAN SELECTION PERIOD

If your employer offers more than one benefit plan option, you may choose another plan option only upon your plan's anniversary date. You may select a different plan option by completing a selection form or application form. Coverage under the new plan option becomes effective on your plan's anniversary date.

WHEN COVERAGE ENDS

If you leave your job for any reason or your work hours are reduced below your employer's minimum requirement, coverage for enrolled individuals will end. Coverage ends on the last day of the last month in which you worked full time and for which a premium was paid. Enrolled individuals may be

eligible to continue coverage for a limited time. For more information, see Continuation of Insurance section.

Dependent Children

When your enrolled child no longer qualifies as a dependent, their coverage will end on the last day of that month.

Dissolution of Domestic Partnership

If you dissolve your domestic partnership, coverage for your domestic partner and their children not related to you by birth or adoption will end on the last day of the month in which the dissolution of the domestic partnership is final. You must notify your employer of the dissolution of the domestic partnership. Domestic partners and their covered children are not recognized as qualified beneficiaries under federal COBRA continuation laws. Domestic partners and their covered children may not continue this plan's coverage under COBRA independent of the employee.

Divorced Spouses

If you divorce, coverage for your spouse will end on the last day of the month in which the divorce decree or legal separation is final. You must notify your employer of the divorce or separation, and continuation coverage may be available for your spouse. If there are special child custody circumstances, please contact our Membership Services team.

CONTINUATION OF INSURANCE

Under federal law, you and your covered family members may have the right to continue this plan’s coverage for a specified time. You and your family members may be eligible if:

- Your employment ends or you have a reduction in hours.
- You take a leave of absence for military service.
- You divorce or dissolve your domestic partnership.
- You die.
- You become eligible for Medicare benefits and it causes a loss of coverage for your family members.
- Your children no longer qualify as dependents.

The following sections describe your rights to continuation under federal law, and the requirements you must meet to enroll in continuation coverage.

USERRA CONTINUATION

If you take a leave of absence from your job due to military service, you have continuation rights under the Uniformed Services Employment and Re-employment Rights Act (USERRA).

Enrolled individuals may continue this plan’s coverage if you, the employee, no longer qualify for coverage under the plan because of military service. Continuation coverage under USERRA is available for up to 24 months while you are on military leave. If your military service ends and you do not return to work, your eligibility for USERRA continuation coverage will end. Premium for continuation coverage is your responsibility.

The following requirements apply to USERRA continuation:

- Only family members who were enrolled in the group plan can take continuation. The only exceptions are newborn babies and newly acquired eligible family members not covered by another group health plan.

- To apply for continuation, you must submit a completed Continuation Election form to your employer within 60 days after the last day of coverage under the group plan.
- You must pay continuation premium to your employer by the first of each month. Your employer will include your continuation premium in the group's regular monthly payment. PacificSource cannot accept the premium directly from you.
- Your employer must still be insured by PacificSource. If your employer discontinues this plan, you will no longer qualify for continuation.

COBRA CONTINUATION

If you work for an employer that has 20 or more employees, your employer is probably subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended. To find out if you have continuation rights under COBRA, ask your health plan administrator.

COBRA Eligibility

A qualifying event is the event that causes your regular group coverage to end and makes you eligible for continuation coverage. When the following qualifying events happen, you may continue coverage for the lengths of time shown:

Qualifying Event	Continuation Period
Employee's termination of employment or reduction in hours	Employee, spouse, and children may continue for up to 18 months[1]
Employee's divorce	Spouse and children may continue for up to 36 months[2]
Employee's eligibility for Medicare benefits if it causes a loss of coverage	Spouse and children may continue for up to 36 months
Employee's death	Spouse and children may continue for up to 36 months[2]
Child no longer qualifies as a dependent	Child may continue for up to 36 months[2]

[1] *If the employee or covered family member is determined disabled by the Social Security Administration prior to or within the first 60 days of COBRA coverage, all qualified beneficiaries may continue coverage for up to 29 months.*

[2] *The total maximum continuation period is 36 months, even if there is a second qualifying event. A second qualifying event might be a divorce, death, or child no longer qualifying as a dependent after the employee's termination or reduction in hours.*

If your family members were not covered prior to your qualifying event, they may enroll in the continuation coverage while you are on continuation. They will be subject to the same rules that apply to active employees.

If your employment is terminated for gross misconduct, you and your family members are not eligible for COBRA continuation.

Domestic partners and their covered children may not continue this plan's coverage under COBRA independent of the employee.

When Continuation Coverage Ends

Your continuation coverage will end before the end of the continuation period above if any of the following occur:

- Your continuation premium is not paid on time.
- You become entitled to Medicare benefits.
- Your employer discontinues its health policy and no longer offers a group health plan to any of its employees.
- Your continuation period was extended from 18 to 29 months due to disability, and you are no longer considered disabled.

Type of Coverage

Under COBRA, you may continue any coverage you had before the qualifying event. If your employer provides both medical and dental coverage and you were enrolled in both, you may continue both medical and dental. If your employer provides only one type of coverage, or if you were enrolled in only one type of coverage, you may continue only that coverage.

COBRA continuation benefits are always the same as your employer's current benefits. Your employer has the right to change the benefits of its health plan or eliminate the plan entirely. If that happens, any changes to the group health plan will also apply to everyone enrolled in continuation coverage.

Your Responsibilities and Deadlines

You must notify your employer within 60 days if you divorce, or if your child no longer qualifies as a dependent. That will allow your employer to notify you or your family members of your continuation rights.

When your employer learns of your eligibility for continuation, your employer will notify you of your continuation rights and provide a Continuation Election form. You then have 60 days from that date or 60 days from the date coverage would otherwise end, whichever is later, to enroll in continuation coverage by submitting a completed Continuation Election form to your employer. If continuation coverage is not elected during that 60 day period, coverage will end on the last day of the last month you were an active employee, or when your family member lost eligibility.

If you or your employer do not provide these notifications within the time frames required by COBRA, PacificSource's responsibility to provide coverage under the group policy will end.

Continuation Premium

Enrolled individuals are responsible for the full cost of continuation coverage. Your employer uses the services of a third-party COBRA administrator to collect premium for continuation coverage. Please see your employer for more information about your plan's COBRA administrator. The monthly premium must be paid to your plan's COBRA administrator. PacificSource cannot accept continuation premium directly from you. You may make your first premium payment any time within 45 days after you return your Continuation Election form to your plan's COBRA administrator. After the first premium payment, each monthly payment must reach your plan's COBRA administrator within 30 days of your plan's COBRA administrator's premium due date. If your plan's COBRA administrator does not receive your continuation premium on time, continuation coverage will end. If your coverage is canceled due to a missed payment, it will not be reinstated for any reason. Premium rates are established annually and may be adjusted if the plan's benefits or costs change.

CONTINUATION WHEN YOU RETIRE

Continuation upon retirement is based on meeting all the retirement requirements set forth in your employment agreement with your employer.

If you retire, you and your insured family members are eligible to continue coverage subject to the following:

- You must apply for continued coverage within 60 days after retirement.
- You must be eligible to receive benefits from a retirement plan offered by the policyholder.
- You must meet all requirement guidelines and criteria in accordance with Chapter 13 of Title 59 of the Idaho Code.
- You are not enrolled in another group health plan with substantially the same or greater benefits at an equivalent cost.
- You are not eligible to participate as an employee in another group health plan with substantially the same or greater benefits at an equivalent cost.

You and/or your enrolled family members are responsible for paying the full premium.

Your continuation coverage will end when any one of the following occurs:

- When full premium is not paid or when your coverage is voluntarily terminated, your coverage will end on the last day of the month for which premium was paid.
- When you retire and enroll in Medicare Part A & B, your coverage will end on the last day of the month prior to your 65th birthday. You and your dependents may be entitled to coverage under another plan offered by the School District in accordance with Chapter 13 of Title 59 of the Idaho Code.
- When you no longer qualify for coverage under this plan, your family members may continue coverage until they are no longer eligible in accordance with Chapter 12 of Title 33 of the Idaho Code.
- When the regular group policy is terminated, your coverage will end on the date of termination.

Your family member's continuation coverage will end when any one of the following occurs:

- When full premium for the family member is not paid or when the family member's coverage is voluntarily terminated by you or your family member, coverage will end on the last day of the month for which premium was paid.
- When your family member turns 65 years of age and becomes entitled to Medicare, their coverage will end on the last day of the month prior to their 65th birthday. They may be entitled to coverage under another plan offered by the School District in accordance with Chapter 13 of Title 59 of the Idaho Code.
- When the regular group policy is terminated, your family member's coverage will end on the date of termination.

BENEFITS AFTER TERMINATION OF GROUP POLICY

Extension of Benefits for Disability

If the member is totally disabled on the date of termination of this group policy, coverage may continue for up to 12 months. Once PacificSource receives medical documentation of disability, PacificSource will continue to provide benefits for covered expenses related to disabling conditions until any one of the following occurs:

- The member is no longer totally disabled;
- The policy's maximum visits have been met; or
- The policy has been discontinued for 12 months.

Extension of Benefits for Maternity Care Benefits

If the member is pregnant on the date of termination of this group policy and not eligible for any replacement group coverage within 60 days, this policy's maternity benefits may continue for up to 12 months. PacificSource will then provide maternity benefits to the extent they are covered in this policy for up to 12 months after this policy is discontinued.

USING THE PROVIDER NETWORK

This section explains how your plan's benefits differ when you use Tier One and/or Tier Two in-network and out-of-network providers and explains how we apply the reimbursement rate. 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. Your network name is listed at the beginning of your Medical Benefit Summary.

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

IN-NETWORK PROVIDERS

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

PacificSource contracts directly and/or indirectly with in-network providers throughout our networks' service area. We also have agreements with nationwide provider networks. These providers outside our service area are also considered PacificSource in-network providers under your plan.

It is not safe to assume that when you are treated at an in-network medical 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 contracted allowable fee. However, the agreement does not prohibit the provider from collecting co-payments, deductibles, co-insurance, and amounts for non-covered services from the member. And, if PacificSource was to become insolvent, an in-network provider agrees to continue to provide covered services to a member for the duration of the period for which premium was paid to PacificSource on behalf of the member. Again, the in-network provider may only collect applicable co-payments, deductibles, co-insurance, and amounts for non-covered services from the member.

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 to whom you have reasonable access (explained in the next section), you may be responsible for more than the deductibles, co-payments, and/or co-insurance amounts stated in your Medical Benefit Summary.

Allowable Fee for Out-of-network Providers

To maximize your plan's benefits, always make sure your healthcare provider is a PacificSource in-network provider. Do not assume all services at an in-network facility are performed by in-network providers.

PacificSource bases payment to out-of-network providers on our allowable fee which is derived from several sources depending on the service or supply and the geographical area where it is provided. The allowable fee may be based on data collected from the Centers for Medicare and Medicaid Services (CMS), contracted vendors, other nationally recognized databases, or PacificSource, as documented in PacificSource's payment policy.

In PacificSource's service areas, the allowable fee for professional services is based on PacificSource's standard out-of-network provider reimbursement rate. Outside the PacificSource service area and in areas where our members do not have reasonable access to an in-network provider through one of our third party provider networks, the allowable fee, depending upon the service and supply, can be based on data collected from PacificSource or other nationally recognized databases. If the service is based on the usual, customary, and reasonable charge (UCR), PacificSource will utilize the 85th percentile. UCR is based on data collected for a geographic area. Provider charges for each type of service are collected and ranked from lowest to highest. Charges at the 85th position in the ranking are considered to be the 85th percentile.

To calculate our payment to out-of-network providers, we determine the allowable fee, then subtract the out-of-network provider benefits shown in the Out-of-network Provider column of your Medical Benefit Summary. Our allowable fee is often less than the out-of-network provider's charge. In that case, the difference between our allowable fee and the provider's billed charge is also your responsibility. That amount does not count toward this plan's out-of-pocket maximum. It also does not apply toward any deductibles or co-payments required by the plan.

To maximize your plan's benefits, please check with us before receiving care from an out-of-network provider. Our Customer Service team can help you locate an in-network provider in your area.

Example of Provider Payment

The following illustrates how payment could be made for a covered service in three different settings: with a Tier One in-network provider, Tier Two in-network provider, and with an out-of-network provider. This is only an example; your plan's benefits may be different.

	Tier one In-network Provider	Tier two In-network Provider	Out-of-network Provider
Provider's usual charge	$120	$120	$120
Billed charge after negotiated provider discounts	$100	$100	$120
PacificSource's allowable fee	$100	$100	$100
Allowable fee less patient co-insurance	$80	$70	$50
Percent of payment	80%	70%	50%
PacificSource's payment	**$80**	**$70**	**$50**
Patient's responsibility:			
Co-insurance	20%	30%	50%
Patient's amount of allowable fee	$20	$30	$50
Difference between allowable fee and billed charge after discounts	$0	$0	$20
Patient's total responsibility to the provider	**$20**	**$30**	**$70**

COVERAGE WHILE TRAVELING

Your PacificSource plan is powered by the network shown at the beginning of your Medical Benefit Summary. You can save out-of-pocket expense by using an in-network provider in your service area. When you need medical services outside of your network, you can save out-of-pocket expense by using the providers identified on our website at providerdirectory.pacificsource.com.

Nonemergency Care While Traveling

To find an in-network provider outside the regions covered by your network, go to providerdirectory.pacificsource.com. Nonemergency care outside of the United States is not covered.

- If an in-network provider is available in your area, your plan's in-network provider benefits will apply if you use an in-network provider.
- If an in-network provider is available but you choose to use an out-of-network provider, your plan's out-of-network provider benefits will apply.

Emergency Services While Traveling

In medical emergencies (see Emergency Services section), your plan pays benefits at the in-network provider level regardless of your location. Your covered expenses are based on our allowable fee. If you are admitted to a hospital as an inpatient following the stabilization of your emergency condition, your physician or hospital should contact our PacificSource Health Services team at (888) 691-8209 as soon as possible to make a benefit determination on your admission. If you are admitted to an out-of-network hospital, PacificSource may require you to transfer to an in-network facility once your condition is stabilized in order to continue receiving benefits at the in-network provider level.

