Your plan: PacificSource

Pocatello Chubbuck School District No 25
Group No.: G0032790
PSN 1700+35-50_30+Rx S4
Effective: 09/01/2017

PacificSource HEALTH PLANS

We're in it for the people.

6/22/2017 3666447
PSGCC.ID.LG.0117

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.

PacificSource Customer Service Team
Phone (208) 333-1523 or (855) 203-4410
Email cs@pacificsource.com

PacificSource Boise Office
408 E. Park Center Blvd., Suite 100, Boise, ID 83706
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PacificSource.com

Para asistirle en español, por favor llame el nùmero (800) 624-6052, extensión 5456.

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POLICY INFORMATION

Group Name: Pocatello Chubbuck School District No 25
Group Number: G0032790
Provider Network: PSN

EMPLOYEE ELIGIBILITY REQUIREMENTS

Minimum Hour Requirement: Full Time Employees 32.5 or more hours per week
Part Time Employees 20 to 32 hours per week
Waiting Period for New Employees: First of the month following date of hire

Annual Deductible	Per Person, Per Calendar Year	Per Family, Per Calendar Year
All Providers	$1,700	$5,100
Out-of-Pocket Limit	**Per Person, Per Calendar Year**	**Per Family, Per Calendar Year**
Participating Providers	$4,200	$8,400
Non-participating Providers	$6,000	$12,000

Please Note: Your actual costs for services provided by a non-participating provider may exceed this policy's out-of-pocket limit for non-participating services. In addition, non-participating 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 non-participating out-of-pocket limit.

The member is responsible for the above deductible and the following amounts:

Service	Participating Providers:	Non-participating Providers:
Preventive Care		
Well baby/Well child care	No charge*	Deductible then 50% co-insurance
Routine physicals	No charge*	Deductible then 50% co-insurance
Well woman visits	No charge*	Deductible then 50% co-insurance
Routine mammograms	No charge*	Deductible then 50% co-insurance
Immunizations	No charge*	Deductible then 50% co-insurance
Routine colonoscopy	No charge*	Deductible then 50% co-insurance
Prostate cancer screening	No charge*	Deductible then 50% co-insurance
Professional Services		

Office and home visits	$35 co-pay/visit*	Deductible then 50% co-insurance
Specialist office and home visits	$50 co-pay/visit*	Deductible then 50% co-insurance
Office procedures and supplies	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Surgery	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Outpatient habilitation services	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Outpatient rehabilitation services	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Hospital Services		
Inpatient room and board	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Inpatient habilitation services	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Inpatient rehabilitation services	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Skilled nursing facility care	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Outpatient Services		
Outpatient surgery/services	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Advanced diagnostic imaging	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Diagnostic and therapeutic radiology/lab	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Urgent and Emergency Services		
Urgent care center visits	$35 co-pay/visit*	Deductible then 50% co-insurance
Emergency room visits - medical emergency	Deductible then $200 co-pay/visit plus 30% co-insurance^	Deductible then $200 co-pay/visit plus 30% co-insurance^
Emergency room visits - non-emergency	Deductible then $200 co-pay/visit plus 30% co-insurance^	Deductible then $200 co-pay/visit plus 50% co-insurance^
Ambulance, ground	Deductible then 30% co-insurance	Deductible then 30% co-insurance
Ambulance, air	Deductible then 30% co-insurance	Deductible then 30% co-insurance+

Maternity Services		
Physician/Provider services (global charge)	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Hospital/Facility services	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Mental Health/Chemical Dependency Services		
Office visits	$35 co-pay/visit*	Deductible then 50% co-insurance
Inpatient care	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Residential programs	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Other Covered Services		
Allergy injections	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Durable medical equipment	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Home health care	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Chiropractic manipulations and acupuncture care	30% co-insurance*	50% co-insurance*
Transplants	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Temporomandibular Joint	Deductible then 30% co-insurance	Deductible then 50% co-insurance

This is a brief summary of benefits. Refer to your 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.
* Not subject to annual deductible
+ Please note that non-participating air ambulance coverage is covered at 200 percent of the Medicare allowable. Contact Customer Service with questions.

Additional Information

What is the annual 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.

Participating provider expense and non-participating 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 covered charges 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 participating and non-participating providers when it comes to meeting your out-of-pocket limit. Only participating provider expense applies to the participating provider out-of-pocket limit. Only non-participating provider expense applies to the non-participating provider out-of-pocket limit.

Payments to providers

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. Participating providers accept the fee allowance as payment in full. Non-participating providers are allowed to balance bill any remaining balance that your plan did not cover. Services of non-participating 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. You'll find the most current preauthorization list on our website, PacificSource.com.

This PacificSource health plan includes coverage for prescription drugs and certain other pharmaceuticals, subject to the information below. This benefit includes some drugs required by federal health care reform.

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, differential between brand and generic drugs, drugs obtained without using the PacificSource ID card, and non-participating pharmacy charges do not accumulate toward the deductible. The deductible does not apply to Tier one drugs.

The amount you pay for covered prescriptions at participating and non-participating pharmacies applies toward your plan's participating 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 a participating or non-participating pharmacy are waived during the remainder of a calendar year in which you have satisfied the medical out-of-pocket limit.

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

	Tier 1:	Tier 2:	Tier 3:
Participating Retail Pharmacy^			
Up to a 30 day supply:	$15 co-pay*	Deductible then $40 co-pay	Deductible then $50 co-pay
31 - 60 day supply:	$30 co-pay*	Deductible then $80 co-pay	Deductible then $100 co-pay
61 - 90 day supply:	$45 co-pay*	Deductible then $120 co-pay	Deductible then $150 co-pay
Participating Mail Order Pharmacy			
Up to a 30 day supply:	$15 co-pay*	Deductible then $40 co-pay	Deductible then $50 co-pay
31 - 60 day supply:	$30 co-pay*	Deductible then $80 co-pay	Deductible then $100 co-pay
61 - 90 day supply:	$45 co-pay*	Deductible then $120 co-pay	Deductible then $150 co-pay
Non-participating Pharmacy			
30 day max fill, no more than three fills allowed per year:	Same as retail		
Tier 4 Specialty Drugs - Participating Specialty Pharmacy			
Up to a 30 day supply:	Same as retail		
Tier 4 Specialty Drugs - Not filled through Participating Specialty Pharmacy			

30 day max fill, no more than three fills allowed per year:	Same as retail
Compound Drugs**	
Up to a 30 day supply:	$50 co-pay*

^Remember to show your PacificSource ID Card each time you fill a prescription at a retail pharmacy. If your ID card is not used, your benefits cannot be applied.

