As with any insurance plan, there are some services and treatments that have coverage limits or are not covered at all. For example, experimental procedures are typically not covered. This document outlines what’s not covered by your medical plan.

Please note: A full explanation of benefits, including limitations and exclusions, will be provided in your policy. Only the language of the actual policy is legally binding.

Below is a complete list of services and treatments that are not covered under our medical plans.

- 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.
- Acupuncture (depending on policy).
- Any amounts in excess of the allowable fee for a given service or supply.
- Aversion therapy.
- Biofeedback (other than as specifically noted under the Covered Expenses – Other Covered Services, Supplies, and Treatment section of the policy).
- Charges for phone consultations, missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims unless otherwise contracted.
- Charges over the usual, customary, and reasonable fee (UCR) – Any amount in excess of the UCR for a given service or supply.
- Charges that are the responsibility of a third party who may have caused the illness, injury, or disease or other insurers covering the incident (such as workers’ compensation insurers, automobile insurers, and general liability insurers).
- Chelation therapy including associated infusions of vitamins and/or minerals, except as medically necessary for the treatment of selected medical conditions and medically significant heavy metal toxicities.
- Chiropractic manipulations (depending on policy).
- Computer or electronic equipment for monitoring asthmatic, similar medical conditions, or related data.
- Cosmetic/reconstructive services and supplies – Except as specified in the Covered Expenses – Other Covered Services, Supplies, and Treatments section of the policy. Services and supplies, including drugs, rendered primarily for cosmetic/reconstructive purposes (does not apply to emergency services). Cosmetic/reconstructive services and supplies are those performed primarily to improve the body’s appearance and not primarily to restore impaired function of the body, unless the area needing treatment is a result of congenital anomaly or gender dysphoria.
- Dental examinations and treatment – For the purpose of this exclusion, the term dental examinations and treatment means services or supplies provided to prevent, diagnose, or treat diseases of the teeth and supporting tissues or structures. This includes services, supplies, hospitalization, anesthesia, dental braces or appliances, or dental care rendered to repair defects that have developed because of tooth loss, or to restore the ability to chew, or dental treatment necessitated by disease. For related provisions, see hospitalization for dental procedures in the Other Covered Services, Supplies, and Treatments section of the policy.
- 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.
- Electronic Beam Tomography (EBT).
- Equine/animal therapy.
- Equipment commonly used for non-medical purposes or marketed to the general public.
- Equipment used primarily in athletic or recreational activities. This includes exercise equipment for stretching, conditioning, strengthening, or relief of musculoskeletal problems.
• Experimental, investigational, or unproven procedures – Your PacificSource plan does not cover experimental, investigational, or unproven treatment. By that, we mean services, supplies, protocols, procedures, devices, chemotherapy, drugs or medicines, or the use thereof that are experimental, investigational, or unproven for the diagnosis and treatment of the patient. It includes treatment that, when and for the purpose rendered: has not yet received full U.S. government agency approval (for example, FDA) for other than experimental, investigational, unproven, or clinical testing; is not of generally accepted medical practice in your policy’s state of issuance or as determined by medical advisors, medical associations, and/or technology resources; is not approved for reimbursement by the Centers for Medicare and Medicaid Services; is furnished in connection with medical or other research; or is considered by any governmental agency or subdivision to be experimental, investigational, or unproven, not reasonable and necessary, or any similar finding.

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

When making benefit determinations about whether treatments are experimental, investigational, or unproven, we rely on the above resources as well as: expert opinions of specialists and other medical authorities; published articles in peer-reviewed medical literature; external agencies whose role is the evaluation of new technologies and drugs; and external review by an independent review organization.

The following will be considered in making the determination whether the service is in an experimental, investigational, or unproven status: whether there is sufficient evidence to permit conclusions concerning the effect of the services on health outcomes; whether the scientific evidence demonstrates that the services improve health outcomes as much or more than established alternatives; whether the scientific evidence demonstrates that the services’ beneficial effects outweigh any harmful effects; and whether any improved health outcomes from the services are attainable outside an investigational setting.

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

• Eye examinations (preventive) for members age 19 and older (depending on policy).

• Eye exercises and eye refraction, therapy and procedures – Orthoptics, vision therapy, and procedures intended to correct refractive errors.

• Eye glasses/Contact Lenses for members age 19 and older – The fitting, provision, or replacement of eye glasses, lenses, frames, contact lenses, or subnormal vision aids intended to correct refractive error (depending on policy).

• Family planning – Services and supplies for artificial insemination, in vitro fertilization, treatment of infertility, or surgery to reverse voluntary sterilization.
  • Infertility includes: Services and supplies, surgery, treatment, or prescriptions determined to be experimental, investigational, or unproven in nature are not covered, except for medically necessary medication to preserve fertility during treatment with cytotoxic chemotherapy.