FINDING IN-NETWORK PROVIDER INFORMATION

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

- On the PacificSource website, PacificSource.com. Go to Find a Doctor or Drug to easily look up in-network providers, specialists, behavioral health providers, and hospitals. You can also print your own customized directory.
- Contact our Customer Service team. Our team can answer your questions about specific providers. If you'd like a complete provider directory for your plan, just ask. We will be glad to send you a directory free of charge.
- Ask your healthcare provider if they are an in-network provider for your network.

TERMINATION OF PROVIDER CONTRACTS

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

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

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

You may be entitled to continue care with an individual provider for a limited period of time after the medical services contract terminates. Contact our Customer Service team for additional information.

COVERED EXPENSES

Understanding Medical Necessity

This plan provides comprehensive medical coverage when care is medically necessary to treat an illness, injury, or disease. Be careful – just because a treatment is prescribed by a healthcare professional does not mean it is medically necessary under the terms of this plan. Also remember that just because a service or supply is a covered benefit under this plan does not necessarily mean all billed charges will be paid.

Medically necessary services and supplies that are excluded from coverage under this plan can be found in the Benefit Limitations and Exclusions section, as well as the section on Preauthorization. If you ever have a question about your plan benefits, contact our Customer Service team.

Understanding Experimental, Investigational, or Unproven Services

Except for specified Preventive Care services, the benefits of this group plan are paid only toward the covered expense of medically necessary diagnosis or treatment of illness, injury, or disease. This is true even though the service or supply is not specifically excluded. All treatment is subject to review for medical necessity. Review of treatment may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. For more information, see medically necessary in the Definitions section.

Be careful. Your healthcare provider could prescribe services or supplies that are not covered under this plan. Also, just because a service or supply is a covered benefit does not mean all related charges will be paid.

New and emerging medical procedures, medications, treatments, and technologies are often marketed to the public or prescribed by physicians before FDA approval, or before research is available in qualified peer-reviewed literature to show they provide safe, long term positive outcomes for patients.

To ensure you receive the highest quality care at the lowest possible cost, we review new and emerging technologies and medications on a regular basis. Our internal committees and Health Services team make decisions about PacificSource coverage of these methods and medications based on literature reviews, standards of care and coverage, consultations, and review of evidence-based criteria with medical advisors and experts.

Eligible Healthcare Providers

This plan provides benefits only for covered expenses and supplies rendered by a physician (M.D. or D.O.), Nurse Practitioner, hospital or specialized treatment facility, durable medical equipment supplier, or other licensed medical providers as specifically stated in this handbook. The services or supplies provided by individuals or companies that are not specified as eligible providers are not eligible for reimbursement under the benefits of this plan. For more information, see practitioner, specialized treatment facility, and durable medical equipment supplier in the Definitions section.

To be eligible, the provider must also be practicing within the scope of their license. For example, although an Optometrist is an eligible provider for vision exams, they are not eligible to provide chiropractic services.

After Hours and Emergency Care

If you have a medical emergency, always go directly to the nearest emergency room, or call 911 for help.

If you are facing a non-life-threatening emergency, contact your provider's office, or go to an urgent care facility. Urgent care facilities are listed in our online provider directory at providerdirectory.pacificsource.com. Simply enter your City and State or Zip code, then select Urgent Care in the Specialty Category field and enter your Plan or Network. It is not safe to assume that when you are treated at an in-network urgent care facility, all services are performed by in-network providers.

Appropriate Setting

It is important to have services provided in the most suitable and least costly setting. For example, if you go to the emergency room to have a throat culture instead of going to a doctor's office or urgent care facility it could result in higher out-of-pocket expenses for you.

Your Annual Out-of-Pocket Limit

This plan has an out-of-pocket limit provision to protect you from excessive medical expenses. The Medical Benefit Summary shows your plan's annual out-of-pocket limits for in-network and/or out-of-network providers. If you incur covered expenses over those amounts, this plan will pay 100 percent of eligible charges, subject to the allowable fee.

Your expenses for the following do not count toward the annual out-of-pocket limit:

- Charges over the allowable fee for services of out-of-network providers.
- Incurred charges that exceed amounts allowed under this plan.

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

Out-of-pocket limits are applied on a calendar year basis. If this plan renews or is modified mid calendar year, the previously satisfied out-of-pocket amount will be credited toward the renewed plan. If the out-of-pocket limit increases mid calendar year, you will need to satisfy the difference between the increase and the amount you have already satisfied under the prior plan's requirement. If the out-of-pocket limit decreases, any excess in the amount credited to the lower amount is not refundable.

We will apply third party payments of cost-sharing contributions towards the member's deductible and out-of-pocket maximums as if the member made the payment. If payment is from a financially interested third party, the payment will be excluded from the accumulation towards the deductible and out-of-pocket maximum. For more information, see Plan Administration - Third Party Payments section.

PLAN BENEFITS

This plan provides benefits for the following services and supplies as outlined on your Benefit Summaries. The following list of benefits is exhaustive. These services and supplies may require you to satisfy a deductible, make a co-payment, and/or pay co-insurance, and they may be subject to additional limitations or maximum dollar amounts (maximum dollar amounts do not apply to Essential Health Benefits (EHB)). For a medical expense to be eligible for payment, you must be covered under this plan on the date the expense is incurred. For more information, see your Benefit Summaries and the Benefit Limitations and Exclusions section.

PREVENTIVE CARE SERVICES

This plan covers the following preventive care services when provided by a physician, physician assistant, or nurse practitioner:

Preventive physicals including appropriate screening radiology and laboratory tests and other screening procedures for members age 22 and older are covered once per calendar year. Screening exams and laboratory tests may include, but not limited to, 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 diagnostic testing procedures related to the preventive physical exam are covered by this benefit. Any laboratory tests and other diagnostic testing procedures ordered during, but not related to, a preventive physical examination are not covered by this preventive care benefit. For more information, see Outpatient Services section.

- **Well woman visits**, including the following:
  - One **preventive gynecological exam** each calendar year for women 18 and over. Exams may include Pap smear, pelvic exam, breast exam, blood pressure check, and weight check. Covered lab services are limited to occult blood, urinalysis, and complete blood count.
  - **Preventive mammograms** for women as recommended.
    - There is no deductible, co-payment, and/or co-insurance for in-network mammograms that are considered preventive according to the guidelines of the U.S. Preventive Services Task Force (USPSTF).
    - Diagnostic mammograms for any woman desiring a mammogram for medical cause. The deductibles, co-payments, and/or co-insurance stated in your Medical Benefit Summary for

Outpatient Services – Diagnostic and therapeutic radiology/lab apply to diagnostic mammograms related to the ongoing evaluation or treatment of a medical condition.

- **Pelvic exams and Pap smear exams** for women 18 to 64 years of age annually, or at any time when recommended by a women's healthcare provider.
- **Breast exams** annually for women 18 years of age or older or at any time when recommended by a women's healthcare provider for the purpose of checking for lumps and other changes for early detection and prevention of breast cancer.

  Members have the right to seek care from obstetricians and gynecologists for covered services without preapproval, or preauthorization.

- **Colorectal cancer screening** exams and lab work including the following:
  - A colonoscopy;
  - A fecal occult blood test;
  - A flexible sigmoidoscopy; or
  - A double contrast barium enema.

  A colonoscopy performed for preventive screening purposes is considered to be a preventive service. The deductibles, co-payments, and/or co-insurance stated in your Medical Benefit Summary for Preventive Care – Preventive colonoscopy applies to colonoscopies that are considered preventive according to the guidelines of the USPSTF for age 50 through 75. It is not safe to assume that when you are treated at an in-network medical 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.

  A colonoscopy performed for screening purposes on individuals at high risk younger than age 50 is also considered a preventive service. An individual is at high risk for colorectal cancer if the individual has:
  - Family medical history of colorectal cancer;
  - Prior occurrence of cancer or precursor neoplastic polyps;
  - Prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease;
  - Crohn's disease or ulcerative colitis; or
  - Other predisposing factors.
- **Prostate cancer screening**, including a digital rectal examination and a prostate-specific antigen test.
- **Well baby/well child care exams** for members age 21 and younger according to the following schedule:
  - At birth: One standard in-hospital exam
  - Ages 0-2: 12 additional exams during the first 36 months of life
  - Ages 3-21: One exam per calendar year

  Only laboratory tests and other diagnostic testing procedures related to a well baby/well child care exam are covered by this benefit. Any laboratory tests and other diagnostic testing procedures ordered during, but not related to, a well baby/well child care exam are not covered by this preventive care benefit. For more information, see Outpatient Services section.

- Age-appropriate childhood and adult **immunizations** for primary prevention of infectious diseases as recommended and adopted by the Centers for Disease Control and Prevention, American Academy of Pediatrics, American Academy of Family Physicians, or similar standard-setting body. Benefits do not include immunizations for more elective, investigative, unproven, or discretionary reasons (for example, travel). Covered immunizations include, but may not be limited to the following:
  - Diphtheria, pertussis, and tetanus (DPT) vaccines, given separately or together;
  - Hemophilus influenza B vaccine;
  - Hepatitis A vaccine;
  - Hepatitis B vaccine;
  - Human papillomavirus (HPV) vaccine;
  - Influenza virus vaccine;
  - Measles, mumps, and rubella (MMR) vaccines, given separately or together;
  - Meningococcal (meningitis) vaccine;
  - Pneumococcal vaccine;
  - Polio vaccine;
  - Shingles vaccine for recommended adult age groups; or
  - Varicella (chicken pox) vaccine.
- **Tobacco cessation program services and drugs** are covered at no charge. Prescribed tobacco cessation related medication will be covered to the same extent this plan covers other prescription medications.

Any plan deductible, co-payment, and/or co-insurance amounts stated in your Medical Benefit Summary are waived for the following recommended preventive care services when provided by an in-network provider:

- Services that have a rating of A or B from the USPSTF;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- Preventive care and screening for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA);
- Preventive care and screening for women supported by the HRSA that are not included in the USPSTF recommendations.

The A and B list for preventive services can be found on the USPSTF website at: uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

The list of women's preventive services can be found on the HRSA website at: hrsa.gov/womensguidelines2016/

For members who do not have Internet access, please contact our Customer Service team at the number shown on the first page of this handbook for a complete description of the preventive services lists.

USPSTF recommendations include the January 2016 recommendations regarding breast cancer screening, mammography, and prevention. Cancer risk-reducing medications are covered according

to the September 2013 USPSTF recommendations, at no cost, subject to reasonable medical management.

PROFESSIONAL SERVICES

This plan covers the following professional services when medically necessary:

- Services of a **physician (M.D., D.O., or other provider practicing within the scope of their license),** for diagnosis or treatment of illness, injury, or disease.
- Services of a licensed **physician assistant** under the supervision of a physician.
- Services of a **nurse practitioner**, including certified registered nurse anesthetist (C.R.N.A.) and certified nurse midwife (C.N.M.), or other provider practicing within the scope of their license, for medically necessary diagnosis or treatment of illness, injury, or disease.
- **Urgent care services** provided by a physician. Urgent care means services for an unforeseen illness, injury, or disease 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.
- **Outpatient habilitation services** provided by a licensed provider for physical, occupational, or speech therapy for medically necessary treatment of illness or injury. The service must be within the scope of the provider's license. Services must be prescribed in writing by a licensed physician, dentist, podiatrist, nurse practitioner, or physician assistant. The prescription must include site, modality, duration, and frequency of treatment. Total covered expenses for outpatient habilitation services are limited to a combined maximum of 30 visits per benefit year subject to review for medical necessity. Covered services are for the purpose of restoring certain functional losses due to disease, illness, or injury only, and do not include maintenance services. Only treatment of neurologic conditions (for example, stroke, spinal cord injury, head injury, pediatric neurodevelopmental problems, and other problems associated with autism spectrum disorders for which habilitation services would be appropriate) may be considered for benefits when criteria for individual benefits are met.
  - Services for speech therapy will only be allowed when needed to correct stuttering, hearing loss, peripheral speech mechanism problems, and deficits due to neurological disease or injury. Speech and/or cognitive therapy for acute illnesses and injuries are covered with reasonable expectation that the services will produce measurable improvement in the member's condition in a reasonable period of time when the services do not duplicate those provided by other eligible providers, including occupational therapists or neuropsychologists. This exclusion does not apply if medically necessary as part of a treatment plan. For more information, see Durable Medical Equipment section.
  - For related provisions, see oral/facial motor therapy in the Excluded Services section.
- **Outpatient rehabilitation services** provided by a licensed provider for physical, occupational, or speech therapy for medically necessary treatment of illness or injury. The service must be within the scope of the provider's license. Services must be prescribed in writing by a licensed physician, dentist, podiatrist, nurse practitioner, or physician assistant. The prescription must include site, modality, duration, and frequency of treatment. Total covered expenses for outpatient rehabilitation services are limited to a combined maximum of 30 visits per benefit year subject to review for medical necessity. Covered services are for the purpose of restoring certain functional losses due to disease, illness, or injury only, and do not include maintenance services. Only treatment of neurologic conditions (for example, stroke, spinal cord injury, head injury, pediatric neurodevelopmental problems, and other problems associated with autism spectrum disorders for

which rehabilitation services would be appropriate) may be considered for benefits when criteria for individual benefits are met.

  - Services for speech therapy will only be allowed when needed to correct stuttering, hearing loss, peripheral speech mechanism problems, and deficits due to neurological disease or injury. Speech and/or cognitive therapy for acute illnesses, and injuries are covered with reasonable expectation that the services will produce measurable improvement in the member's condition in a reasonable period of time when the services do not duplicate those provided by other eligible providers, including occupational therapists or neuropsychologists. This exclusion does not apply if medically necessary as part of a treatment plan. For more information, see Durable Medical Equipment section.
  - Outpatient pulmonary rehabilitation programs are covered when prescribed by a physician for patients with severe chronic lung disease that interferes with normal daily activities despite optimal medication management.
  - For related provisions, see motion analysis, vocational rehabilitation, and oral/facial motor therapy in the Excluded Services section.