** Not subject to annual medical deductible.*

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

MAC A - Regardless of the reason or medical necessity, if you receive a brand name drug or if your prescribing 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 deductible is met. The cost difference between the brand name and generic drug does not apply toward the medical plan's deductible or out-of-pocket limit.

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

CHIROPRACTIC MANIPULATION AND ACUPUNCTURE SUMMARY

This benefit allows you to receive services from licensed providers for chiropractic manipulation and acupuncture for medically necessary treatment of illness or injury. The service must be within the scope of the provider's license. Refer to the Medical Benefit Summary for your deductible, co-payment, and/or co-insurance information.

Covered Services

- Acupuncture from a licensed provider for medically necessary treatment of illness or injury.
- Chiropractic manipulations from a licensed provider for medically necessary treatment of illness or injury.

The combined benefit for all chiropractic manipulation and acupuncture care is limited to 20 visits per person in any calendar year.

Excluded Services

- Any service or supply noted as being excluded or not otherwise covered by the medical plan.
- Homeopathic medicines or homeopathic supplies.
- Services or supplies from a Naturopathic provider.
- Massage therapy.

NON-GRANDFATHERED HEALTH PLAN

The consumer protections of the Patient Protection and Affordable Care Act (PPACA) apply to this plan.

Questions regarding which protections apply and which protections do not apply to your plan can be directed to your employer (the plan administrator), or you may contact PacificSource at:

PacificSource Health Plans
PO Box 7068
Springfield OR 97475-0068
Phone (541) 686-1242 or (800) 624-6052

If this plan is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If this plan is not subject to ERISA, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

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 those 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 qualified domestic partner.
- Your, your spouse's, or your qualified domestic partner's natural or step 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 qualified 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, and will review the case before determining eligibility for coverage.
- A child placed for adoption with you, your spouse, or your qualified domestic partner. 'Placed' means the physical placement in the care of the adoptive member. When physical placement is prevented or delayed, such as when the child requires care in a medical facility, 'placed' occurs when the adoptive member signs an agreement for adoption of the child including assumption of financial responsibility. Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.
- A foster child placed with you, your spouse, or your qualified domestic partner. Placement means an individual who is placed by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. Coverage will continue assuming continued eligibility under this plan unless placement is disrupted and the child is removed from placement.
- A child placed in your, your spouse's, or your qualified domestic partner's guardianship. To be eligible for coverage, the child must be unmarried; not in a qualified domestic partnership; under age 19; *and* for whom you are the court appointed legal custodian or guardian with the expectation the child will live in your household for at least a year.

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 60 day window the initial enrollment period. To enroll you must submit the enrollment application provided by 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

‘Special Enrollment Periods’ and ‘Late Enrollment’ under the 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 application and your employer’s premium payment for that month.

ENROLLING NEW FAMILY MEMBERS

Newborns

Your newborn child is eligible from the date of birth for 60 days. To enroll your child, PacificSource must receive your enrollment change within 60 days of birth. If the child is born the 1st through the 15th of the month, full premium is due. If the child is born the 16th of the month through the last day of the month, no premium is charged for that month. 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 a notice of premium is provided to you by the employer. PacificSource may ask for legal documentation to confirm validity.

Adopted Children

Your adopted child is eligible from the date of birth, placement, or finalization for 60 days. To enroll your child, PacificSource must receive your enrollment change within 60 days of birth, placement, or finalization. If the date of placement is the 1st through the 15th of the month, full premium is due. If the date of the placement is the 16th through the last day of the month, no premium is charged for that month. Premium for the first 60 days of coverage and any additional premium is due 31 days from the date a notice of premium is provided to you by the employer. PacificSource may ask for legal documentation to confirm validity.

Foster Children

When a foster child is placed in your home, you have 60 days from the date of placement to enroll them on your plan. To enroll the child, PacificSource must receive your enrollment change within 60 days of the placement. If the date of placement is the 1st through the 15th of the month, full premium is due. If the date of the placement is the 16th through the last day of the month, no premium is charged for that month. Premium for the first 60 days of coverage and any additional premium is due 31 days from the date a notice of premium is provided to you by the employer. PacificSource may ask for legal documentation to confirm validity.

Family Members Acquired by Marriage

If you marry, you have 60 days from the date of the marriage to enroll your new spouse and any newly eligible dependent children in your plan. PacificSource must receive your enrollment change and any additional premium from your employer within 60 days of the marriage. Coverage for your new family members will then begin on the first day of the month after the marriage. You may be required to submit a copy of your marriage certificate to complete enrollment.

Family Members Acquired by Qualified Domestic Partnership

If you and your qualified domestic partner have been issued a Certificate of Registered Domestic Partnership, your domestic partner and your partner’s dependent children are eligible for coverage during the 60 day initial enrollment period after the registration of the domestic partnership. PacificSource must receive your enrollment change and additional premium during the initial enrollment period. Coverage for your new family members will then begin on the first day of the

month after the registration of the domestic partnership. You may be required to submit a copy of your Certificate of Registered Domestic Partnership to complete enrollment.

Unregistered domestic partners and their children may also become eligible for enrollment. If you and your unregistered domestic partner meet the criteria on the Affidavit of Domestic Partnership supplied by your employer, your domestic partner and your partner's dependent children are eligible for coverage during the 60 day initial enrollment period after the requirements of the Affidavit of Domestic Partnership are satisfied. PacificSource must receive your enrollment change, a copy of your Affidavit of Domestic Partnership, and additional premium during the initial enrollment period. Coverage for your new family members will then begin on the first day of the month after the Affidavit of Domestic Partnership is received by PacificSource.

Family Members Placed in Your Guardianship

If a court appoints you custodian or guardian of an eligible dependent child, you have 60 days from the court appointment to enroll them on your plan. PacificSource must receive your enrollment change and any additional premium within 60 days of the court appointment. Coverage will then begin on the date of court order. If the date of the court order is the 1st through the 15th of the month, full premium is due. If the date of the court order is the 16th through the last day of the month, no premium is charged for that month. You may be required to submit a copy of the court order to complete enrollment. When the court order terminates or expires, the child is no longer eligible for coverage.