• Fitness or exercise programs and health or fitness club memberships.

• Food dependencies.

• 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.

• Growth hormone injections or treatments, except to treat documented growth hormone deficiencies.

• Homeopathic medicines or homeopathic supplies.

• Hypnotherapy.

• Immunizations when recommended for, or in anticipation of, exposure through travel or work.

• Instructional or educational programs, except diabetes self-management programs unless medically necessary.

• Jaw – Services or supplies for developmental or degenerative abnormalities of the jaw, malocclusion, dental implants, or improving placement of dentures.

• Maintenance supplies and equipment not unique to medical care.

• Massage or massage therapy, even as part of a physical therapy program.

• Mattresses and mattress pads are only covered when medically necessary to heal pressure sores.

• Mental health treatments for conditions defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) that are not attributable to a mental health disorder or disease. Mental illness does not include – relationship problems (for example, parent-child, partner, sibling, or other relationship issues), except the treatment of children five years of age or younger for parent-child relational problems, physical abuse of a child, sexual abuse, neglect of a child, or bereavement.
The following are also excluded: court-mandated psychological evaluations for child custody determinations; voluntary mutual support groups such as Alcoholics Anonymous; adolescent wilderness treatment programs; mental examinations for the purpose of adjudication of legal rights; psychological testing and evaluations not provided as an adjunct to treatment or diagnosis of a stress management, parenting skills, or family education; and assertiveness training.

- Modifications to vehicles or structures to prevent, treat, or accommodate a medical condition.
- Motion analysis, including videotaping and 3-D kinematics, dynamic surface and fine wire electromyography, including physician review.
- Myeloablative high dose chemotherapy, except when the related transplant is specifically covered under the transplantation provisions of this plan. For related provisions, see Transplant Services section of the policy.
- Narcosynthesis.
- Naturopathic supplies (depending on policy).
- 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), whether or not there are other medical conditions related to or caused by obesity. This also includes services or supplies used for weight loss, such as food supplementation programs and behavior modification programs, regardless of the medical conditions that may be caused or exacerbated by excess weight, and self-help or training programs for weight reduction control. Obesity screening and counseling are covered for children and adults. For related provisions, see dietary or nutritional counseling in the Other Covered Services, Supplies, and Treatments section of the policy.
- Oral/facial motor therapy for strengthening and coordination of speech-producing musculature and structures, except as medically necessary in the restoration or improvement of speech following a traumatic brain injury or for members diagnosed with a pervasive developmental disorder.
- Orthognathic surgery – Services and supplies to augment or reduce the upper or lower jaw, except as specified in the Professional Services section of the policy. For related provisions, see jaw and temporomandibular joint in this section.
- Orthopedic shoes, diabetic shoes, and shoe modifications.
- Over-the-counter nonprescription medications. Does not apply to tobacco cessation medications covered under USPSTF guidelines.
- Panniculectomy for any indication.
- 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 charges 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 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 of the policy.
- Self-help health or instruction or training programs.
- Sensory integration training. This exclusion does not apply if the program, training, or therapy is part of a treatment plan for a pervasive developmental disorder.
- Services of providers who are not eligible for reimbursement under this plan. An individual organization, facility, or program is not eligible for reimbursement for services or supplies, regardless of whether this plan includes benefits for such services or supplies, unless the individual, organization, facility, or program is licensed by the state in which services are provided as an independent provider, hospital, ambulatory surgical center, skilled nursing facility, durable medical equipment supplier, or mental health and/or substance use disorder healthcare facility. To the extent PacificSource maintains credentialing requirements, the provider or facility must satisfy those requirements in order to be considered an eligible provider.
- Services or supplies provided by or payable under any plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law.
- Services or supplies with no charge, or for which the member is not legally required to pay, or for which a provider or facility is not licensed to provide even though the service or supply may otherwise be eligible. This exclusion includes any service provided by the member, or any licensed medical professional that is directly related to the member by blood or marriage.
- Services required by state law as a condition of maintaining a valid driver license or commercial driver license.
• Services, supplies, and equipment not involved in diagnosis or treatment but provided primarily for the comfort, convenience, intended to alter the physical environment, or education of a patient. This includes appliances like adjustable power beds sold as furniture, air conditioners, air purifiers, room humidifiers, heating and cooling pads, home blood pressure monitoring equipment, light boxes, conveyances other than conventional wheelchairs, whirlpool baths, spas, saunas, heat lamps, tanning lights, and pillows.

• Sexual disorders – Services or supplies for the treatment of erectile or sexual dysfunction unless defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

• Snoring – Services or supplies for the diagnosis or treatment of snoring and/or upper airway resistance disorders, including somnoplasty unless medically necessary to treat a mental health diagnosis.