- Services of a licensed audiologist for medically necessary **audiological (hearing) services**.
- Services of a dentist or physician to treat **injury of the jaw or natural teeth**. Services must be provided within 18 months of the injury. Except for the initial examination, services for treatment of an injury to the jaw or natural teeth require preauthorization to be covered.
- Services of a dentist or physician for **orthognathic (jaw) surgery** as follows:
  - When medically necessary to repair an accidental injury. Services must be provided within one year after the accident; or
  - For removal of a malignancy, including reconstruction of the jaw within one year after that surgery.
- Services of a board-certified or board-eligible **genetic counselor** when referred by a physician or nurse practitioner for evaluation of genetic disease.
- Treatment of **temporomandibular joint syndrome (TMJ)** for medical reasons only. All TMJ-related services including, but not limited to, diagnostic and surgical procedures, must be medically necessary and preauthorized. Services are covered only when medically necessary due to a history of advanced pathologic process (arthritic degeneration) or in the case of severe acute trauma. Benefits for the treatment of TMJ and all related services are subject to the deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary under Other Covered Services – Temporomandibular Joint.
- Medically necessary **telemedical health services** for health services covered by this plan when provided by a healthcare professional.
- Services for **chiropractic manipulation and acupuncture** for medically necessary treatment of illness or injury are covered**.** Benefit is limited up to a combined benefit of 20 visits per person per calendar year.

HOSPITAL AND SKILLED NURSING FACILITY SERVICES

- This plan covers medically necessary **hospital inpatient services**. Charges for a hospital room are covered up to the hospital's semi-private room rate (or private room rate, if the hospital does not offer semi-private rooms). Charges for a private room are covered if the attending physician orders hospitalization in an intensive care unit, coronary care unit, or private room for medically

necessary isolation. Coverage includes eligible services provided by a hospital owned or operated by the state, or any state approved mental health and developmental disabilities program.

In addition to the hospital room, covered inpatient hospital services may include, but not limited to:

- Anesthesia and post-anesthesia recovery;
- Dressings, equipment, and other necessary supplies;
- Inpatient medications;
- Intensive and/or specialty care units;
- Lab services provided by hospital;
- Operating room;
- Radiology services;
- Respiratory care; or
- Substance use disorders.

The plan does not cover charges for rental of telephones, radios, or televisions, or for guest meals or other personal items.

- Services of **skilled nursing facilities and convalescent homes** are covered for up to 60 days per calendar year. Services must be medically necessary. Confinement for custodial care is not covered.
- **Inpatient rehabilitation services** are covered when medically necessary to restore and improve lost body functions after illness, injury, or disease. **Inpatient habilitation services** are covered when medically necessary to help a person keep, restore, or improve skills and functioning for daily living related to skills that have been lost or impaired because a person was sick, injured, or disabled. These services must be consistent with the condition being treated, and must be part of a formal written treatment program prescribed by a physician and subject to preauthorization by PacificSource. These benefits are limited to a combined maximum of 30 days per calendar year except in cases of head or spinal cord injury. Covered services for rehabilitation after a head or spinal cord injury are limited to 60 days per condition, when criteria for supplemental services are met. Recreation therapy is only covered as part of an inpatient rehabilitation admission.

OUTPATIENT SERVICES

Outpatient services are medical services that take place without being admitted to the hospital. This plan covers the following outpatient services:

- **Advanced diagnostic imaging procedures** that are medically necessary for the diagnosis of illness, injury, or disease. For purposes of this benefit, advanced diagnostic imaging procedures include CT scans, MRIs, PET scans, CATH labs, and nuclear cardiology studies. In all situations and settings, benefits require preauthorization and are subject to the deductibles, co-payments, and/or co-insurance stated in your Medical Benefit Summary for Outpatient Services – Advanced diagnostic imaging. Please note that the co-payment for these services is per test. For example, if separate MRIs are performed on different regions of the back, there will be a co-payment charged for each region imaged.
- **Diagnostic radiology and laboratory procedures** provided or ordered by a physician, nurse practitioner, alternative care provider, or physician assistant. These services may be performed or provided by laboratories, radiology facilities, hospitals, and physicians, including services in conjunction with office visits.

For services performed in an ambulatory surgical center or outpatient hospital setting, the benefits stated in your Medical Benefit Summary for Outpatient Services – Diagnostic and therapeutic radiology/lab apply.

- **Emergency room services.** The emergency room benefit stated in your Medical Benefit Summary covers only physician and hospital facility charges in the emergency room. The benefit does not cover further treatment provided on referral from the emergency room.

  Emergency medical screening and emergency services, including any diagnostic tests necessary for emergency care (including radiology, laboratory work, CT scans and MRIs) are subject to the deductibles, co-payments, and/or co-insurance stated in your Medical Benefit Summary for either Outpatient Services – Diagnostic and therapeutic radiology/lab or Outpatient Services – Advanced diagnostic imaging, depending on the specific service provided.

  For emergency medical conditions, out-of-network providers are paid at the in-network provider level.

- **Surgery** and other outpatient services. Benefits are based on the setting where services are performed.
  - For surgeries or outpatient services performed in a physician's office, the benefit stated in your Medical Benefit Summary for Professional Services – Office procedures and supplies applies.
  - For surgeries or outpatient services performed in an ambulatory surgical center or outpatient hospital setting, both the benefits shown on your Medical Benefit Summary for Professional Services – Surgery and the Outpatient Services – Outpatient surgery/services apply.

- **Therapeutic radiology services, chemotherapy, and renal dialysis** provided or ordered by a physician. Covered services include a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells.

- Absent a specifically negotiated amount, benefits for members who are receiving services for **end-stage renal disease (ESRD)**, beyond 90 days (30 days for peritoneal dialysis), are limited to 125 percent of the current Medicare allowable amount for in-network and out-of-network ESRD service providers.

  In accordance with federal and state laws, there is an initial period where this plan will be primary to Medicare. Once that period of time has elapsed the plan will pay up to the amount it would have paid in the secondary position.

- Other medically necessary **diagnostic services** provided in a hospital or outpatient setting, including testing or observation to diagnose the extent of a medical condition.

EMERGENCY SERVICES

For emergency medical conditions (see Definitions section), this plan covers services and supplies necessary to evaluate and treat an emergency condition.

Examples of emergency medical conditions include, but not limited to:

- Convulsions or seizures;
- Difficulty breathing;
- Major traumatic injuries;
- Poisoning;
- Serious burns;
- Sudden abdominal or chest pains;

- Sudden fevers;
- Suspected heart attacks;
- Unconsciousness; or
- Unusual or heavy bleeding.

If you need immediate assistance for a medical emergency, call 911. *If you have an emergency medical condition, you should go directly to the nearest emergency room or appropriate facility. Emergency and non-emergency services are subject to the deductibles, co-payments, and/or co-insurance stated in your Medical Benefit Summary.*

If you are admitted to an out-of-network hospital after your emergency condition is stabilized, PacificSource may require you to transfer to an in-network facility in order to continue receiving benefits at the in-network provider level.

MATERNITY SERVICES

Maternity means, in any one pregnancy, all prenatal services including complications and miscarriage, delivery, postnatal services provided within six weeks of delivery, and routine nursery care of a newborn child. Maternity services are covered subject to the deductibles, co-payments, and/or co-insurance stated in your Medical Benefit Summary.

Services of a physician or other provider practicing within the scope of their license. Services are subject to the same payment amounts, conditions, and limitations that apply to similar expenses for illness.

Please contact our 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 free prenatal care program.

This plan provides **routine nursery care** of a newborn 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.

Special Information about Childbirth – PacificSource covers hospital inpatient services for childbirth according to the Newborns' and Mothers' Health Protection Act of 1996. This plan does not restrict the length of stay for the mother or newborn child to less than 48 hours after vaginal delivery, or to less than 96 hours after Cesarean section delivery. Your provider is allowed to discharge you or your newborn sooner than that, but only if you both agree. For childbirth, your provider does not need to preauthorize your hospital stay with PacificSource.

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

This plan covers medically necessary crisis intervention, diagnosis, and treatment of mental health conditions and substance use disorders the same as any other illness. For more information on services not covered by your plan, see the Benefit Limitations and Exclusions section.

Providers Eligible for Reimbursement

A mental health and/or substance use disorder healthcare provider (see Definitions section) is eligible for reimbursement if:

- The mental health and/or substance use disorder healthcare provider is authorized for reimbursement under the laws of your policy's state of issuance; and
- The mental health and/or substance use disorder healthcare provider is accredited for the particular level of care for which reimbursement is being requested by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities; and

- The patient is staying overnight at the mental health and/or substance use disorder healthcare facility (see Definitions section) and is involved in a structured program at least eight hours per day, seven days per week; or
- The mental health and/or substance use disorder healthcare provider is providing a covered benefit under this plan.

Eligible mental health and/or substance use disorder healthcare providers are:

- A program licensed, approved, established, maintained, contracted with, or operated by the accrediting and licensing authority of the state wherein the program exists;
- A Medical or Osteopathic physician licensed by the State Board of Medical Examiners;
- A Psychologist (PhD) licensed by the State Board of Psychologists' Examiners;
- A Nurse Practitioner registered by the State Board of Nursing;
- A Licensed Clinical Social Worker (LCSW) licensed by the State Board of Clinical Social Workers;
- A Licensed Professional Counselor (LPC) licensed by the State Board of Licensed Professional Counselors and Therapists;
- A Licensed Marriage and Family Therapist (LMFT) licensed by the State Board of Licensed Professional Counselors and Therapists;
- A Board Certified Behavior Analyst (BCBA) certified by the State Board of Behavior Analysis;
- A Board Certified Assistant Behavior Analyst (BCaBA) certified by the State Board of Behavior Analysis;
- A Board Certified Behavior Analyst, Doctoral level (BCBA-D) certified by the State Board of Behavior Analysis;
- A Behavior Analyst Interventionist (BAI) certified by the State Board of Behavior Analysis; and
- A hospital or other healthcare facility accredited by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities for inpatient or residential care and treatment of mental health conditions and/or substance use disorders.

Medical Necessity and Appropriateness of Treatment

- As with all medical treatment, mental health and substance use disorders treatment is subject to review for medical necessity and/or appropriateness. Review of treatment may involve pre-service review, concurrent review of the continuation of treatment, post-treatment review, or a combination of these. PacificSource will notify the patient and patient's provider when a treatment review is necessary to make a determination of medical necessity.
- A second opinion may be required for a medical necessity determination. PacificSource will notify the patient when this requirement is applicable.
- Medication management by a licensed physician (such as a psychiatrist) does not require review.
- Treatment of substance use disorders and related disorders is subject to placement criteria established by the American Society of Addiction Medicine, Third Edition (ASAM).

Mental Health Parity and Addiction Equity Act of 2008

This group health plan complies with all state and federal laws and regulations related to the Mental Health Parity and Addiction Equity Act of 2008.

HOME HEALTH AND HOSPICE SERVICES

- This plan covers **home health services** when preauthorized by PacificSource. Covered services include services by a licensed Home Health Agency providing skilled nursing; physical, occupational, and speech therapy; and medical social work services. Private duty nursing is not covered. All home health services are limited to 130 visits per calendar year.
- **Home infusion services** are covered when preauthorized by PacificSource. This benefit covers parenteral nutrition, medications, and biologicals (other than immunizations) that cannot be self-administered. Benefits are paid at the percentage stated in your Medical Benefit Summary for Home health services.
- This plan covers **hospice services**. Hospice services, including respite care, are 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 intended to supplement the efforts of an unpaid caregiver. Hospice benefits do not cover services of a primary caregiver such as a relative, friend, or private duty nurse. PacificSource uses the following criteria to determine eligibility for hospice benefits:
  - The member's physician must certify that the member is terminally ill with a life expectancy of less than six months;
  - The member must be living at home;
  - A non-salaried primary caregiver must be available and willing to provide custodial care to the member on a daily basis; and
  - The member must not be undergoing treatment of the terminal illness other than for direct control of adverse symptoms.

  Only the following hospice services are covered:
  - Durable medical equipment, oxygen, and medical supplies;
  - Home health aides when necessary to assist in personal care;
  - Home infusion therapy;
  - Home nursing visits;
  - Home visits by a medical social worker;
  - Home visits by the hospice physician;
  - Inpatient hospice care when provided by a Medicare-certified or state-certified program when admission to an acute care hospital would otherwise be medically necessary;
  - Medically necessary physical, occupational, and speech therapy provided in the home;
  - Pastoral care and bereavement services;
  - Prescription medications for the relief of symptoms manifested by the terminal illness; and
  - Respite care provided in a nursing facility to provide relief for the primary caregiver, subject to a maximum of five consecutive days and to a lifetime maximum benefit of 30 days. A member must be enrolled in a hospice program to be eligible for respite care benefits.

  The member retains the right to all other services provided under this contract, including active treatment of non-terminal illnesses, except for services of another provider that duplicate the services of the hospice team.