Qualified Medical Child Support Orders

This health plan complies with qualified medical child support orders (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 plan member.

If a court or state agency orders coverage for your spouse, qualified domestic partner, or child, you have 60 days from the date of the court order to enroll them on this plan. PacificSource must receive your enrollment change and any additional premium from your employer within 60 days of the court order. Coverage will become effective on the first day of the month after the court order. If the date of the support order is the 1st through the 15th of the month, full premium is due. If the date of the support order is the 16th through the last day of the month, no premium is charged for that month. You may be required to submit a copy of the QMCSO to complete enrollment.

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 31 day initial 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 31 day initial 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 31 day initial enrollment period following your return to work.

Special Enrollment Periods

You and your family members may decline coverage during your initial enrollment period.

If you wish to do so, you must submit a written 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.

If you enroll during your initial enrollment period, your family members may decline coverage, and they may enroll in the plan later if they qualify under the Special Enrollment Rules below.

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 group health insurance coverage, you or your family members may enroll in the plan later if the other coverage ends. To do so, you must request enrollment within 60 days after the other health insurance coverage ends. Coverage will begin on the day after the other coverage ends.

- Special Enrollment Rule #2

  If you acquire new family members because of marriage, newly qualified domestic partnership, birth, placement of foster child, or placement for or finalization of adoption, you may be able to enroll yourself and/or your newly acquired family members at that time. To do so, you must request enrollment within 60 days after the marriage, qualification of the domestic partnership, birth, placement of foster child, or placement for adoption. In the case of marriage or qualified domestic partnership, coverage begins on the first day of the month after the marriage or qualification of the domestic partnership. In the case of birth, placement of foster child, or placement for adoption, coverage begins on the date of birth, placement, or finalization.

- 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. To do so, you must request enrollment within 60 days of the date you and/or your family members become eligible for such assistance. 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. You may, however, be eligible to continue coverage for a limited time. (See the Continuation section for information.)

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 the PacificSource Membership Services team. (See the Continuation section for information.)

Dependent Children

When your enrolled child no longer qualifies as a dependent, their coverage will end on the last day of that month. Please see Eligibility in the Becoming Covered section for information on when your dependent child is eligible. The Continuation section includes information on other coverage options for those children who no longer qualify for coverage.

Dissolution of Qualified Domestic Partnership

If you dissolve your qualified domestic partnership, coverage for your qualified 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 qualified domestic partnership is final. You must notify your employer of the dissolution of the qualified domestic partnership. Qualified domestic partners and their covered children are not recognized as qualified beneficiaries under federal COBRA continuation laws. Qualified domestic partners and their covered children may not continue this policy's coverage under COBRA independent of the employee. (See COBRA Continuation in the Continuation of Insurance section.)

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 qualified 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:

- Family members who were not enrolled in the group plan cannot 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 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.

Qualified 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 policy or eliminate the policy entirely. If that happens, any changes to the group health policy 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. The monthly premium must be paid to your employer. 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 employer. After the first premium payment, each monthly payment must reach your employer within 30 days of your employer premium due date. If your employer 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.
- When you no longer qualify for coverage under this plan, your family members may continue coverage until they are not longer eligible in accordance with Chapter 13 of title 33 of the Idaho Code.

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 and 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.

covered under this retiree plan for five years whichever comes first, your coverage will end on the last day of the month.

- 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 benefits have been paid; 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 participating and non-participating 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 the 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.

PARTICIPATING PROVIDERS

Participating 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. Participating providers agree not to collect more than the contracted allowable fee. Participating providers bill PacificSource directly, and we pay them directly. When you receive covered services or supplies from a participating provider, you are only responsible for the amounts stated in your

Medical Benefit Summary. Depending on your plan, those amounts can include a deductible, co-payment, and/or co-insurance payment.

PacificSource contracts directly and/or indirectly with participating providers throughout Oregon, Idaho, Montana, and communities in southwest Washington. We also have agreements with nationwide provider networks. These providers outside our service area are also considered PacificSource participating providers under your plan.

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

Risk-sharing Arrangements

By agreement, a participating 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 non-covered services from the member. And, if PacificSource was to become insolvent, a participating 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 participating provider may only collect applicable amounts for non-covered services, deductibles, co-payments, and/or co-insurance from the member.

NON-PARTICIPATING PROVIDERS

When you receive services or supplies from a non-participating provider, your out-of-pocket expense is likely to be higher than if you had used a participating provider. If the same services or supplies are available from a participating provider to whom you have reasonable access (explained in the next section), you may be responsible for more than the deductible, co-payment, and/or co-insurance amounts stated in your Medical Benefit Summary.

Allowable Fee for Non-participating Providers

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

PacificSource bases payment to non-participating 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 area the allowable fee for professional services is based on PacificSource's standard non-participating provider reimbursement rate. Outside the PacificSource service area and in areas where our members do not have reasonable access to a participating 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 non-participating providers, we determine the allowable fee, then subtract the non-participating provider benefits shown in the 'Non-participating Provider' column of your Medical Benefit Summary. Our allowable fee is often less than the non-participating 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. In any case, after any co-payments or deductibles, the amount PacificSource pays to a non-participating provider will not be less than 50 percent of the allowable fee for a like service or supply.

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

Example of Provider Payment

The following illustrates how payment could be made for the same service in two different settings: with a participating provider for your plan, and with a non-participating provider. This is only an example; your plan's benefits may be different.

	Participating Provider	**Non-participating Provider**
Provider's usual charge	$120	$120
Billed charge after negotiated provider discounts	$100	$120
PacificSource's allowable fee	$100	$100
Allowable fee less patient co-insurance	$80	$50
Percent of payment	80%	50%
PacificSource's payment	**$80**	**$50**
Patient's responsibility:		
Co-insurance	20%	50%
Patient's amount of allowable fee	$20	$50
Difference between allowable fee and billed charge after discounts	$0	$20
Patient's total responsibility to the provider	**$20**	**$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 a participating provider in your service area. Your network covers Oregon, Idaho, Montana, southwest Washington, and eastern Washington. When you need medical services outside of your network, you can save out-of-pocket expense by using the participating providers identified on our website at PacificSource.com.

