



2020-2021 Portland State University Scholars Scholar Health Insurance Plan

psuweeklyscolars.myahpcare.com



IMPORTANT CONTACTS

Benefits and claims questions:

PacificSource Health Plans
P.O. Box 7068
Springfield, OR 97475

(855) 274-9814 (toll-free)

psuweeklyscolars.myahpcare.com

Underwritten by:

PacificSource Health
Plans **Policy #G0033730**

To find a doctor or health care provider:

PacificSource Voyager Network

(855) 274-9814 (toll-free)

psuweeklyscolars.myahpcare.com

Prescriptions:

PacificSource

Pharmacy Management

(855) 274-9814

or direct to Pharmacy Services

(800) 624-6052, ext 3784

psuweeklyscolars.myahpcare.com

24-Hour Nurse Advice Line: **(844) 224-3145**

24/7 Emergency Travel Assistance:

Academic Emergency Services

(855) 873-3555 (Toll-free within the U.S.)

1 (610) 263-4660 (Outside the U.S.)

assistance@ahpcare.com

Eligibility, coverage, and general questions:

Academic HealthPlans, Inc.

psuweeklyscolars.myahpcare.com

help.myahpcare.com

Plan brokered by:

Academic HealthPlans, Inc.

OR License No. 100168556

The Portland State University student health insurance plan is underwritten by PacificSource Health Plans also referred to as PacificSource. You can view the standard Summary of Benefits & Coverage (SBC) which is required by Health Care Reform. It summarizes your coverage in a format that all insurance companies now use. To view your plan SBC, go to: psuweeklyscolars.myahpcare.com.

IMPORTANT NOTICE

This is just a brief description of your benefits. For information regarding the full Student Guide (which includes plan benefits, exclusions and limitations, and information about refund requests, how to file a claim, mandated benefits and other important information) please visit psuweekklyscholars.myahpcare.com. You will be able to obtain a copy of the full Student Guide as soon as it is available. If any discrepancy exists between this Benefit Summary and the Policy, the Student Guide will govern and control the payment of benefits.

When Coverage Begins

Coverage under the Plan once premium has been collected will become effective at 12:01 a.m. on the **later of**, but **no sooner than**:

- The beginning date of the term for which premium has been paid;
- The day after the online enrollment is complete and premium payment are received by Academic HealthPlans, Authorized Agent or University.

IMPORTANT NOTICE - Final decisions regarding coverage effective dates are made by PacificSource Health Plans.

When Coverage Ends

Insurance of all Insured Persons terminates at 11:59 p.m. **on the earlier of**:

- Date the Student Guide terminates for all Insured Persons; or
- End of the period of coverage for which premium has been paid; or
- Date the Insured Person enters military service.
- In the event there is overlapping coverage under the same Student Guide number, the policy with the earliest effective date will stay in force through its termination date and the subsequent policy will go into effect immediately afterward with no gap in coverage.

COVERAGE IS NOT AUTOMATICALLY RENEWED. Eligible Persons must re-enroll when coverage terminates to maintain coverage. NO notification of plan expiration or renewal will be sent.

Health Insurance Requirement and Eligibility

All international scholars possessing and maintaining a current passport and valid J-1 visa status and engaged in educational activities, who are temporarily located outside their home country and have not been granted permanent residency status are required to purchase this insurance plan unless proof of comparable coverage is furnished.

Scholars must be actively engaged in their Program Objective.

Scholars who enroll may also insure their Dependents. Eligible Dependents are the Scholar's legal spouse or Domestic Partner and dependent children under 26 years of age. See the Definitions section of the Certificate for the specific requirements needed to meet Domestic Partner eligibility.

The eligibility date for Dependents shall be determined in accordance with the following:

- If the Scholar has Dependents on the date he or she is eligible for insurance;
- If the Scholar acquired a Dependent after the Effective Date, such Dependent becomes eligible:
 - A) On the date the Scholar acquires a legal spouse or a Domestic Partner who meets the specific requirements set forth in the Definitions section of the Certificate.
 - B) On the date the Scholar acquired a dependent child who is within the limits of a dependent child set forth in the Definitions section of the Certificate.