DURABLE MEDICAL EQUIPMENT

- This plan covers **prosthetic and orthotic devices** that are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience. Benefits include coverage of all services and supplies medically necessary for the effective use of a prosthetic or orthotic device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device. Benefits also include coverage for any repair or replacement of a prosthetic or orthotic device that is determined medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for comfort or convenience.
- This plan covers **durable medical equipment** prescribed exclusively to treat medical conditions. Covered equipment includes crutches, wheelchairs, orthopedic braces, home glucose meters, equipment for administering oxygen, and non-power assisted prosthetic limbs and eyes. Durable medical equipment must be prescribed by a licensed M.D., D.O., N.P., P.A., D.D.S., D.M.D., or D.P.M. to be covered. This plan does not cover equipment commonly used for nonmedical purposes, for physical or occupational therapy, or prescribed primarily for comfort. For more information, see Excluded Services section. The following limitations apply to durable medical equipment:
  - Durable medical equipment that is available over the counter and/or without a prescription is excluded from coverage.
  - This benefit covers the cost of either purchase or 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. If the cost of the purchase, rental, repair, or replacement is over $1,000, preauthorization by PacificSource is required.
  - Only expenses for durable medical equipment, or prosthetic and orthotic devices that are provided by a PacificSource contracted 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. Mail order or Internet/web based providers are not eligible providers.
  - Purchase, rental, repair, lease, or replacement of a power-assisted wheelchair (including batteries and other accessories) requires preauthorization by PacificSource and is payable only in lieu of benefits for a manual wheelchair.
  - The durable medical equipment benefit also covers lenses to correct a specific vision defect resulting from a severe medical or surgical problem, such as stroke, neurological disease, trauma, or eye surgery other than refraction procedures. Coverage is 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 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, co-payment, and/or co-insurance stated in your Medical Benefit Summary for durable medical equipment and is in lieu of, and not in addition to any other vision benefit payable.

- Hearing aids, auditory osseointegrated (bone conduction) devices, cochlear implants and examination for or fitting of them, for dependent children with a congenital anomaly or acquired hearing loss which may result in cognitive or speech development deficits without intervention. The durable medical equipment benefit covers one device per hearing impaired ear every 36 months and up to 45 speech therapy visits during the 12 months after delivery of the covered device.
- Medically necessary treatment for sleep apnea and other sleeping disorders (including snoring) is covered when preauthorized by PacificSource. Coverage of oral devices includes charges for consultation, fitting, adjustment, follow-up care, and the appliance. The appliance must be prescribed by a physician specializing in evaluation and treatment of obstructive sleep apnea, and the condition must meet criteria for obstructive sleep apnea.
- Manual and electric breast pumps are covered once per pregnancy when purchased or rented from a licensed provider, or purchased from a retail outlet. Hospital-grade breast pumps are not covered. For more information, see Allowable Fee for Out-of-network Providers section.
- Wigs following chemotherapy or radiation therapy are covered up to a maximum benefit of $150 per calendar year.

TRANSPLANT SERVICES

This plan covers certain medically necessary organ and tissue transplants. It also covers the cost of acquiring organs or tissues needed for covered transplants and limited travel expenses for the patient, subject to certain limitations.

All pre-transplant evaluations, services, treatments, and supplies for transplant procedures require preauthorization by PacificSource.

This plan covers the following medically necessary organ and tissue transplants:

- Bone marrow, peripheral blood stem cell and high-dose chemotherapy when medically necessary;
- Heart;
- Heart - Lungs;
- Kidney;
- Kidney - Pancreas;
- Liver;
- Lungs;
- Pancreas whole organ transplantation; or
- Intestine (adult and pediatric).

This plan only covers transplants of human body organs and tissues. Transplants of artificial, animal, or other non-human organs and tissues are not covered.

Expenses for the acquisition of organs or tissues for transplantation are covered only when the transplantation itself is covered under this contract, and is subject to the following limitations:

- 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 PacificSource member.
  - If the donor is not a PacificSource member, only those complications of the donation that occur during the initial hospitalization are covered, and such complications are covered only 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 PacificSource member, 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 section.

Travel and housing expenses for the recipient and one caregiver are covered. The member must live at least 100 miles from the treating facility to qualify for this benefit. Housing expenses are covered up to 40 days per transplant. Travel and living expenses are not covered for the donor.

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 plan deductibles (co-insurance and co-payment amounts after deductibles are waived). If our contract with the facility includes the services of the medical professionals performing the transplant (such as physicians, nurse practitioners, and anesthesiologists), those charges are also subject to plan deductibles (co-insurance and co-payment amounts after deductibles are waived). If the professional fees are not included in our contract with the facility, then those benefits are provided according to your 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 your Medical Benefit Summary. The maximum benefit payment for transplant services of out-of-network providers is 125 percent of the Medicare allowance.

PRESCRIPTION DRUGS

This plan covers certain prescription medications included on your Drug List. Please refer to our website 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 our Customer Service team. See your Prescription Drug Benefit Summary for specific benefit information.

To use your PacificSource pharmacy benefits, you must show your PacificSource member ID card at the in-network pharmacy.

Some medications may qualify for third-party co-payment assistance programs that could lower your out-of-pocket costs for these products. For any such medication where third-party co-payment assistance is used and there is a generic equivalent available, the member shall not receive credit toward their maximum out-of-pocket or deductible for any co-payment or co-insurance amounts that are applied to a manufacturer coupon or rebate.

Essential Health Benefit Preventive Care Drugs

Your prescription benefit includes preventive care drugs at no cost to you. This benefit includes some drugs required by the Affordable Care Act. These drugs are identified on the drug list as Tier 0.

PacificSource Expanded No Cost Drug List

Your prescription benefit includes certain outpatient drugs as a preventive benefit. Preventive drugs are taken regularly to prevent a disease or to keep a specific disease or condition from progressing.

Mail Order Service

This plan includes an in-network mail order service for prescription drugs. Questions about the plan's in-network mail order pharmacy may be directed to our Customer Service team. Forms and instructions for using the mail order pharmacy are available on our website, Pacificsource.com/member/mail-order-rx.aspx.

Specialty Drug Program

PacificSource contracts with a specialty pharmacy provider for high-cost injectable medications and biotech drugs. A pharmacist-led Care Team provides individual follow-up care and support to covered members with prescriptions for specialty medications 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. More information is available on our website, Pacificsource.com/member/pharmacy-network. 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 network, mail order service, or non-contracted Specialty pharmacies without preauthorization.

No Duplication of Services

Medications and supplies covered under your pharmacy benefit are in place of, not in addition to, those same covered supplies under the medical plan.

Diabetic Supplies

Refer to the applicable Drug List, available on our website, to see which diabetic supplies are only covered under your pharmacy benefit. Some diabetic supplies, such as glucose monitoring devices, may only be covered under your medical benefit. Diabetic testing supplies are subject to plan quantity limits.

Contraceptives

Contraceptives approved by the Food and Drug Administration (FDA) are covered as recommended by the USPSTF, HRSA, and CDC. Any deductibles, co-payments, and/or co-insurance amounts are waived if a generic is filled. Brand name contraceptives will remain subject to regular pharmacy plan benefits. When no generic exists, brand name contraceptives may be covered at no cost. If your physician prescribes a brand name contraceptive due to medical necessity, it may be subject to preauthorization for coverage at no charge.

Orally Administered Anticancer Medications

Orally administered anticancer medications used to kill or slow the growth of cancerous cells are available. Co-payments for orally administered anticancer medication are applied on the same basis as for other drugs.

Limitations and Exclusions

- This plan only covers drugs prescribed by an eligible healthcare provider prescribing within the scope of their professional license. This plan does not cover the following:
  - Contraceptive drugs, devices, or products that are approved by the FDA are covered by your plan when prescribed by your physician. Over-the-counter contraceptive drugs, approved by the FDA, purchased without a prescription are reimbursable by the plan.
  - Drugs for any condition excluded under the health plan.
  - Some specialty drugs that are not self-administered are not covered by this pharmacy benefit, but may be covered under the medical plan's office supply benefit. For a list of drugs that are covered under your medical benefit and which require preauthorization, please refer to the Medical Drug and Diabetic Supply formulary on our website.
  - Some immunizations may be covered under either your medical or pharmacy benefit. Vaccines covered under the pharmacy benefit include, but not limited to: influenza, hepatitis B, herpes zoster (shingles), and pneumococcal. Most other immunizations must be provided by your doctor under your medical benefit.
  - Some drugs and all devices to treat erectile dysfunction.
  - Drugs used as a preventive measure against hazards of travel.
  - Vitamins, minerals, and dietary supplements, except for prescription prenatal vitamins and fluoride products.
- Certain drugs require pre-authorization (PA), which means we need to review documentation from your doctor before a drug will be covered. An up-to-date list of drugs requiring preauthorization along with all our requirements is available on our website.
- Certain drugs are subject to step therapy (ST) protocols, which means we may require you to try a pre-requisite drug before we will pay for the requested drug. An up-to-date list of drugs requiring step therapy along with all of our requirements, is available on our website. Step therapy decisions can be appealed.
- Certain drugs have quantity limits (QL), which means we will generally not pay for quantities above the FDA approved maximum dosing without an approved exception. An up-to-date list of drugs with quantity limits is available on our website.
- Your 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 day's supply of the prescription.
  - Retail pharmacies: you can get up to a 90 day supply.
  - Mail order pharmacies: you can get up to a 90 day supply.
  - Specialty pharmacies: you can get up to a 30 day supply.
- For drugs purchased at out-of-network pharmacies or at in-network pharmacies without using the PacificSource pharmacy benefits, reimbursement is limited to our in-network contracted rates. This means you may not be reimbursed the full cash price you pay to the pharmacy.
- 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 generally not approve early refills, except under the following circumstances:
  - The request is for ophthalmic solutions or gels which are susceptible to spillage.

- The member will be on vacation in a location that does not allow for reasonable access to a network pharmacy for subsequent refills.

All early refills are subject to standard co-payments and are reviewed on a case by case basis.

Formulary Exception and Coverage Determination Process

Requests for formulary exceptions can be made by the member or provider by contacting our Pharmacy Services team. Standard exception requests are determined within 72 hours, expedited requests are determined within 24 hours. 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:

- A reasonable number of similar drugs that are on the formulary have been tried;
- 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 evidenced-based and generally accepted medical practice; and
- Special circumstances and individual needs, including the availability of service providers in the patient's region.

OTHER COVERED SERVICES, SUPPLIES, AND TREATMENTS

- This plan covers services of a state certified ground or air **ambulance** when private transportation is medically inappropriate because the acute medical condition requires paramedic support. Benefits are provided for emergency ambulance service and/or transport to the nearest facility capable of treating the condition. Air ambulance service is covered only when ground transportation is medically or physically inappropriate. Whenever possible, you should seek services from an air ambulance service that participates in PacificSource's network of providers. Reimbursement to out-of-network air ambulance services are based on 200 percent of the Medicare allowance. In some cases, 200 percent of Medicare may be significantly lower than the provider's billed amount. Your in-network provider deductibles and co-insurance will apply when out-of-network ground or air ambulance is part of medically necessary emergency services, and the provider may still bill you for the amounts in excess of PacificSource's allowable charge. Non-emergency medically necessary travel, other than transportation by a licensed ambulance service, to the nearest facility qualified to treat the patient's medical condition is covered when approved in advance by PacificSource. Non-emergency ground or air ambulance between facilities requires preauthorization.
- This plan covers **biofeedback** to treat migraine headaches or urinary incontinence when provided by an otherwise eligible provider. Benefits are limited to a lifetime maximum of ten sessions.
- This plan covers **blood transfusions**, including the cost of blood or blood plasma.
- This plan covers removal, repair, or replacement of **breast prostheses** due to a contracture or rupture, but only when the original prosthesis was for a medically necessary mastectomy. Preauthorization by PacificSource is required, and eligibility for benefits is subject to the following criteria:
  - The contracture or rupture must be clinically evident by a physician's physical examination, imaging studies, or findings at surgery;
  - This plan covers removal, repair, and/or replacement of the prosthesis; and

  - 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.
- As required by the Women's Health and Cancer Rights Act of 1998 this plan covers **breast reconstruction** in connection with a medically necessary mastectomy. Coverage is provided in a manner determined in consultation with the attending physician and patient 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, co-payments, and/or co-insurance stated in your Medical Benefit Summary.
- This plan covers **cardiac rehabilitation** as follows:
  - Phase I (inpatient) services are covered under inpatient hospital benefits.
  - Phase II (short-term outpatient) services are covered subject to the deductibles, co-payments, and/or co-insurance amounts stated in your Medical Benefit Summary for Diagnostic and therapeutic radiology/lab. Benefits are limited to services provided in connection with a cardiac rehabilitation exercise program up to a lifetime maximum of 36 visits and are considered reasonable and necessary.
  - Phase III (long-term outpatient) services are not covered.
- This plan covers single or bilateral **cochlear implants** when medically necessary including programming and reprogramming.
- This 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. Contraceptive devices that can be obtained over the counter without a prescription, such as condoms, are not covered.
- This plan covers **corneal transplants**. Preauthorization is not required.
- In the following situations, this plan covers one attempt at **cosmetic or reconstructive surgery:**
  - When necessary to correct a functional disorder; or
  - When necessary because of an accidental injury, or to correct a scar or defect that resulted from treatment of an accidental injury; or
  - When necessary to correct a scar or defect on the head or neck that resulted from a covered surgery.

  Cosmetic or reconstructive surgery must take place within 18 months after the injury, surgery, scar, or defect first occurred unless the area needing treatment is a result of a congenital anomaly. For related provisions, see cosmetic/reconstructive services and supplies in the Excluded Services section. Preauthorization by PacificSource is required for all cosmetic and reconstructive surgeries covered by this plan. For related provisions, see breast prostheses and breast reconstruction in this section.
- This plan provides coverage for certain **diabetic equipment, supplies, and training** as follows:
  - Diabetic supplies other than insulin and syringes (such as lancets, test strips, and glucostix) are covered subject to the deductibles, co-payments, and/or co-insurance stated in your

Medical Benefit Summary for durable medical equipment. You may purchase those supplies from any retail outlet and send your receipts to PacificSource, along with your name, group number, and member ID number. We will process the claim and reimburse you according to your plan's benefits.

  - Insulin pumps are covered subject to preauthorization by PacificSource.
  - Diabetic insulin and syringes are covered under your prescription drug benefit, if your plan includes prescription coverage. Lancets and test strips are also available under that prescription benefit in lieu of those covered supplies under the medical plan.
  - This plan covers outpatient and self-management training and education for the treatment of diabetes, subject to the deductibles, co-payments, and/or co-insurance for office visits stated in your Medical Benefit Summary. To be covered, the training must be provided by a licensed healthcare professional with expertise in diabetes.