Nonemergency Care While Traveling

To find a participating provider outside the regions covered by your network, go to the PacificSource.com website. Nonemergency care outside of the United States is not covered.

- If a participating provider is available in your area, your plan's participating provider benefits will apply if you use a participating provider.
- If a participating provider is available but you choose to use a non-participating provider, your plan's non-participating provider benefits will apply.

Emergency Services While Traveling

In medical emergencies (see Covered Expenses – Emergency Services section), your plan pays benefits at the participating 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 the 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 a non-participating hospital, PacificSource may require you to transfer to a participating facility once your condition is stabilized in order to continue receiving benefits at the participating provider level.

FINDING PARTICIPATING PROVIDER INFORMATION

You can find up-to-date participating provider information:

- Ask your healthcare provider if he or she is a participating provider for your network.
- On the PacificSource website, PacificSource.com. Go to 'Find a Doctor or Drug' and you can easily look up participating providers, specialists, behavioral health providers, and hospitals. You can also print your own customized directory.
- Contact the PacificSource 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.

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 three 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 a non-participating provider and any services you receive from them will be paid at the percentage shown in the 'Non-Participating 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 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 additional 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 practitioners are not eligible for reimbursement under the benefits of this plan. For additional 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’re 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 PacificSource.com. Simply enter your City and State or Zip code, then select Urgent Care in the ‘Specialty Category’ field.

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 participating and/or non-participating 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 non-participating 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.

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. Please refer to your Benefit Summaries and the Benefit Limitations and Exclusions section for more information.

PREVENTIVE CARE SERVICES

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

- **Routine 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 are 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 routine physical exam are covered by this benefit. Any laboratory tests and other diagnostic testing procedures ordered during, but not related to, a routine physical examination are not covered by this preventive care benefit. (See Outpatient Services in this section.)

- **Well woman visits**, including the following:

- One **routine 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.
- **Routine preventive mammograms** for women as recommended.
  - There is no deductible, co-payment, and/or co-insurance for mammograms that are considered 'routine' according to the guidelines of the U.S. Preventive Services Task Force.
  - Diagnostic mammograms for any woman desiring a mammogram for medical cause. The deductible, co-payment, 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 routine screening purposes is considered to be a preventive service. The deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for 'Participating Providers Preventive Care – Routine colonoscopy' applies to colonoscopies that are considered 'routine' according to the guidelines of the U.S. Preventive Services Task Force. It is not safe to assume that when you are treated at a participating medical facility, all services are performed by participating providers. Whenever possible, you should arrange for professional services such as surgery and anesthesiology to be provided by a participating 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:

  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. Please see Outpatient Services in this 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 ages 60 and older; 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 a participating provider:

- Services that have a rating of ‘A’ or ‘B’ from the U.S. Preventive Services Task Force (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: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

The list of women’s preventive services can be found on the HRSA website at: http://www.hrsa.gov/womensguidelines/.

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

USPSTF recommendations include the September 2002 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 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 pervasive developmental disorders for which rehabilitation services would be appropriate for children age 18 and younger) may be considered for additional benefits when criteria for supplemental services 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.

  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 'speech therapy' under 'Excluded Services - Types of Treatments' in the Benefit Limitations and Exclusions section.
- **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 pervasive developmental disorders for which rehabilitation services would be appropriate for children age 18 and younger) may be considered for additional benefits when criteria for supplemental services 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 related provisions, see 'speech therapy' under 'Excluded Services – Types of Treatments' in the Benefit Limitations and Exclusions section.

- Services of a licensed audiologist for medically necessary **audiological (hearing) tests**.
- 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 Member Benefit Summary under 'Other Covered Services – Temporomandibular Joint'.
- Medically necessary **telemedical health services** for health services covered by this plan when provided in person by a healthcare professional when the telemedical health service does not duplicate or supplant a health service that is available to the patient in person. The location of the patient receiving telemedical health services may include, but is not limited to: hospital; rural health clinic; federally qualified health center; physician's office; community mental health center; skilled nursing facility; renal dialysis center; or site where public health services are provided. Coverage of telemedical health services are subject to the same deductible, co-payment, and/or co-insurance requirements that apply to comparable health services provided in person.

- Services for **chiropractic manipulation and acupuncture** are covered. See your Chiropractic Manipulation and Acupuncture Benefit Summary for benefit details.

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 are 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; or
- Respiratory care.

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 when preauthorized by PacificSource. For skilled nursing benefits to renew after each stay the member must be discharged and at least 90 consecutive days must pass before readmission. 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 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 visits 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 practitioner, or physician assistant. These services may be performed or provided by laboratories, radiology facilities, hospitals, and physicians, including services in conjunction with office visits.
- **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, non-participating providers are paid at the participating provider level.

  Emergency room charges for services, supplies, or conditions excluded from coverage under this plan are not eligible for payment.
- **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 charges’ 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 participating and non-participating 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, this plan covers services and supplies necessary to determine the nature and extent of the emergency condition and to stabilize the patient.

An emergency medical condition is an injury or sudden illness, including severe pain, so severe that a prudent layperson with an average knowledge of health and medicine would expect that failure to receive immediate medical attention would risk seriously damaging the health of a person or fetus in

the case of a pregnant woman. Examples of emergency medical conditions include (but are 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 a non-participating hospital after your emergency condition is stabilized, PacificSource may require you to transfer to a participating facility in order to continue receiving benefits at the participating 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 a licensed certified nurse midwife for **pregnancy**. Services are subject to the same payment amounts, conditions, and limitations that apply to similar expenses for illness.

Please contact the PacificSource 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 CHEMICAL DEPENDENCY SERVICES

This plan covers medically necessary crisis intervention, diagnosis, and treatment of mental health conditions and chemical dependency the same as any other illness. Refer to the Benefit Limitations and Exclusions section for more information on services not covered by your plan.

Providers Eligible for Reimbursement

A mental and/or chemical healthcare provider (see Definitions section) is eligible for reimbursement if:

- The mental and/or chemical healthcare provider is authorized for reimbursement under the laws of your policy's state of issuance; and
- The mental and/or chemical healthcare provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities; and
- The patient is staying overnight at the mental and/or chemical healthcare facility (see Definitions section) and is involved in a structured program at least eight hours per day, five days per week; or
- The mental and/or chemical healthcare provider is providing a covered benefit under this plan.