Dependent eligibility expires concurrently with that of the Scholar.

Dependent enrollment on this plan is voluntary. In order to enroll your dependent(s) visit psuweekklyscholars.myahpcare.com.

SCHOLAR & DEPENDENT PLAN COST

Weekly Rate (7 Calendar Days), Available From:
09/20/2020 – 09/19/2021

| | |
|--|---------|
| Scholar only | \$31.00 |
| NOTE: Costs below are in addition to the student premium. Dependents must be enrolled for the same term of coverage as student. Dependent enrollment in this plan is voluntary. | |
| Spouse only | \$31.00 |
| One Child only (Age 0-25) | \$31.00 |
| Two or More Children only (Age 0-25) | \$62.00 |

Rates include a premium payable to Academic Health Plans, as well as administrative fees payable to PSU and AHP. Rates also include Academic Emergency Services provided through 4 Ever Life International Limited and administered by Worldwide Insurance Services, LLC, separate and independent companies from Academic HealthPlans.

Premium Refund/Cancellation

A refund of premium will be granted for the reasons listed below only. No other refunds will be granted.

1. If you or your insured dependents enter the armed forces of any country you and your insured dependents will not be covered under the Master Policy as of the date of such entry. If you enter the armed forces the policy will be cancelled as of the date of such entry. If your dependent enters the armed forces, a pro-rata refund of premium will be made for such person, upon written request received by USI Student Insurance within **31 days** of entry into service.
2. Refunds will be granted for insured dependents in case of a qualifying event such as legal separation, divorce or death within **31 days** of the occurred event, provided that your insured dependents did not file a medical claim during the insured period. Written proof of such qualifying event must be submitted. Refunds will not be prorated.

Where to Go for Care - Voyager Network

PacificSource has arranged for you to access the PacificSource Voyager Network. It is to your advantage to utilize an In-Network Provider because savings can be achieved from the Contracted Allowable Fee these providers have agreed to accept as payment for their services. Scholars are responsible for informing their providers of potential out-of-pocket expenses for a referral to both an In-Network Provider and an Out-of-Network Provider. In-Network Providers are independent contractors and are neither employees nor agents of either University or PacificSource. To find an In-Network Provider, you can use PacificSource's online provider directory located at: psuweekklyscholars.myahpcare.com.

ID Cards

Medical ID cards may be shipped before or shortly after of your policy effective date. Providers need the ID number shown on your ID card to identify you, verify your coverage and bill PacificSource. You do not need an ID card to be eligible to receive benefits; if you need medical attention before receiving your ID card, benefits will be payable according to the Policy. Once you have received your ID card, present it to the provider to facilitate prompt payment of your claim. You can also print your ID cards at: psuweeklyscholars.myahpcare.com or access an ID card on your mobile device.

Prescription Drug Claim Procedure

When obtaining a covered prescription, please present your ID card to an In-Network Pharmacy, along with your applicable Co-payment. The pharmacy will bill PacificSource for the cost of the drug, plus a dispensing fee, less the Co-payment amount.

When you need to fill a prescription, and do not have your ID card with you, you may obtain your prescription from an In-Network Pharmacy, and be reimbursed by submitting a completed Prescription Drug claim form. You will be reimbursed for the covered medications using the PacificSource contracted amount for the medication, less your co-payment. For a prescription claim form, go to psuweeklyscholars.myahpcare.com.

Prescriptions from an Out-of-Network Pharmacy must be paid for in full at the time of service and submitted for reimbursement.

Member Web: InTouch for Members

Got Questions? Get Answers with InTouch

As a PacificSource insurance member, you have access to InTouch, your secure member website, with access to your insurance information and a wealth of health and wellness resources. You can take full advantage of the interactive website to complete a variety of self-service transactions online 24 hours a day. You can also stay “InTouch” no matter where you are with the free Mobile App available both on iPhone® and Android™ at: psuweeklyscholars.myahpcare.com

By logging into InTouch, you can:

- Look up coverage information and review benefit summaries
- Check the status of a claim and access your claim history
- View Explanation of Benefits (EOB) statements for paid claims
- Order new and print temporary ID cards
- Access health and wellness resources
- Find a provider, hospital, or urgent care center

How do I register?