- This plan covers **dietary or nutritional counseling** provided by a registered dietitian under certain circumstances. It is covered under benefits for diabetic education management of inborn errors of metabolism, or management of anorexia nervosa or bulimia nervosa. Intensive counseling and behavioral interventions to promote sustained weight loss for obese adults, and comprehensive, intensive behavioral interventions to promote improvement in weight status for children are also covered.
- This plan covers nonprescription **elemental enteral formula** ordered by a physician for home use. Formula is covered when medically necessary to treat severe intestinal malabsorption and the formula comprises a predominant or essential source of nutrition. Coverage is subject to the deductibles, co-payments, and/or co-insurance stated in your Medical Benefit Summary for durable medical equipment.
- This plan covers routine **foot care** for patients with diabetes mellitus.
- **Growth hormone therapy** is covered when medically necessary and preauthorized by PacificSource.
- **Hospitalization for dental procedures** is covered when the patient has another serious medical condition that may complicate the dental procedure, such as serious blood disease, unstable diabetes, severe cardiovascular disease, or the patient is physically or developmentally disabled with a dental condition that cannot be safely and effectively treated in a dental office. Coverage requires preauthorization by PacificSource, and only charges for the facility, anesthesiologist, and assistant physician are covered. Hospitalization because of the patient's apprehension or convenience is not covered.
- This 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. Nutritional supplies are covered subject to the deductibles, co-payments, and/or co-insurance stated in your Medical Benefit Summary for durable medical equipment.
- **Injectable drugs and biologicals** administered by a physician are covered when medically necessary for diagnosis or treatment of illness, injury, or disease. This benefit does not include immunizations (see Preventive Care Services section), drugs, or biologicals that can be self-administered or are dispensed to a patient.

- This plan covers **maxillofacial prosthetic services** when prescribed by a physician 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. Coverage is limited to the least costly clinically appropriate treatment, as determined by the physician. Cosmetic procedures and procedures to improve on the normal range of functions are not covered. Dentures and artificial larynx are also not covered.
- For **pediatric dental care requiring general anesthesia**, this plan covers the facility charges of a hospital or ambulatory surgery center. Benefits are limited to one visit annually, and are subject to preauthorization by PacificSource.
- **Post-mastectomy care** is covered for hospital inpatient care for a period of time as determined by the attending physician and, in consultation with the patient, determined to be medically necessary following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.
- The **routine costs of care associated with approved clinical trials** are covered. For more information, see routine costs of care in the Definitions section. A qualified individual is someone who is eligible to participate in an approved clinical trial. 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 individual as a participant in the trial.
- **Sleep studies** are covered when ordered by a pulmonologist, neurologist, otolaryngologist, internist, family practitioner, or certified sleep medicine specialist.
- This plan covers medically necessary therapy and services for the treatment of **traumatic brain injury.**
- This plan covers **tubal ligation and vasectomy** procedures.

BENEFIT LIMITATIONS AND EXCLUSIONS

EXCLUDED SERVICES

Types of Treatment – This plan does not cover the following:

- Abdominoplasty for any indication.
- Academic skills training.
- Acute care, rehabilitative, diagnostic testing, except as specified as a covered service in this policy.
- Any amounts in excess of the allowable fee for a given service or supply.
- Biofeedback (other than as specifically noted under the Covered Expenses – Other Covered Services, Supplies, and Treatment section).
- Charges for phone consultations, missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims unless otherwise contracted.
- Charges over the usual, customary, and reasonable fee (UCR) – Any amount in excess of the UCR for a given service or supply.
- Charges that are the responsibility of a third party who may have caused the illness, injury, or disease 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.
- Cosmetic/reconstructive services and supplies – Except as specified in the Covered Expenses – Other Covered Services, Supplies, and Treatments section. Services and supplies, including drugs, rendered primarily for cosmetic/reconstructive purposes and any complications as a result of non-covered cosmetic/reconstructive surgery. 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 congenital anomaly or gender dysphoria.
- Court-ordered sex offender treatment programs.
- Court-ordered screening interviews or drug or alcohol treatment programs.
- Day care or custodial care – Care and related services designed essentially to assist a person in maintaining activities of daily living, such as services to assist with walking, getting in/out of bed, bathing, dressing, feeding, preparation of meals, homemaker services, special diets, rest crews, day care, and diapers. (This does not include habilitation or rehabilitation services that are covered under the Professional Services section.) Custodial care is only covered in conjunction with respite care allowed under this plan's hospice benefit. For related provisions, see Hospital and Skilled Nursing Facility Services and Home Health and Hospice Services sections.
- Dental examinations and treatment – For the purpose of this exclusion, the term dental examinations and treatment means services or supplies provided to prevent, diagnose, or treat diseases of the teeth and supporting tissues or structures. This includes services, supplies, hospitalization, anesthesia, dental braces or appliances, or dental care rendered to repair defects that have developed because of tooth loss, or to restore the ability to chew, or dental treatment necessitated by disease. For related provisions, see hospitalization for dental procedures in the Other Covered Services, Supplies, and Treatments section.
- Durable medical equipment available over the counter and/or without a prescription.
- Educational or correctional services or sheltered living provided by a school or halfway house, except outpatient services received while temporarily living in a shelter.
- Elective abortions, except to save the life of the female upon whom the abortion is performed. For more information, see elective abortion in the Definitions section.
- Equine/animal therapy.
- Equipment commonly used for nonmedical purposes 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.
- Experimental, investigational, or unproven procedures – Your PacificSource plan does not cover experimental, investigational, or unproven treatment. By that, we mean 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 patient. It includes treatment that, when and for the purpose rendered: has not yet received full U.S. government agency approval (for example, FDA) for other than experimental, investigational, unproven, or clinical testing; is not of generally accepted medical practice in your policy'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, unproven, not reasonable and necessary, or any similar finding.

An experimental, investigational, or unproven service is not made eligible for benefits by the fact that other treatment is considered by your healthcare provider to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.

When making benefit determinations about whether treatments are experimental, investigational, or unproven, we rely 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.

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

- Eye examinations (preventive).
- Eye exercises and eye refraction, therapy and procedures – Orthoptics, vision therapy, and procedures intended to correct refractive errors.
- Eye glasses/Contact Lenses – The fitting, provision, or replacement of eye glasses, lenses, frames, contact lenses, or subnormal vision aids intended to correct refractive error.
- Family planning – Services and supplies for artificial insemination, in vitro fertilization, diagnosis and treatment of infertility, erectile dysfunction, sexual dysfunction, or surgery to reverse voluntary sterilization. Services and supplies, diagnostic laboratory and x-ray studies, surgery, treatment, or prescriptions to diagnose, prevent, or cure infertility or to induce fertility (including Gamete and/or Zygote Intrafallopian Transfer; such as GIFT or ZIFT), except for medically necessary medication to preserve fertility during treatment with cytotoxic chemotherapy.
- 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 patients being treated for diabetes mellitus.
- Hearing Aids including the fitting, provision or replacement of hearing aids. For related provisions, see Durable Medical Equipment section.
- Homeopathic medicines or homeopathic supplies.
- Hypnotherapy except in the treatment of mental or nervous conditions.
- Immunizations when recommended for, or in anticipation of, exposure through travel or work.

- Inpatient or outpatient custodial care; or inpatient or outpatient services consisting mainly of educational therapy, behavioral modification, self-care or self-help training, except as specified as a covered service in this policy.
- Instructional or educational programs, except diabetes self-management programs unless medically necessary.
- Jaw – Procedures, services, and supplies for developmental or degenerative abnormalities of the head and face that can be replaced with living tissue; services and supplies that do not control or eliminate pain or infection or that do not restore functions such as speech, swallowing, or chewing; cosmetic procedures and procedures to improve on the normal range of functions; and dentures, prosthetic devices for treatment of artificial larynx. (This does not include services for congenital anomalies as defined in the Definitions section.)
- Jaw surgery – Treatment for malocclusion of the jaw, including services for TMJ, anterior and internal dislocations, derangements and myofascial pain syndrome, orthodontics or related appliances, or improving the placement of dentures and dental implants. (This does not include services for congenital anomalies as defined in the Definitions section.)
- Learning disorders.
- 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 treatments for conditions defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) that are not attributable to a mental health disorder or disease.
  - Mental illness does not include – relationship problems (for example, parent-child, partner, sibling, or other relationship issues), except the treatment of children five years of age or younger for parent-child relational problems, physical abuse of a child, sexual abuse, neglect of a child, or bereavement.

    The following are also excluded: court-mandated diversion and/or substance use disorder education classes; court-mandated psychological evaluations for child custody determinations; voluntary mutual support groups such as Alcoholics Anonymous; adolescent wilderness treatment programs; 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 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 physician review.
- Naturopathic supplies.
- Nicotine related disorders, other than those covered through tobacco cessation program services.
- Obesity or weight reduction control – Surgery or other related services or supplies provided for weight reduction control or obesity (including all categories of obesity), when not medically necessary to control other medical conditions that are eligible for covered services and nonsurgical methods have been unsuccessful in treating obesity. This also includes services or supplies used for weight loss, such as food supplementation programs and behavior modification programs, and self-help or training programs for weight reduction control. Obesity screening and

counseling are covered for children and adults. For related provisions, see dietary or nutritional counseling in the Other Covered Services, Supplies, and Treatments section.

- 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 an autism spectrum disorder.
- Orthognathic surgery – Services and supplies to augment or reduce the upper or lower jaw, except as specified in the Professional Services section. For related provisions, see jaw surgery in this section.
- Orthopedic shoes, diabetic shoes, and shoe modifications.
- Osteopathic manipulation, except for treatment of disorders of the musculoskeletal system.
- Over-the-counter medications or nonprescription drugs. Does not apply to tobacco cessation medications covered under USPSTF guidelines.
- Panniculectomy for any indication.
- Paraphilias.
- Personal items such as telephones, televisions, and guest meals during a stay at a hospital or other inpatient facility.
- Physical or eye examinations required for administrative purposes such as participation in athletics, admission to school, or by an employer.
- 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 or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present.
- Recreation therapy – Outpatient.
- Rehabilitation – Functional capacity evaluations, work-hardening programs, vocational rehabilitation, community reintegration services, and driving evaluations and training programs.
- Replacement costs for worn or damaged durable medical equipment that would otherwise be replaceable without charge under warranty or other agreement.
- Scheduled and/or non-emergent medical care outside of the United States.
- 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 under Preventive Care Services in the Covered Expenses section.
- Self-administered drugs or medication (including prescription drugs, injectable drugs, and biologicals), except when prescribed for inborn errors of metabolism, diabetic insulin, autism spectrum disorder, or unless given during a visit for outpatient chemotherapy or dialysis or during a medically necessary hospital, emergency room, or other institutional stay.
- Self-help health or instruction or training programs.
- Sensory integration training.
- Services for which no charge is normally made in the absence of insurance.

- Services of providers who are not eligible for reimbursement under this plan. An individual organization, facility, or program is not eligible for reimbursement for services or supplies, regardless of whether this plan includes benefits for such services or supplies, unless the individual, organization, facility, or program is licensed by the state in which services are provided as an independent provider, hospital, ambulatory surgical center, skilled nursing facility, durable medical equipment supplier, or mental health and/or substance use disorder healthcare facility. To the extent PacificSource maintains credentialing requirements the provider or facility must satisfy those requirements in order to be considered an eligible provider.
- Services or supplies provided by or payable under any plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law.
- Services or supplies with no charge, or for which your employer has paid for, 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 to the member, or any licensed medical professional that is directly related to the member by blood or marriage.
- 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, intended to alter 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 sexual dysfunction or inadequacy. For related provisions, see family planning, and mental illness in this section.
- Social skills training.
- Support groups.
- Transplants – Any services, treatments, or supplies for the transplantation of bone marrow or peripheral blood stem cells or any human body organ or tissue, except as expressly provided under the provisions of this plan for covered transplantation expenses. For related provisions, see Transplant Services section.
- Treatment after insurance ends – Services or supplies a member receives after the member's coverage under this plan ends, except as follows:
  - If the member is pregnant and not eligible for any replacement group coverage within 60 days, this plan's maternity benefits may continue for up to 12 months. PacificSource will then provide maternity benefits to the extent they are covered in this plan for up to 12 months after this plan is discontinued.
  - If the member is totally disabled, coverage may continue for up to 12 months. PacificSource will continue to provide benefits for covered expenses related to disabling conditions until the member is no longer totally disabled, the policy's maximum benefits have been paid, or the policy coverage has been discontinued for 12 months.
- Treatment not medically necessary – Services or supplies that are not medically necessary for the diagnosis or treatment of an illness, injury, or disease. For related provisions, see medically necessary in the Definitions section and Understanding Medical Necessity in the Covered Expenses section.

- Treatment of any illness, injury, or disease arising out of an illegal act or occupation or participation in a felony.
- Treatment of any work-related illness, injury, or disease, unless you are the owner, partner, or principal of the employer group insured by PacificSource, injured in the course of employment of the employer group insured by PacificSource, and are otherwise exempt from, and not covered by, state or federal workers' compensation insurance. This includes illness, injury, or disease caused by any for-profit activity, whether through employment or self-employment.
- Treatment of intellectual disabilities, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Intellectual disability means a disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills.
- Treatment prior to enrollment – Services or supplies a member received prior to enrolling in coverage provided by this plan, such as inpatient stays or admission to a hospital, skilled nursing facility, or specialized facility that began before the patient's coverage under this plan.
- Unwilling to release information – Charges for services or supplies for which a member is unwilling to release medical or eligibility information necessary to determine the benefits payable under this plan.
- Vocational rehabilitation, functional capacity evaluations, work-hardening programs, community reintegration services, and driving evaluations and training programs, except as medically necessary in the restoration or improvement of speech following a traumatic brain injury or for members diagnosed with an autism spectrum disorder.
- War-related conditions – The treatment of any condition caused by or arising out of any act of war, or any war declared or undeclared, or while in the service of the armed forces.