Eligible mental and/or chemical 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 (Ph.D.) licensed by the State Board of Psychologists' Examiners;
- A Nurse Practitioner registered by the State Board of Nursing;
- A Licensed Clinical Social Worker (L.C.S.W.) licensed by the State Board of Clinical Social Workers;
- A Licensed Professional Counselor (L.P.C.) licensed by the State Board of Licensed Professional Counselors and Therapists;
- A Licensed Marriage and Family Therapist (L.M.F.T.) licensed by the State Board of Licensed Professional Counselors and Therapists; and
- A hospital or other healthcare facility accredited by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities for inpatient or residential care and treatment of mental health conditions and/or chemical dependency.

Medical Necessity and Appropriateness of Treatment

- As with all medical treatment, mental health and chemical dependency 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 abuse and related disorders is subject to placement criteria established by the American Society of Addiction Medicine.

Mental Health Parity and Addiction Equity Act of 2008

This group health plan complies with all 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 care.
- This plan covers **hospice services** when preauthorized by PacificSource. 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 or 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 nursing visits;
  - Home health aides when necessary to assist in personal care;
  - Home infusion therapy;
  - 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. Please see Benefit Limitations and Exclusions section for information on items not covered. 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 $800, 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.
- 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 at no cost once per pregnancy when purchased or rented from a participating licensed provider, or purchased from a retail outlet. Hospital-grade breast pumps are not covered.
- 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
- Pediatric bowel.

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. (See Payment of Transplant Benefits, below.)

Travel and housing expenses for the recipient and one caregiver are covered when the distance traveled is greater than 100 miles from home. 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 a participating Center of Excellence transplantation facility, covered charges of the facility are subject to plan deductibles (co-insurance and co-payment amounts after deductible 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 deductible 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 a participating Center of Excellence and/or services of non-participating medical professionals are paid at the non-participating provider percentages stated in your Medical Benefit Summary. The maximum benefit payment for transplant services of non-participating providers is 125 percent of the Medicare allowance.

PRESCRIPTION DRUGS

Using Your PacificSource Pharmacy Benefits

Refer to your Prescription Drug Summary for your specific benefit information.

Retail Pharmacy Network

To use your PacificSource pharmacy benefits, at your plan's highest benefit level, you must show the pharmacy plan number on your PacificSource ID card at the participating pharmacy. The PacificSource pharmacy benefits can only be accessed through the pharmacy plan number printed on your PacificSource ID card. That plan number allows the pharmacy to collect the appropriate deductibles, co-payments, and/or co-insurance amounts from you and bill PacificSource electronically for the balance.

Mail Order Service

This plan includes a participating mail order service for prescription drugs. Most, but not all, covered prescription drugs are available through this service. Questions about availability of specific drugs may be directed to the PacificSource Customer Service team or to the plan's participating mail order service vendor. Forms and instructions for using the mail order service are available our website, PacificSource.com.

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.

Specialty drugs are not available through the participating retail pharmacy network, mail order service, or non-contracted Specialty pharmacies without preauthorization exception. More information regarding our exclusive specialty pharmacy provider and a list of drugs requiring preauthorization and/or are subject to restrictions is available on our website, PacificSource.com/drug-list.

Other Covered Pharmaceuticals

Supplies covered under your pharmacy benefit are in place of, not in addition to, those same covered supplies under the medical plan. Member cost share for items in this section are applied on the same basis as for other prescription drugs, unless otherwise noted.

Diabetic Supplies

Refer to the applicable Drug List, at PacificSource.com/drug-list, 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.

Contraceptives

Any deductible, co-payment, and/or co-insurance amounts are waived for Food and Drug Administration (FDA) approved contraceptive methods for all women with reproductive capacity, as supported by the Health Resources and Services Administration (HRSA), when provided by a participating pharmacy. If a generic exists, preferred brand contraceptives will remain subject to regular pharmacy plan benefits unless deemed medically necessary by the member's attending provider. Providers must request for formulary exceptions by contacting our Pharmacy Services team. When no generic exists, preferred brands are covered at no cost. If a generic becomes available, the preferred brand will no longer be covered under the preventive care benefit unless deemed medically necessary by the member's attending provider.

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. Orally administered anticancer medications covered under the pharmacy plan are in place of, not in addition to, those same covered drugs under the medical plan.

Limitations and Exclusions

- This plan only covers drugs prescribed by a licensed physician (or other licensed practitioner eligible for reimbursement under your plan) prescribing within the scope of his or her professional license. This plan does not cover the following:
  - Over-the-counter drugs or other drugs that federal law does not prohibit dispensing without a prescription.
  - Over-the-counter tobacco cessation drugs are covered under your plan, but will require a prescription from your doctor.
  - Drugs for any condition excluded under the health plan. This includes drugs intended to promote fertility, improve sexual function, treat obesity or weight loss, improve cosmetic conditions (such as hair loss or wrinkles), and drugs that are deemed experimental or investigational.
  - 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 prior authorization, please refer to the

Medical Drug and Diabetic Supply formulary on our website, PacificSource.com/drug-list. If you have additional questions about your medical drug benefit, or if your drug is not listed on our website, please contact our Customer Service team.

  - Some Immunizations may be covered under either your medical or pharmacy benefit. Vaccines covered under the pharmacy benefit include: influenza, hepatitis B, herpes zoster (shingles), and pneumococcal. Most other immunizations must be provided by your doctor under your medical benefit.
  - Drugs and 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, and for services that have a rating of ‘A’ or ‘B’ from the U.S. Preventive Services Task Force (USPSTF).

- Certain drugs require prior 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, PacificSource.com/drug-list.
- 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, PacificSource.com/drug-list.
- 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, PacificSource.com/drug-list.
- 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 non-participating pharmacies or at participating 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.
- Prescription drug benefits are subject to your plan’s coordination of benefits provision.
- 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

A separate benefit may apply to some drugs, such as specialty drugs. If you have questions about your coverage, please contact our Customer Service team at (888) 977-9299 or by email at cs@pacificsource.com.

Requests for formulary exceptions can be made by the member or practitioner by contacting PSHP Pharmacy Services by telephone, fax, or on-line. 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 patients' 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 non-participating 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 participating 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 practitioner. 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;

  - 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.