• Social skills training. This exclusion does not apply if the program, training, or therapy is part of a treatment plan for a pervasive developmental disorder.

• Support groups.

• Temporomandibular joint (TMJ) – Related services, or treatment for associated myofascial pain including physical or orofacial therapy. Advice or treatment, including physical therapy and/or orofacial therapy, either directly or indirectly for temporomandibular joint dysfunction, myofascial pain, or any related appliances. For related provisions, see jaw and orthognathic surgery in this document and in the Professional Services section of the policy.

• Transplants – Any services, treatments, or supplies for the transplantation of bone marrow or peripheral blood stem cells or any human body organ or tissue, except as expressly provided under the provisions of this plan for covered transplantation expenses. For related provisions, see Transplant Services section of the policy.

• Treatment after insurance ends – Services or supplies a member receives after the member’s coverage under this plan ends, except as follows:
  • (Small group only: If this policy is replaced by another group health policy while the member is hospitalized, PacificSource will continue paying covered hospital expenses until the member is released or benefits are exhausted, whichever occurs first.)

• 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 of the policy.

• Treatment of any work-related illness, injury, or disease, except in the following circumstances:
  You are the owner, partner, or principal (or for small group plans, principal of the employer group insured by PacificSource, were injured in the course of employment with the employer group that is insured by PacificSource); were injured in the course of self-employment; and are otherwise exempt from the applicable state or federal workers’ compensation insurance program;
  The appropriate state or federal workers’ compensation insurance program has determined that coverage is not available for your injury. This exclusion includes any illness, injury, or disease that is caused by any for-profit activity, whether through employment or self-employment; or
  You are employed by an Oregon based group and have timely filed an application for coverage with the State Accident Insurance Fund or other Workers’ Compensation carrier, and are waiting for determination of coverage from that entity.

• 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 policy.

• Vocational rehabilitation, functional capacity evaluations, work-hardening programs, community reintegration services, and driving evaluations and training programs, except as medically necessary in the restoration or improvement of speech following a traumatic brain injury or for members diagnosed with a pervasive development disorder.

• War-related conditions – The treatment of any condition caused by or arising out of an act of war, armed invasion, or aggression, or while in the service of the armed forces unless not covered by the member’s military or veterans coverage.
Prescription Drug Exclusions

- This plan only covers drugs prescribed by an eligible healthcare provider prescribing within the scope of their professional license. This plan does not cover the following:
  - 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 provider.
  - Drugs for any condition excluded under the health plan.
  - Some specialty drugs that are not self-administered are not covered by this pharmacy benefit, but may be covered under the medical plan’s office supply benefit. For a list of drugs that are covered under your medical benefit and which require preauthorization, please refer to the Medical Drug and Diabetic Supply formulary on our website.
  - Some immunizations may be covered under either your medical or pharmacy benefit. Vaccines covered under the pharmacy benefit include: influenza, hepatitis B, herpes zoster (shingles), and pneumococcal. Most other immunizations must be provided by your doctor under your medical benefit.
  - Some drugs and devices to treat erectile or sexual dysfunction unless defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).
  - 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 USPSTF, some restrictions may apply.

- Certain drugs require preauthorization (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 of our requirements, is available on our website.

- Certain drugs are subject to Step Therapy (ST) protocols, which means we may require you to try a pre-requisite drug before we will pay for the requested drug. An up-to-date list of drugs requiring Step Therapy, along with all of our requirements, is available on our website. Step therapy decisions can be appealed.

- Certain drugs have quantity limits (QL), which means we will generally not pay for quantities above the FDA approved maximum dosing without an approved exception. An up-to-date list of drugs with quantity limits is available on our website.

- Your plan has limitations on the quantity of medication that can be filled or refilled. This quantity depends on the type of pharmacy you are using and the days’ supply of the prescription.
  - Retail pharmacies: you can get up to a 90 day supply.
  - Mail order pharmacies: you can get up to a 90 day supply.
  - Specialty pharmacies: you can get up to a 30 day supply.

- For drugs purchased at out-of-network pharmacies or at in-network pharmacies without using the PacificSource pharmacy benefits, reimbursement is limited to our in-network contracted rates. This means you may not be reimbursed the full cash price you pay to the pharmacy.

- For most prescriptions, you may refill your prescription only after 75 percent of the previous supply has been taken. This is calculated by the number of days that have elapsed since the previous fill and the days’ supply entered by the pharmacy. PacificSource will generally not approve early refills, except under the following circumstances:
  - The request is for ophthalmic solutions or gels which are susceptible to spillage.
  - The member will be on vacation in a location that does not allow for reasonable access to a network pharmacy for subsequent refills.

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