PREAUTHORIZATION

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called preauthorization.

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

Your healthcare provider can request preauthorization from the PacificSource Health Services team. If your provider will not request preauthorization for you, you may contact us yourself. In some cases, we may ask for more information or require a second opinion before authorizing coverage.

Because of the changing nature of medicine, PacificSource continually reviews new technologies and standards of healthcare practice. The list of procedures and services requiring preauthorization is therefore subject to revision and update. ***The list is not intended to suggest that all the items included are necessarily covered by the benefits of this plan.*** You'll find the most current preauthorization list on our website, Pacificsource.com/member/preauthorization.aspx.

When services are received from your in-network provider, the provider is responsible for contacting PacificSource to obtain preauthorization.

You are responsible for obtaining preauthorization when seeking treatment from an out-of-network provider. If the preauthorization of your treatment by an out-of-network provider is not approved by PacificSource, you can still seek treatment, but benefits will not be payable under this policy for those services not medically necessary or not covered by this plan. Remember, any time you are unsure if an expense will be covered, contact our Customer Service team.

Notification of PacificSource's benefit determination will be communicated by letter, fax, or electronic transmission to the hospital, the provider, and you. If time is a factor, notification will be made by telephone and followed up in writing.

PacificSource reserves the right to employ a third party to perform preauthorization procedures on its behalf.

In a medical emergency, services and supplies necessary to determine the nature and extent of the emergency condition and to stabilize the patient are covered without preauthorization requirements. A hospital or other healthcare facility must notify PacificSource of an emergency admission within two business days.

If your provider's preauthorization request is denied as not medically necessary or as experimental, investigational, or unproven your provider may appeal our benefit determination. You retain the right to appeal our benefit determination independent from your provider.

CASE MANAGEMENT

Case management is a service provided by Registered Nurses who are Certified Case Managers and Licensed Behavioral Health Clinicians with specialized skills to respond to the complexity of a member's healthcare needs. 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, open heart surgery, neuromuscular disease, spinal cord injury, or any acute or chronic condition that may necessitate specialized treatment or care coordination. When case management services are implemented, the Case Manager will work in collaboration with the patient's provider and the PacificSource Medical Director to enhance the quality of care and maximize available health plan benefits. A case manager may authorize benefits for supplemental services not otherwise covered by this plan. For more information, see Individual Benefits Management section.

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

INDIVIDUAL BENEFITS MANAGEMENT

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

UTILIZATION REVIEW

PacificSource has a utilization review program to determine coverage of hospital admissions. This program is administered by our Health Services team. All hospital admissions are reviewed by PacificSource Case Managers, who are all Registered Nurses or Licensed Behavioral Health Clinicians. Questions regarding medical necessity, possible experimental, investigational, or unproven services, appropriate setting, and appropriate treatment are forwarded to the PacificSource Medical Director for review and benefit determination.

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

Authorization of Hospital Admissions

When a PacificSource member is admitted to a hospital within the area covered by PacificSource's provider networks (see Using the Provider Network section), the hospital calls PacificSource to verify the patient's eligibility and benefits. The hospital gives us information about the patient's diagnosis, procedure, and attending physician and we use this information to evaluate how long each patient is expected to remain hospitalized.

This is called the target length of stay. We use the target length of stay to monitor the patient's progress and plan for any necessary follow-up care after the patient is discharged.

The PacificSource Health Services team assigns the target length of stay based on the patient's diagnosis and/or procedure. For standard hospitalizations, we use written procedures that were developed based on the following guidelines:

- American Society of Addiction Medicine, Third Edition (ASAM);
- MCG™;
- MCG™ Goal Length of Stay (GLOS); and
- Standard of practice in your policy's state of issue.

If we are unable to assign a target length of stay based on those guidelines, our Case Manager contacts the hospital for more specific information about the case. We then use that information to assign a target length of stay for the patient.

Extension of Hospital Stays

If a patient's hospital stay extends beyond the targeted length of stay, a Case Manager contacts the hospital to obtain current information about the patient's medical progress and assign a new target length of stay or begin planning for the patient's discharge. The PacificSource Medical Director may review the case to determine if extended hospitalization meets coverage criteria.

Occasionally, patients choose to extend their hospital stay beyond the length the attending physician considers medically necessary. Charges for hospital days and services beyond those determined to be medically necessary are the member's responsibility.

Timeliness for Responding to Coverage Request

When PacificSource receives a request for coverage of an admission or extension of a hospital stay, we are generally able to provide an answer that same day. If we do not have enough information to make a benefit determination, we request further information and attempt to provide a determination on the day we receive that information. If a member is discharged before we receive the information we need, the case is reviewed retrospectively by the Case Manager and the Medical Director for a determination regarding coverage.

Questions about Specific Utilization Review Decisions

If you would like information on how we reached a particular utilization review benefit determination, please contact our Health Services team by phone at (208) 333-1563 or (800) 688-5008, or by email at healthservices@pacificsource.com.

CLAIMS PAYMENT

How to File a Claim

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

If you receive care from an out-of-network provider, the provider may submit the claim to PacificSource for you. If not, you are responsible for sending the claim to us for processing. Your claim must include a copy of your provider's itemized bill. It must also include your name, PacificSource member ID number or social security number, group name, 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 must be turned in to PacificSource within 90 days of the date of service. If it is not possible to submit a claim within 90 days, turn in the claim with an explanation as soon as possible. In some cases, PacificSource may accept the late claim. We will never pay a claim that was submitted more than a year after the date of service.

Claim Handling Procedures

A claim for benefits under this plan will be examined by PacificSource on a pre-service, concurrent, and/or a post-services basis. Each time your claim is examined, a new claims determination will be made regarding the category (pre-service, concurrent, or post-service) into which the claim falls at that particular time. In each case, PacificSource must render a claim determination within a prescribed period of time.

Pre-service review – Your plan subjects the receipt of benefits for some services or supplies to a preauthorization review. Although a preauthorization review is generally done on a pre-service basis, it may in some case be conducted on a post-service basis. Unless a response is needed sooner due to the urgency of the situation, a pre-service preauthorization review will be completed and notification made to you and your medical provider as soon as possible, generally within two working days, but no later than 15 days within receipt of the request.

Urgent care review – If the time period for making a non-urgent care determination could seriously jeopardize your life, health, or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is proposed, a preauthorization review will be completed as soon as possible, generally within 24 hours, but no later than 48 hours of receipt of the request.

Concurrent care review – Inpatient hospital or rehabilitation facilities, skilled nursing facilities, substance use disorder and psychiatric day treatment facilities, partial hospitalization, and residential behavioral healthcare require concurrent review for a benefit determination with regard to an appropriate length of stay or duration of service. Benefit determinations will be made as soon as possible but no later than one working day of receipt of all the information necessary to make such a determination.

Post-service claims – A claim determination that involves only the payment of reimbursement of the cost of medical care that has already been provided will be made as soon as reasonably possible but no later than 30 days from the day after receiving the claim.

Retrospective review – A claim for benefits for which the service or supply requires a preauthorization review, but was not submitted for review on a pre-service basis, will be reviewed on a retrospective basis within 30 working days after receipt of the information necessary to make a claim determination.

Payment of claims – PacificSource will pay benefits to the member, the provider, or both jointly. In other cases, payment shall be payable to the estate of the member or beneficiary who is a minor or otherwise not competent to give an authorized release, PacificSource may pay such benefits, up to an amount not exceeding $1,000, to any relative by blood or connection by marriage of the member or beneficiary who is deemed by PacificSource to be equitably entitled to such payment. Any payment made by PacificSource in good faith pursuant to this provision shall fully discharge PacificSource to the extent of such payment.

Adverse benefit determinations – A decision made to reduce or deny benefits applied on a pre-service, post-service, or concurrent care basis may be appealed in accordance with the plan's Appeals procedures. For more information, see Complaints, Grievances, and Appeals section.

Questions about Claims

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

Benefits Paid in Error

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

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

COORDINATION OF BENEFITS

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

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

Definitions

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

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

- Plan includes: group and non-group health insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled

nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

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

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

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

Order of benefit determination rules. The rules that determine whether this plan is a primary plan or secondary plan when the member has healthcare coverage under more than one plan.

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

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

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

- The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.
- If a member is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
- If a member is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
- If a member is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's

payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

- The amount of any benefit reduction by the primary plan because a member has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, preauthorization of admissions, and preferred provider arrangements.

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

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

Order of Benefit Determination Rules

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

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

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

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

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

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

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

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

- For a dependent child whose parents are married or are living together, whether or not they have ever been married:
  - The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

- If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

- For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
  - If a court decree states that one of the parents is responsible for the dependent child's healthcare expenses or healthcare coverage, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to the plan year commencing after the plan is given notice of the court decree;
  - If a court decree states that both parents are responsible for the dependent child's healthcare expenses or healthcare coverage, the provisions above shall determine the order of benefits;
  - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, the provisions above shall determine the order of benefits; or
  - If there is no court decree allocating responsibility for the dependent child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
    - The plan covering the custodial parent;
    - The plan covering the spouse of the custodial parent;
    - The plan covering the non-custodial parent; and then
    - The plan covering the spouse of the non-custodial parent.
- For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions above shall determine the order of benefits as if those individuals were the parents of the child.

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

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

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

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

Effect on the Benefits of this Plan

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

Coordination with Medicare

- *Employers with 20 or more employees:* If you are Medicare eligible due to age, this plan is usually the primary payer and Medicare is secondary. This rule applies to you and your enrolled individuals only if you are an active employee.
- *Employers with 19 or fewer employees:* If you are Medicare eligible due to age, and are enrolled in Medicare Parts A and B, this plan only pays the portion of covered charges that would not be paid by Medicare Parts A and B. In other words, this plan pays secondary for anyone eligible for and enrolled in Medicare Parts A and B.
- *Medicare disabled and end-stage renal disease (ESRD) patients:* The rules above may not apply to disabled people under 65 and ESRD patients enrolled in Medicare. For information on coordination of benefits in those situations, please contact PacificSource.

THIRD PARTY LIABILITY

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

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

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

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

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

- If PacificSource pays any claim that you claim is, or that is alleged to be, the responsibility of another party, you will hold the right of recovery against the other party in trust for PacificSource.
- PacificSource is entitled to reimbursement for any paid claims out of the recovery from a third party if there is a settlement, judgment, or recovery from any source. This is regardless of whether the other party or insurer admits liability or fault, or otherwise disputes the relatedness of the claims paid by PacificSource to the injury caused by the third party. PacificSource shall have the first right of reimbursement in advance of all other parties, including the participant, and a priority to any money recovered from third parties.
- PacificSource may subtract a proportionate share of the reasonable attorney's fees you incurred from the money you are to pay back to PacificSource.
- PacificSource may ask you to take action to recover medical expenses we have paid from the responsible party. PacificSource may also assign a representative to do so on your behalf. If there is a recovery, PacificSource will be reimbursed for any expenses or attorney's fees out of that recovery.
- If you receive a third party settlement, that money must be used to pay your related medical expenses incurred both before and after the settlement. If you have ongoing medical expenses after the settlement, PacificSource may deny your related claims until the full settlement (less reasonable attorney's fees) has been used to pay those expenses.
- You and/or your agent or attorney must agree to keep segregated in its own account any recovery or payment of any kind to you or on your behalf that relates directly or indirectly to an injury or illness giving rise to PacificSource's right of reimbursement or subrogation, until that right is satisfied or released.
- If any of these conditions are not met, then PacificSource may recover any such benefits paid or advanced for any illness or injury through legal action, as well as reasonable attorney fees incurred by PacificSource.
- Unless Federal Law is found to apply.
- PacificSource's right to reimbursement overrides the made whole doctrine and this plan disclaims the application of the made whole doctrine to the extent permitted by law.

Subrogation

Upon payment under this policy, PacificSource shall be subrogated to all of the member's rights of recovery therefore, and the member shall do whatever is necessary to secure such rights and do nothing to prejudice them.

Under this subsection, PacificSource may pursue the third party in its own name, or in the name of the member. PacificSource is entitled to all subrogation rights and remedies under the common and statutory law, as well as under this policy.

Right of Recovery

In addition to its subrogation rights, PacificSource may, at its sole discretion and option, ask that the member, and their attorney, if any, protect PacificSource's reimbursement rights. If PacificSource elects to proceed under this subsection, the following rules apply:

- The member holds any right of recovery against the other party in trust for PacificSource, but only for the amount of benefits PacificSource pays for that illness or injury.
- PacificSource is entitled to receive the amount of benefits it has paid for that illness or injury out of any settlement or judgment which results from exercising the right of recovery against the other party. This is regardless of whether the third party admits liability or asserts that the member is also at fault. In addition, PacificSource is entitled to receive the amount of benefits it has paid whether the healthcare expenses are itemized or expressly excluded in the third party recovery.
- PacificSource holds the option to subtract from the money to be paid back to PacificSource a proportionate share representing the member’s reasonable attorney fees for collecting amounts paid by PacificSource to a third party.
- In addition, and as an alternative, if requested by PacificSource, the member will take such action as may be necessary or appropriate to recover such benefits furnished as damages from the responsible third party. Such action will be taken in the name of the member. If requested by PacificSource, such action will be prosecuted by a representative designated by PacificSource who does not have a conflict of interest with the member. In the event of a recovery, PacificSource will be reimbursed out of such recovery for the member's share of the expenses, costs, and attorney fees incurred by PacificSource in connection with the recovery.

Member Responsibility for Future Medical Expenses

If the member incurs healthcare expenses for treatment of the illness or injury after receiving a recovery from, or on behalf of, a third party, PacificSource will exclude benefits for otherwise covered expenses until the total amount of healthcare expenses incurred before and after the recovery exceeds the amount of the total recovery from all third parties and insurers, less reasonable attorney fees incurred in connection with the recovery.