- 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 deductible, co-payments, and/or co-insurance amounts stated in your Medical Benefit Summary for diagnostic lab and x-ray. 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.
- This plan covers IUD, diaphragm, and cervical cap **contraceptives and contraceptive devices** along with their insertion or removal, as well as hormonal contraceptives including oral, patches, and rings. Contraceptive devices that can be obtained over the counter or 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.

  For additional information related to services related to congenital anomaly refer to the Cosmetic/reconstructive services and supplies in the Exclusions section.

  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. Preauthorization by PacificSource is required for all cosmetic and reconstructive surgeries covered by this plan. For information on breast reconstruction, 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 mail you a reimbursement check.

  - 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 the Medical Benefit Summary. To be covered, the training must be provided by a licensed healthcare professional with expertise in diabetes.
  - This plan covers medically necessary telemedical health services provided in connection with the treatment of 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, or 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 in this 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. Benefits are only provided for routine costs of care associated with approved clinical trials. Expenses for services or supplies that are not considered routine costs of care are not covered. 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 a participating provider is participating in an approved clinical trial, the qualified individual may be required to participate in the trial through that participating 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

Least Costly Setting for Services

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

EXCLUDED SERVICES

***Types of Treatment* -** This plan does not cover the following:

- Abdominoplasty for any indication.
- Academic skills training. This exclusion does not apply if the program, training, or therapy is part of a treatment plan for a pervasive developmental disorder.
- Acute care, rehabilitative, diagnostic testing except as specified as a covered service in this policy; for mental or nervous conditions and substance abuse or addiction services not recognized by the American Psychiatric and American Psychological Associations.

- 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.
- 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, or 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.
- 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 rehabilitative or habilitative 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' in the Covered Expenses section.
- 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' under 'Other Covered Services, Supplies, and Treatments' in the Covered Expenses section.
- Drugs and biologicals that can be self-administered (including injectables) are excluded from the medical benefit, except those provided in a hospital emergency room, or other institutional setting, or as outpatient chemotherapy and dialysis, which are covered. Covered drugs and biologicals that can be self-administered are otherwise available under the pharmacy benefit, subject to plan requirements.
- Drugs or medications not prescribed for inborn errors of metabolism, diabetic insulin, or autism spectrum disorder that can be self-administered (including prescription drugs, injectable drugs,

and biologicals), unless given during a visit for outpatient chemotherapy or dialysis or during a medically necessary hospital, emergency room or other institutional stay.

- 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. (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 or investigational procedures - Your PacificSource plan does not cover experimental or investigational treatment. By that, we mean services, supplies, protocols, procedures, devices, chemotherapy, drugs or medicines or the use thereof that are experimental or investigational 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, 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 or investigational, not reasonable and necessary, or any similar finding.

  An experimental or investigational 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 investigational or experimental, 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 and/or investigational 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 (routine).
- 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.
  - Infertility includes: 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 Interfallopian 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.
- 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.
- 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.
- Learning disorders.
- Maintenance supplies and equipment not unique to medical care.
- Marital/partner counseling.
- Massage or massage therapy, even as part of a physical therapy program.
- Maternity charges incurred by a covered person acting as a Surrogate Mother are not covered charges. For the purpose of this plan, the newborn of a Surrogate Mother will not be considered an eligible dependent if the Surrogate Mother has entered into a contract or other understanding to which she relinquishes the newborn to intended parents following the birth.
- 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 or Mental Disorders, Fifth Edition (DSM-5)’ that are not attributable to a mental health disorder or disease.

- Mental illness does not include -relationship problems (such as 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 chemical dependency 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; assertiveness training; image therapy; sensory movement group therapy; marathon group therapy; sensitivity training; and psychological evaluation for sexual dysfunction or inadequacy.

- 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.
- Narcosynthesis.
- Naturopathic treatment and 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. (See ‘dietary or nutritional counseling’ section under ‘Other Covered Services’.)
- Oral/facial motor therapy for strengthening and coordination of speech-producing musculature and structures.
- Orthognathic surgery – Services and supplies to augment or reduce the upper or lower jaw, except as specified under ‘Professional Services’ in the Covered Expenses section. For related provisions, see exclusions for ‘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-help or training programs.
- Sensory integration training.
- 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 practitioner, hospital, ambulatory surgical center, skilled nursing facility, durable medical equipment supplier, or mental and/or chemical healthcare facility. To the extent PacificSource maintains credentialing requirements the practitioner 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.
- Sex reassignment – Procedures, services or supplies (including gender-reassignment drug therapies in a pre-surgery situation) related to a sex reassignment. For related provisions, see exclusions for ‘mental illness’ in this section.
- Sex transformations – Excluded procedures include, but are not limited to: staged gender reassignment surgery, including breast augmentation; penile implantation; facial bone

reconstruction, blepharoplasty, liposuction, thyroid chondroplasty, laryngoplasty, or shortening of the vocal cords, and/or hair removal to assist the appearance of other characteristics of gender reassignment, and complications resulting from gender reassignment procedures.

- Sexual disorders – Services or supplies for the treatment of sexual dysfunction or inadequacy. For related provisions, see exclusions for 'family planning', and 'mental illness' in this section.
- Social skills training.
- Speech therapy – Oral/facial motor therapy for strengthening and coordination of speech-producing muscles and structures, except as medically necessary in the restoration or improvement of speech following a traumatic brain injury or for individuals diagnosed with a pervasive developmental disorder.
- Support groups.
- Training or self-help health or instruction.
- 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' in the Covered Expenses 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, or treatment received while in the custody of any law enforcement authority.
- 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 children 18 years of age and younger diagnosed with a pervasive development 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 medical 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 medical 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.

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

Services requiring preauthorization:

- All inpatient admissions to a hospital (not including emergency room care), skilled nursing facility or a rehabilitation facility, all emergency hospitalizations (PacificSource must be notified within two business days) and all hospital birthing center admissions for maternity/delivery services;
- All outpatient surgical procedures;
- All inpatient, residential and day or partial hospitalization treatment services for mental health and chemical dependency conditions;
- All human organ/tissue transplant related services;
- All restoration of head/facial structures: Limited dental services;
- All PET, CT, CTA, MRI, and MRA imaging and nuclear cardiac study services;
- All home health care services;
- All inpatient hospice services;
- All medical supplies, appliances, prosthetic and orthotic devices, and durable medical equipment in excess of $800; or
- All outpatient hospitalization and anesthesia for dental.