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

This plan does not cover any work-related illness or injury, including those arising from self-employment. The only exception is if you are an owner, partner, or principal of the employer group insured by PacificSource, injured in the course of employment of the employer group insured by PacificSource, and are otherwise exempt from, and not covered by, state or federal workers’ compensation insurance.

If you are not the owner, partner, or principal of this group then PacificSource may pay your medical claims if a workers’ compensation claim has been denied on the basis that the illness or injury is not work related, and the denial is under appeal.

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

COMPLAINTS, GRIEVANCES, AND APPEALS

Questions, Concerns, or Complaints

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

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

GRIEVANCE PROCEDURES

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

APPEAL PROCEDURES

First Internal Appeal: If you believe PacificSource 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 Definitions section) may appeal (request a review) our decision. The request for appeal must be made in writing and within 180 days of the adverse benefit determination. For more information, see How to Submit Grievances or Appeals section. You may appeal if there is an adverse benefit determination based on a:

- Denial of eligibility for or termination of enrollment in a healthcare plan;
- 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 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.

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

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

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

Second Internal Appeal: If you are not satisfied with the first internal appeal decision, you may request an additional review. Your appeal and any additional information not presented with your first internal appeal should be forwarded to PacificSource within 60 days of the first appeal response.

Request for Expedited Response: If there is a clinical urgency to do so, you or your authorized representative may request in writing or orally, an expedited response to an internal or external review of an adverse benefit determination. To qualify for an expedited response, your attending physician must attest to the fact that the time period for making a non-urgent benefit determination could seriously jeopardize your life, health, your ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the 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 Independent External Review section), you may request that the internal and external reviews be performed at the same time.

Timelines for Responding to Appeals

You will be afforded two levels of internal appeal and, if applicable to your case, an external review. PacificSource will acknowledge receipt of an appeal no later than seven days after receipt. A decision in response to the appeal will be made within 30 days after receiving your request to appeal.

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

Information Available with Regard to an Adverse Benefit Determination

The final adverse benefit determination will include:

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

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

HOW TO SUBMIT GRIEVANCES OR APPEALS

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

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

Email cs@pacificsource.com, with Grievance as the subject

Fax (541) 225-3628

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

Assistance Outside PacificSource

You have the right to file a complaint or seek other assistance from the Idaho Department of Insurance. Assistance is available by contacting:

Idaho Department of Insurance
Consumer Affairs
700 W State St, 3rd Floor
PO Box 83720
Boise, ID 83720-0043

Call (208) 334-4250 or (800) 721-3272

Website doi.idaho.gov

INDEPENDENT EXTERNAL REVIEW

Please read this section carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with your health plan. If you request an independent external review of your claim, the decision made by the independent reviewer will be binding and final on the health carrier. You will have the right to further review of your claim by a court, arbitrator, mediator, or other dispute resolution entity only if your plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), as more fully explained below under Binding Nature of the External Review Decision.

If we issue a final adverse benefit determination of your request to provide or pay for a healthcare service or supply, you may have the right to have our decision reviewed by healthcare professionals who have no association with us. You have this right only if our denial decision involved:

- The medical necessity, appropriateness, healthcare setting, level of care, or effectiveness of your healthcare service or supply; or
- Our determination your healthcare service or supply was investigational.

You must first exhaust our internal grievance and appeal process. Exhaustion of that process includes completing all levels of appeal, or unless you requested or agreed to a delay, our failure to respond to a standard appeal within 30 days in writing or to an urgent appeal within three business days of the date you filed your appeal. We may also agree to waive the exhaustion requirement for an external review request. You may file for an internal urgent appeal with us and for an expedited external review with the Idaho Department of Insurance at the same time if your request qualifies as an urgent care request defined below.

You may submit a written request for an external review to:

Idaho Department of Insurance
ATTN: External Review
700 W State St., 3rd Floor
Boise, ID 83720-0043

For more information and for an external review request form:

Call (208) 334-4250 or (800) 721-3272

Website doi.idaho.gov

You may represent yourself in your request or you may name another person, including your treating healthcare provider, to act as your authorized representative for your request. If you want someone else to represent you, you must include a signed Designation of Authorized Representative form with your request.

Your written external review request to the Department of Insurance must include a completed form authorizing the release of any of your medical records the independent review organization may require to reach a decision on the external review, including any judicial review of the external review decision pursuant to ERISA, if applicable. The department will not act on an external review request without your completed authorization form. If your request qualifies for external review, our final adverse benefit determination will be reviewed by an independent review organization selected by the department. We will pay the costs of the review.

Standard External Review Request: You must file your written external review request with the department within six months after the date we issue a final notice of denial.

- Within seven days after the department receives your request, the department will send a copy to us.
- Within 14 days after we receive your request from the department, we will review your request for eligibility. Within five business days after we complete that review, we will notify you and the department in writing if your request is eligible or what additional information is needed. If we deny your eligibility for review, you may appeal that determination to the department.
- If your request is eligible for review, the department will assign an independent review organization to your review within seven days of receipt of our notice. The department will also notify you in writing.
- Within seven days of the date you receive the department's notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization that you want the organization to consider in its review.
- The independent review organization must provide written notice of its decision to you, to us, and to the department within 42 days after receipt of an external review request.

Expedited External Review Request: You may file a written urgent care request with the department for an expedited external review of a pre-service or concurrent service denial. You may file for an internal urgent appeal with us and for an expedited external review with the department at the same time.

Urgent care request means a claim relating to an admission, availability of care, continued stay, or healthcare service for which the covered person received emergency services but has not been discharged from a facility, or any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

- Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;
- In the opinion of the treating healthcare professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the disputed care or treatment; or
- The treatment would be significantly less effective if not promptly initiated.

The department will send your request to us. We will determine, no later than the second full business day, if your request is eligible for review. We will notify you and the department no later than one business day after our decision if your request is eligible. If we deny your eligibility for review, you may appeal that determination to the department.

If your request is eligible for review, the department will assign an independent review organization to your review upon receipt of our notice. The department will also notify you. The independent review organization must provide notice of its decision to you, to us, and to the department within 72 hours after the date of receipt of the external review request. The independent review organization must

provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses our denial, we will notify you and the department of our intent to pay the covered benefit as soon as reasonably practicable, but not later than one business day after receiving notice of the decision.

Binding Nature of the External Review Decision: If your plan is subject to federal ERISA laws (generally, any plan offered through an employer to its employees), the external review decision by the independent review organization will be final and binding on us. You may have additional review rights provided under federal ERISA laws.

If your plan is not subject to ERISA requirements, the external review decision by the independent review organization will be final and binding on both you and us. **This means that if you elect to request external review, you will be bound by the decision of the independent review organization. You will not have any further opportunity for review of our denial after the independent review organization issues its final decision.** If you choose not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration, or filing an action in court.

Under Idaho law, the independent review organization is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

RESOURCES FOR INFORMATION AND ASSISTANCE

Assistance in Other Languages

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

Information Available from PacificSource

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

- A directory of in-network healthcare providers under your plan;
- Information about our drug list (also known as a formulary);
- A copy of our annual report on complaints and appeals;
- A description (consistent with risk-sharing information required by the Centers for Medicare and Medicaid Services, formerly known as Health Care Financing Administration), of any risk-sharing arrangements we have with providers;
- A description of our efforts to monitor and improve the quality of health services;
- Information about how we check the credentials of our network providers and how you can obtain the names and qualifications of your healthcare providers;
- Information about our preauthorization and utilization review procedures; or
- Information about any healthcare plan offered by PacificSource.

FEEDBACK AND SUGGESTIONS

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

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

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

RIGHTS AND RESPONSIBILITIES

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

Your Rights as a Member:

- You have a right to receive information about PacificSource, our services, our providers, and your rights and responsibilities.
- You have a right to expect clear explanations of your plan benefits and exclusions.
- You have a right to be treated with respect and dignity.
- You have a right to impartial access to healthcare without regard to race, religion, gender, national origin, or disability.
- You have a right to honest discussion of appropriate or medically necessary treatment options. You are entitled to discuss those options regardless of how much the treatment costs or if it is covered by this plan.
- You have a right to the confidential protection of your medical records and personal information.
- You have a right to voice complaints about PacificSource or the care you receive, and to appeal decisions you believe are wrong.
- You have a right to participate with your healthcare 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 consequences.
- You have a right to refuse to sign any consent form you do not fully understand, or cross out any part you do not want applied to your care.
- You have a right to change your mind about treatment you previously agreed to.
- You have a right to make recommendations regarding PacificSource Health Plans' member rights and responsibilities policy.

Your Responsibilities as a Member:

- You are responsible for reading this benefit handbook and all other communications from PacificSource, and for understanding your plan's benefits. You are responsible for contacting our Customer Service team if anything is unclear to you.
- You are responsible for making sure your out-of-network provider obtains preauthorization for any services that require it before you are treated.
- You are responsible for providing PacificSource with all the information required to provide benefits under your plan.

- You are responsible for giving your healthcare provider complete health information to help accurately diagnose and treat you.
- You are responsible for telling your providers you are covered by PacificSource and showing your member ID card when you receive care.
- You are responsible for being on time for appointments, and calling your provider ahead of time if you need to cancel.
- You are responsible for any fees the provider charges for late cancellations or no shows.
- You are responsible for contacting PacificSource if you believe you are not receiving adequate care.
- You are responsible for supplying information to the extent possible that PacificSource needs in order to administer your benefits or your 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 doctors.
- You are responsible for understanding your health problems and participating in developing mutually agreed upon goals, to the degree possible.

PRIVACY AND CONFIDENTIALITY

PacificSource has strict policies in place to protect the confidentiality of your personal information, including your medical records. Your personal information is only available to the PacificSource staff members who need that information to do their jobs.

Disclosure outside PacificSource is allowed only when necessary to provide your coverage, or when otherwise allowed by law. Except when certain statutory exceptions apply, state law requires us to have written authorization from you (or your representative) before disclosing your personal information outside PacificSource. An example of one exception is that we do not need written authorization to disclose information to a designee performing utilization management, quality assurance, or peer review on our behalf.

PLAN ADMINISTRATION

Group Insurance Contract

This plan is fully insured. Benefits are provided under a group insurance contract between your employer and PacificSource Health Plans. Your employer – the policyholder – has a copy of the group insurance contract, which contains specific information regarding eligibility. Under the group insurance contract, PacificSource – not the policyholder – is responsible for paying claims. However, the policyholder and PacificSource share responsibility for administering the plan's eligibility and enrollment requirements. The policyholder has given PacificSource authority to determine eligibility for benefits under the plan and to interpret the terms of the plan.

Our address is:

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

Plan Funding

Insurance premiums for employees are paid in whole or in part by the plan sponsor (your employer) out of its general assets. Any portion not paid by the plan sponsor is paid by employee payroll deductions.

Third Party Payments

PacificSource will accept third party payments of premiums and cost sharing as if the member made the payment from the following:

- Family and friends;
- A Ryan White HIV/AIDS program;
- An Indian tribe, tribal organization, or urban Indian organization;
- Government programs, including grantees directed by a government program to make payments on its behalf; and
- Religious institutions and other not-for-profit organizations when each of the following criteria is met:
  - The assistance is provided on the basis of the member's financial need;
  - The institution/organization is not a healthcare provider; and
  - The institution/organization is not financially interested. Financially interested institutions/organizations include institutions/organizations that receive the majority of their funding from entities with a pecuniary interest in the payment of health insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a pecuniary interest in the payment of health insurance claims.

If payment is from a financially interested third party, the payment will be excluded from the accumulation towards the deductible and out-of-pocket maximum.

Upon rejecting or otherwise refusing to treat a third party payment as a payment from the insured, carriers must inform the insured in writing of the reason for doing so and of the insured's right to file a complaint with the Department of Insurance.

Plan Changes

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

- The policyholder's board of directors or other governing body;
- The owner or partners of the business; or
- Anyone authorized by the above people to take such action.

The plan administrator is authorized to apply for and accept policy changes on behalf of the policyholder.

If changes occur, PacificSource will provide your plan administrator with information to notify you of changes to your plan. Your plan administrator will then communicate any benefit changes to you.

If your group health plan terminates and your employer does not replace the coverage with another group plan, your employer is required by law to advise you in writing of the termination. When this plan's group policy terminates, PacificSource will notify your employer about any available options for you to continue your coverage, such as state continuation.

Legal Procedures

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

DEFINITIONS

Wherever used in this plan, the following definitions apply to the masculine and feminine, and singular and plural forms of terms. For the purpose of this plan, employee includes the employer when covered by this plan. Other terms are defined where they are first used in the text.

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

Advanced diagnostic imaging means diagnostic examinations using CT scans, MRIs, PET scans, CATH labs, and nuclear cardiology studies.

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

- Denial of eligibility for or termination of enrollment in a health plan;
- Rescission or cancellation of a plan or coverage;
- Imposition of a Third Party Liability, network exclusion, annual benefit limit, or other limitation on otherwise covered services or items;
- Determination that a healthcare item or service is experimental, investigational, unproven, or not 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 dollar amount established by PacificSource for reimbursement of charges for specific services or supplies provided by out-of-network providers. PacificSource uses several sources to determine the allowable fee. Depending on the service or supply and the geographical area in which it is provided, the allowable fee may be based on data collected from the Centers for Medicare and Medicaid Services (CMS), contracted vendors, other nationally recognized databases, or PacificSource, as documented in PacificSource's payment policy.

An out-of-network provider may charge more than the limits established by the definition allowable fee. Charges that are eligible for reimbursement, but exceed the allowable fee, are the member's responsibility. For more information, see Out-of-network Providers section.

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

- Access to healthcare benefits, including an adverse benefit determination made pursuant to utilization management;
- Claims payment, handling, or reimbursement for healthcare services; and
- Other matters as specifically required by law.

Approved clinical trials are Phase I, II, III, or IV clinical trials for the prevention, detection, or treatment of cancer or another life-threatening condition or disease, or:

- 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;
- 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 FDA; or
- Exempt by federal law from the requirement to submit an investigational new drug application to the FDA.