You are responsible for obtaining prior authorization when seeking treatment from a non-participating provider. If the preauthorization of your treatment by a non-participating 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 the PacificSource 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. PacificSource must be notified of an emergency admission to a hospital or specialized treatment center as an inpatient within two business days.

If your provider's preauthorization request is denied as not medically necessary or as experimental, 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 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 Nurse 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. (See Individual Benefits Management in this 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. (See Case Management above.)

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 Nurse Case Managers, who are all registered nurses and Certified Case Managers. Questions regarding medical necessity, possible experimental or investigational 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 – Coverage While Traveling 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:

- 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 Nurse 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 Nurse 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 Nurse 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 participating provider treats you, your claims are automatically sent to PacificSource and processed. All you need to do is show your PacificSource ID card to the provider.

If you receive care from a non-participating 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 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 72 hours of receipt of the request.

Concurrent care review – Inpatient hospital or rehabilitation facilities, skilled nursing facilities, intensive outpatient, 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.

Extension of time – Despite the specified timeframes, nothing prevents the member from voluntarily agreeing to extend the above timeframes. Unless additional information is needed to process your claim, PacificSource will make every effort to meet the timeframes stated above. If a claim cannot be paid within the stated timeframes because additional information is needed, we will acknowledge receipt of the claim and explain why payment is delayed. If we do not receive the necessary information within 15 days of the delay notice, we will either deny the claim or notify you every 45 days while the claim remains under investigation. No extension is permitted for urgent care claims.

Payment of claims – PacificSource has the sole right to pay benefits to the member, the provider, or both jointly. Neither the benefits of this policy nor a claim for payment of benefits under the policy are assignable in whole or in part to any person or entity.

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. (See Complaints, Grievances, and Appeals section.)

Questions About Claims

If you have questions about the status of a claim, you are welcome to contact the PacificSource 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 for payment. Then we will either reprocess the claim for payment, 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 deductible 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 are 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

If you, or your enrolled family members, are covered by more than one health plan, PacificSource will work with your other insurance carriers to pay up to 100 percent of your covered expenses. This is called 'coordination of benefits' (COB). We do this so you receive the maximum benefits available from all sources for the cost of your care.

Benefits Subject to this Provision

PacificSource provides benefits to all members. Some members may have other employee health plans or Medicare coverage that duplicate benefits provided by this plan, including coverage under another PacificSource plan. If so, the member may never receive a total from all sources of more than the allowable amount for a covered service. PacificSource will use certain rules to coordinate benefits; that is, to decide which insurance or plan should pay first for the member's healthcare cost.

This coordination of benefits provision applies to this plan when a member has healthcare coverage under more than one plan. 'Plan' is defined below.

Definitions

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 insurance contracts and subscriber contracts;

- Uninsured group or group-type coverage arrangements;
- Group and nongroup coverage through closed panel plans;
- Group-type contracts;
- The medical care components of long-term care contracts, such as skilled nursing care;
- Medicare or other governmental benefits, except as provided in subsection 010.10.b.ix. of Idaho Administration Rule 18.01.74, Coordination of Benefits. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.
- The medical benefits coverage in automobile 'no fault' and traditional automobile 'fault' type contracts. No plan is required to coordinate benefits provided that it pays benefits as a primary plan. If a plan coordinates benefits, it shall do so in compliance with the provisions of Idaho Administration Rule 18.01.74, Coordination of Benefits.

Plan does not include:

- Hospital indemnity coverage or other fixed indemnity coverage;
- School accident type coverages, such as contracts that cover students for accidents only, including athletic injuries, either on a twenty-four hour basis or on a 'to and from school' basis;
- Specified disease or specified accident coverage;
- Accident only coverage;
- Benefits provided in long-term care insurance policies for non-medical services; for example, personal care, adult daycare, homemaker services, assistance with activities of daily living, respite care, and custodial care for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
- Limited benefit health coverage, as defined in IDAPA 18.01.30, 'Individual Disability and Group Supplemental Disability Insurance Minimum Standards Rule,' Sections 012 and 029;
- Medicare supplement policies;
- A state plan under Medicaid; or

A governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan. 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 health 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, any may apply another COB provision to coordinate other benefits.

Order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has healthcare coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100 percent of the total allowable expense.

Allowable expense is a healthcare expense, including deductibles, co-insurance, and co-payments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense

and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

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

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

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

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

Order of Benefit Determination Rules

When a person is covered by two or more plans, the rules for determining the order of benefit payments 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.

A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provision of both plans state that the complying plan is primary, except that coverage 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.

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

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

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 primary (the ‘birthday rule’); 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 or 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 the 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 provision of the ‘birthday rule’ shall determine 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: 1) the plan covering the custodial parent; 2) the plan covering the spouse of the custodial parent; 3) the plan covering the non-custodial parent; and then 4) 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 of the ‘dependent child’ section above shall determine the order of benefits as if those individuals were the parents of the child.

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

COBRA or state continuation coverage: If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, 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 rule for 'dependent/nondependent' above can determine the order of benefits.

Longer/shorter length of coverage: If none of the above rules determines the order of benefits, the plan that covered the person as an employee, member, subscriber, or retiree for a longer period of time is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

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

Effects 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 the 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 plan coverage.

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

If the amount of payment made by PacificSource is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has

paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The 'amount of the payments made' includes the reasonable cash value of the benefits provided in the form of services.

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, this plan only pays the portion of covered charges that would not be paid by Medicare Parts A and B. This rule applies regardless of whether you are actually enrolled in Medicare Parts A and B. In other words, this plan pays secondary for anyone eligible for Medicare Parts A and B, even if they have not enrolled in Medicare.

  If you are Medicare eligible due to age, and your employer has 19 or fewer employees, and you have not applied for both Medicare Parts A and B, please contact the PacificSource Membership Services team immediately. We may arrange to pay your claims without a reduction in benefits until your next opportunity to enroll in Medicare coverage. You can reach Membership Services by phone at (541) 684-5583 or toll-free (866) 999-5583, or by email at membership@pacificsource.com.
- *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. If you use this plan's benefits for an illness or injury you think may involve another party, contact PacificSource immediately.