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

Benefit determination means the activity taken to determine or fulfill PacificSource's responsibility for provisions under this health benefit 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 health benefit claims;
- Review of healthcare services with respect to medical necessity (including underlying criteria), coverage under the health plan, appropriateness of care, experimental, investigational, or unproven treatment, justification of charges; and
- Utilization review activities, including precertification and preauthorization of services and concurrent and retrospective review of services.

Calendar year means the 12 month period beginning January 1 of any year through December 31 of the same 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.

Co-insurance means a defined percentage of the allowable fee for covered services and supplies the member receives. It is the percentage the member is responsible for, not including co-pays and deductibles. The co-insurance amounts the member is responsible for are listed in your Benefit Summary.

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

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

Contracted allowable fee is an amount PacificSource agrees to pay an in-network provider for a given service or supply through direct or indirect contract.

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

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

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

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

Domestic partner means an individual that meets the following definition:

- **Registered domestic partner** means an individual, age 18 or older, who is joined in a domestic partnership, and whose domestic partnership is legally registered in any state.
- **Unregistered domestic partner** means an individual of same or opposite gender who is joined in a domestic partnership with the subscriber (employee) and meets the following criteria:
  - Is age 18 or older;
  - Not related to the subscriber by blood closer than would bar marriage in the state where they have permanent residence and are domiciled;
  - Shares jointly the same permanent residence with the subscriber for at least six months immediately preceding the date of application to enroll and intent to continue to do so indefinitely;
  - Has an exclusive domestic partnership with the subscriber and has no other domestic partner;
  - Does not have a legally binding marriage nor has had another domestic partner within the previous six months;
  - Was mentally competent to consent to contract when the domestic partnership began and remains mentally competent.

Drug List (also known as a formulary) is a list of covered medications used to treat various medical conditions. PacificSource uses a variety of drug lists. Please refer to PacificSource.com/drug-list to determine which drug list applies to your coverage. The drug lists are developed and maintained by a committee of regional healthcare providers, including doctors, who are not employed by PacificSource. All PacificSource drug lists are available on our website, PacificSource.com/drug-list.

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 physician. Examples of durable medical equipment include, but not limited to,

hospital beds, wheelchairs, crutches, canes, walkers, nebulizers, commodes, suction machines, traction equipment, respirators, TENS units, and hearing aids.

Durable medical equipment supplier means a PacificSource contracted provider or a provider that satisfies the criteria in the Medicare Qualify Standards for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and Other Items and Services.

Elective abortion means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.

Elective surgery or procedure refers to a surgery or procedure for a condition that does not require immediate attention and for which a delay would not have a substantial likelihood of adversely affecting the health of the patient.

Eligible employee means any employee who works on a full time basis and has a normal workweek of 30 hours. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of an employer, but does not include an employee who works on a part time, temporary, or substitute basis. The term eligible employee may include public officers and public employees without regard to the number of hours worked when designated by an employer.

Emergency medical condition means a medical condition:

- That manifests itself by acute symptoms of sufficient severity, including severe pain that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would:
  - Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy;
  - Result in serious impairment to bodily functions; or
  - Result in 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.

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 those healthcare services that are provided in a hospital or other emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity including, but not limited to, severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent person who possesses an average knowledge of health and medicine, to result in: a) placing the patient's health in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

Employee means any individual employed by an employer.

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

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;
- Laboratory services;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Pediatric services, including oral and vision care;
- Prescription drugs;
- Preventive and wellness services and chronic disease management; and
- Rehabilitation and habilitation services and devices.

Experimental, investigational, or unproven procedures means services, supplies, protocols, procedures, devices, chemotherapy, drugs or medicines, or the use thereof, that are experimental, investigational, or unproven for the diagnosis and treatment of illness, injury, or disease.

- Experimental, investigational, or unproven services and supplies include, but not limited to, services, supplies, procedures, devices, chemotherapy, drugs or medicines, or the use thereof, which at the time they are rendered and for the purpose and in the manner they are being used:
  - Have not yet received full U.S. government agency required approval (for example, FDA) for other than experimental, investigational, unproven, or clinical testing;
  - Are not of generally accepted medical practice in your policy'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, unproven, not considered reasonable and necessary, or any similar finding.
- When making decisions about whether treatments are experimental, investigational, or unproven PacificSource relies on the above resources as well as:
  - Expert opinions of specialists and other 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.

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

Generic drugs are drugs that, under federal law, require a prescription by a licensed physician (M.D. or D.O.) or other licensed medical provider, and are not brand name medications. By law, generic drugs must have the same active ingredients as the brand name medications and are subject to the same standards of their brand name counterparts. Generic drugs must be approved by the FDA through an Abbreviated New Drug Application and generally cannot be limited to a single manufacturer.

Geographical area – PacificSource has direct and indirect provider contracts to offer services to members in specific geographical regions. PacificSource also has an agreement with a nationwide provider network to offer services to members while traveling throughout the United States.

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

Habilitation services means healthcare services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health benefit plan means any hospital expense, medical expense, or hospital or medical expense policy or certificate, healthcare contractor or health maintenance organization subscriber contract, or any plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the extent that plan is subject to state regulation.

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 aids include any amplifying device that does not produce as its output an electrical signal that directly stimulates the auditory nerve. For the purpose of this definition, such amplifying devices include air conduction and bone conduction devices, as well as those that provide vibratory input to the middle ear.

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

- Home health aide services;
- Hospice therapy;

- Medical supplies and equipment suitable for use in the home;
- Medically necessary personal hygiene, grooming and dietary assistance;
- Nursing;
- Occupational therapy;
- Physical therapy; and
- Speech therapy.

Homebound means the ability to leave home only with great difficulty, with absences infrequently and of short duration. Infants and toddlers will not be considered homebound without medical documentation that clearly establishes the need for home skilled care. Lack of transportation is not considered sufficient medical criterion for establishing that a person is homebound.

Hospital means it is primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and provide 24 hour nursing services by or under the supervision of registered nurses.

Illness includes a physical or mental condition that results in a covered expense. Physical illness is a disease or bodily disorder. Mental illness is a psychological disorder that results in pain or distress and substantial impairment of basic or normal functioning.

In-network provider means a physician, healthcare professional, hospital, medical facility, or supplier of medical supplies that directly or indirectly holds a provider contract or agreement with PacificSource.

Incentive drugs are approved medications used to treat certain chronic conditions for a reduced co-payment. The incentive drug list is developed by the pharmacy benefits management company and PacificSource.

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

Infertility means:

- Male: Low sperm counts or the inability to fertilize an egg; or
- Female: The inability to conceive or carry a pregnancy to 12 weeks.

Initial enrollment period means a period of days set by your employer that determines when an individual is first eligible to enroll.

Injury means bodily trauma or damage that is independent of disease or infirmity. The damage must be caused solely through external and accidental means and does not include muscular strain sustained while performing a physical activity.

Inquiry means a written request for information or clarification about any subject matter related to the member’s health benefit plan.

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

Involuntary complications of pregnancy include, but are not limited to:

Cesarean section delivery, ectopic pregnancy that is terminated, spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible, puerperal infection, eclampsia, and toxemia; and

Conditions requiring inpatient confinement (when the pregnancy is not terminated), the diagnoses of which are distinct from pregnancy, but are adversely affected or caused by pregnancy. Examples include: acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity. It does not include false labor, occasional spotting, physician-prescribed bed rest during pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy, but which are not distinct from the pregnancy itself.

Large employer means an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the contract year.

Leave of absence is a period of time off work granted to an employee by the employer at the employee's request and during which the employee is still considered to be employed and is carried on the employment records of the employer. A leave can be granted for any reason acceptable to the employer, including disability and pregnancy.

Lifetime maximum or lifetime benefit means the maximum benefit that will be provided toward the expenses incurred by any one person while the person is covered by a PacificSource insurance policy issued to the employer sponsoring this group health benefit plan. If any covered expense that includes a lifetime maximum benefit amount 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 amount will not apply to that covered expense 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 physician has ordered for the treatment or diagnosis of an illness, injury, or disease. Examples of medical supplies include, but 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 (for example, Albuterol for use in a nebulizer).

Medically necessary means those services and supplies that are required and are appropriate 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 your policy's state of issue, or expert consensus physician 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, injury, or disease 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. 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.

- 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 Excluded Services section.

Member means an individual insured under a PacificSource health plan.

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 mental or nervous conditions which is licensed or 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 the plan, and is:

- A healthcare facility;
- A residential program or facility where appropriately licensed or accredited by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities;
- A day or partial hospitalization program;
- An outpatient service; or
- An individual behavioral health or medical professional authorized for reimbursement under state law.

Mental or nervous conditions means all disorders defined in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) except for neurodevelopmental disorders including:

- Intellectual Developmental Disorder, Global Developmental Delay, and Unspecified Intellectual Disability;
- Learning Disorders related to difficulties in learning and using academic skills which include impairment in reading, written expression, and mathematics;
- Paraphilias which include criminal offenses and are generally treated in correctional settings; and
- Mental health treatments for conditions defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) that are not attributable to a mental health disorder or disease**,** except the treatment of children five years of age or younger for parent-child relational problems, physical abuse of a child, sexual abuse, neglect of a child, or bereavement.

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. Benefits for orthotic devices include orthopedic appliances or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body. An orthotic device differs from a prosthetic in that, rather than replacing a body part, it supports and/or rehabilitates existing body parts. 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 of covered medical services or supplies that does not directly or indirectly hold a provider contract or agreement with PacificSource.

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.

Physician means a state-licensed Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.).

Physician assistant is a person who is licensed by an appropriate state agency as a physician assistant.

Practitioner means Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Doctor of Podiatry Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (O.D.), Licensed Nurse Practitioner (including Certified Nurse Midwife (C.N.M.) and Certified Registered Nurse Anesthetist (C.R.N.A.), Registered Physical Therapist (R.P.T.), Speech Therapist, Occupational Therapist, Psychologist (Ph.D.), Licensed Clinical Social Worker (L.C.S.W.), Licensed Professional Counselor (L.P.C.), Licensed Marriage and Family Therapist (LMFT), Licensed Psychologist Associate (LPA), Physician Assistant (PA), Audiologist, Acupuncturist, Licensed Denturist, and Licensed Massage Therapist.

Prescription drugs are drugs that, under federal law, require a prescription by a licensed physician (M.D. or D.O.) or other licensed medical provider.

Preventive Care means a program of healthcare designed for the prevention and/or reduction of illness by providing such services as regular physical examinations as defined in the Dictionary of Insurance Terms, Sixth Edition.

Prosthetic devices (excluding dental) means artificial limb devices or appliances designed to replace, in whole or in part, an arm or a leg. Benefits for prosthetic devices include coverage of 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, and are furnished on a physician's order. Examples of prosthetic devices include, but not limited to, artificial limbs, cardiac pacemakers, prosthetic lenses, breast prosthesis (including mastectomy bras), and maxillofacial devices.

Rehabilitation services means healthcare services and devices that help a person keep, get back, or improve skills and functioning for daily living to overcome or recover from an illness or diagnosis that is covered by this health plan. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Rescind or rescission means to retroactively cancel or discontinue the policyholder's coverage under a health benefit plan or group health insurance policy for reasons other than failure to timely pay required premiums toward the cost of coverage. PacificSource may not rescind the policyholder's group health benefit plan unless the policyholder, or representative of the policyholder, performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of this plan and PacificSource gives a 30 day prior written notice to all affected members covered under the plan. Rescissions do not include a cancellation or discontinuance of coverage that is prospective or to the extent it is attributable to a failure to timely pay required premiums towards the cost of coverage.

Routine costs of care mean costs for medically necessary services or supplies which would normally be covered by the healthcare plan if the member were not enrolled in an approved 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 the policy if provided outside of a clinical trial;
- 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 of services required solely for the prevention, diagnosis, or treatment of complications arising from the provision 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 the policy if provided outside of the clinical trial.

Seasonal employee is an employee who is hired with the agreement that their employment will end after a predetermined period of time.

Skilled nursing facility or convalescent home means an institution that provides skilled nursing care under the supervision of a physician, provides 24 hour nursing service by or under the supervision of a registered nurse (R.N.), 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, substance use disorder day treatment facilities, 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, 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 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.

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

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 medications have been tried first.

Subscriber means an employee or former employee insured under a PacificSource health policy. When a family that does not include an employee or former employee is insured under a policy, the oldest family member is referred to as the subscriber.

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 physician or addiction counselor licensed by the state; and is licensed or approved as a treatment center by the department of public health and human services, is licensed by the state where the facility is located.

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.

Telemedical is the use of technology for exchange of information when medically necessary.

Tobacco cessation program means a program recommended by a physician 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.

Totally Disabled (or Total Disability) means a licensed physician has certified in writing that a condition is the result of a disease, illness, or an accidental injury causing:

- A member's inability to perform the principal duties of the regular employment or occupation for which the member is or becomes qualified through education, training, or experience; and the member is not in fact engaged in any work profession, or avocation for fees, gain, or profit.
- An enrolled eligible dependent or retiree is so disabled and impaired as to be unable to engage in the normal activities of an individual of the same age and gender.

Unproven means any healthcare services, supplies, procedures, therapies, or devices that the health plan determines, regarding coverage for a particular case, to be:

- Not proven by scientific evidence to be effective; or

- Not accepted by healthcare professionals as being effective.

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.

Usual, customary, and reasonable fee (UCR) is the dollar amount established by PacificSource for reimbursement of eligible charges for specific services or supplies provided by out-of-network providers. PacificSource uses several sources to determine UCR. Depending on the service or supply and the geographical area in which it is provided, UCR may be based on data collected from the Centers for Medicare and Medicaid Services (CMS), contracted vendors, other nationally recognized databases, or PacificSource, as documented in PacificSource's payment policy.

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

Waiting period means the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the group health plan.

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

Contact us.

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

Your privacy is important to us.

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

Discrimination Is Against the Law

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

PacificSource:

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

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

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

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

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

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

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

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