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 will send you a questionnaire to help us determine responsibility.

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 his or her 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 so 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 the PacificSource Third Party Claims team for complete details.

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. (See How to Submit Grievances or Appeals below.)

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 Definition 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. (See How to Submit Grievances or Appeals below.) You may appeal if there is an adverse benefit determination based on a:

- Denial of eligibility for or termination of enrollment in a 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, 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 External Independent Review below), 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 treatment, or a similar exclusion.

Upon request, PacificSource will provide you with any additional documents, records or information that is relevant to the adverse benefit determination.

HOW TO SUBMIT GRIEVANCES OR APPEALS

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:

Writing to:

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

Emailing cs@pacificsource.com, with ‘Grievance’ as the subject

Faxing (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 calling (208) 334-4250, or toll-free (800) 721-3272

By writing to:

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

Boise, ID 83720-0043

Through their website at 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:

- See the department's website at doi.idaho.gov, or
- Call the department's telephone number, (208) 334-4250, or toll-free (800) 721-3272.

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 participating 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 PacificSource Customer Service if anything is unclear to you.
- You are responsible for making sure your non-participating 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 and benefits. 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.

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 the masculine and feminine, and the 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, 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 non-participating 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.

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 United States Food and Drug Administration; or
- Exempt by federal law from the requirement to submit an investigational new drug application to the United States Food and Drug Administration.

Authorized representative is an individual who by law or by the consent of a 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 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.

Chemical dependency 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. Chemical dependency does not include addiction to, or dependency on, tobacco products or foods.

Chemical dependency treatment facility means a treatment facility that provides a program for the treatment of alcoholism or drug addiction 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.

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 participating and non-participating provider co-insurance amounts the member is responsible for are listed in the 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 is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies.

Contract year means a 12 month period beginning on the date 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 a participating 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 the 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 qualified 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. (See Becoming Covered – Eligibility section.)

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 are 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 noted in this handbook.

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.

Enrollee means an employee, family member of the employee, or individual otherwise eligible and enrolled for coverage under this plan. In this policy, enrollee is referred to as subscriber, member, or you.

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

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

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

- Experimental or investigational services and supplies include, but are 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, 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 or investigational, not considered reasonable and necessary, or any similar finding.
- When making decisions about whether treatments are investigational or experimental, 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 and/or investigational 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 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 a brand name medication. By law, generic drugs must have the same active ingredients as the brand name medication and are subject to the same standards of their brand name counterpart. Generic drugs must be approved by the FDA through an Abbreviated New Drug Application and generally cannot be limited to a single manufacturer.

Geographical area – PacificSource has direct and indirect provider contracts to offer services to members in Oregon, Idaho, Montana, and bordering communities in southwest Washington. 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, and fetal non-stress test 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 are 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;
- Medically necessary personal hygiene, grooming and dietary assistance;
- Medical supplies and equipment suitable for use in the home;
- 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 twenty-four 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.

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 a 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. (For muscular strain, see definition of 'illness'.)

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. Lifetime maximums and lifetime benefits are not applicable to services or supplies that are deemed 'Essential Health Benefits'.

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 are not limited to syringes and needles, splints and slings, ostomy supplies, sterile dressings, elastic stockings, enteral foods, drugs, or biologicals that must be put directly into the equipment in order to achieve the therapeutic benefit of the durable medical equipment or to assure the proper functioning of this equipment (for example, Albuterol for use in a nebulizer).

Medically necessary means those services and supplies that are required for diagnosis or treatment of illness, injury, or disease and that are:

- Consistent with the symptoms or diagnosis and treatment of the condition;
- Consistent with generally accepted standards of good medical practice in 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. (See General Exclusions – Screening tests.)

Member means an individual insured under a PacificSource health plan.

Mental and/or chemical healthcare facility means a corporate or governmental entity or other provider of services for the care and treatment of chemical dependency and/or mental or nervous conditions which is licensed or accredited by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities for the level of care which the facility provides.

Mental and/or chemical healthcare program means a particular type or level of service that is organizationally distinct within a mental and/or chemical healthcare facility.

Mental and/or chemical 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 on Accreditation of Hospitals 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 Development 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 as 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.

Non-participating provider is a provider of covered medical services or supplies that does not directly or indirectly hold a provider contract or agreement with PacificSource.

Orthotic devices means rigid or semirigid 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 are not limited to Ankle Foot Orthosis (AFO), Knee Ankle Foot Orthosis (KAFO), Lumbosacral Orthosis (LSO), and foot orthotics.

Participating 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.

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.

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 are not limited to artificial limbs, cardiac pacemakers, prosthetic lenses, breast prosthesis (including mastectomy bras), and maxillofacial devices.

Qualified domestic partner means:

- **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.

Rehabilitation services and devices are those medically necessary to aid in re-learning skills or functions necessary to overcome or recover from an illness or diagnosis that is covered by this health plan.

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 covered by the health benefit plan in the absence of a clinical trial. Routine costs of care do not include:

- The drug, device, or service being tested in the clinical trial unless the drug, device, or service would be covered for that indication by 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,

chemical dependency/substance abuse day treatment facilities, hospice facilities, inpatient rehabilitation facilities, mental and/or chemical healthcare facilities, organ transplant facilities, psychiatric day treatment facilities, residential treatment facilities, skilled nursing facilities, substance abuse treatment facilities, and urgent care treatment facilities.

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

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

Spouse is any individual who is legally married.

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.

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.

Surrogate Mother means an adult woman who enters into an agreement to bear a child conceived through assisted conception for intended parents.

Telemedical means the use of interactive audio, video, or other telecommunications technology in compliance with HIPAA 42 USC 1320d. Telemedical does not include the use of audio-only telephone, email, or facsimile transmissions.

Tobacco cessation program means a program recommended by a physician that follows the United States Public Health Services guidelines for tobacco cessation. Tobacco cessation services include 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 Alaska Natives.

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 non-participating 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.

A non-participating 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. (See Non-participating Providers in the Using the Provider Network 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, or nurse practitioner specializing in women's health, or certified nurse midwife practicing within the applicable scope of practice.

PacificSource
HEALTH PLANS

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