- Go to psuweeklyscholars.myahpcare.com
- Have your PacificSource Member ID card handy
- Click on the Register Now link on the right side of your screen
- Follow the onscreen instructions

Need help with registering onto InTouch?

Technical assistance is available toll free, Monday through Friday at **(855) 274-9814**. Hours are 7am - 5pm PST.

Coordination of Benefits

If the Enrollee is insured under more than one group health plan, the benefits of this Plan, that covers the insured student, will be used before those of a plan that provides coverage as a dependent. When both parents have group health plans that provide coverage as a dependent, the benefits of the plan of the parent whose birth date falls earlier in the year will be used first. The benefits available under this Plan may be coordinated with other benefits available to the Enrollee under any auto insurance, Workers' Compensation, Medicare, or other coverage. This Plan pays in accordance with the rules set forth in the Policy.

Extension of Benefits

If an Enrollee is confined to a hospital on the date his or her insurance terminates, expenses incurred after the termination date and during the continuance of that hospital confinement, shall be payable in accordance with the Plan until the Enrollee is released or benefits are exhausted, whichever occurs first.

How Do I File a Claim?

Your In-Network Provider will file claims with PacificSource. All you need to do is show your ID card to the In-Network Provider.

If you receive care from an Out-of-Network Provider, the provider may submit the claim to PacificSource for you. If not, you are responsible for sending the claim to PacificSource for processing. Your claim must include a copy of your provider's itemized bill. It must also include your name, ID number and/or the patient's name. If you were treated for an accidental injury, please include the date, time, place, and circumstances of the accident.

All claims for benefits should be turned in to PacificSource within **90 days** of the date of service. 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.

PacificSource has the sole right to pay benefits to the Enrollee, the provider, or both jointly. You will receive an “Explanation of Benefits” when your claims are processed. The Explanation of Benefits will explain how your claim was processed, according to the benefits of your Student Health Insurance Plan.

All claims should be sent to:

PacificSource Health Plans

Attn: Claims Department

P.O. Box 7068, Springfield, OR 97475-0068

(541) 225-2741 or (855) 274-9814 (toll-free)

Customer Service Representatives are available 7:00 a.m. to 5:00 p.m. (PST), Monday through Friday, for any questions. Claim forms can be obtained by calling the number above or by visiting psuweeklyscholars.myahpcare.com.

How to Appeal a Claim

In the event an Enrollee disagrees with how a claim was processed, he or she may request a review of the decision. The Enrollee's requests must be made in writing within **180 days** of the date of the Explanation of Benefits (EOB). The Enrollee's request must include why he or she disagrees with the way the claim was processed. The request must also include any additional information that supports the claim (e.g., medical records, physician's office notes, operative reports, physician's letter of medical necessity, etc.). Please submit all requests to:

PacificSource Health Plans

Attn: Appeals

P.O. Box 7068, Springfield, OR 97475-0068

Notice

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.

To obtain a copy of our notice describing in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Customer Services number on your ID card or visit psuweeklyscholars.myahpcare.com.

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This is just a brief description of your benefits. For information regarding the full Student Guide (which includes plan benefits, exclusions and limitations, and information about refund requests, how to file a claim, mandated benefits and other important information) please visit psuweekklyscholars.myahpcare.com. You will be able to obtain a copy of the full Student Guide as soon as it is available. If any discrepancy exists between this Benefit Summary and the Policy, the Student Guide will govern and control the payment of benefits.

Schedule of Benefits

The Plan will pay benefits in accordance with any applicable Oregon State Insurance Law(s).

Waiver of Annual Deductible

In compliance with Federal Health Care Reform legislation, the Annual Deductible is waived for In-Network Covered Medical Expenses rendered as part of the following benefit types: Routine Physical Exam Expense (Office Visits), Pap Smear Screening Expense, Mammogram Expense, Routine Screening for Sexually Transmitted Disease Expense, Routine Colorectal Cancer Screening, Routine Prostate Cancer Screening Expense, Preventive Care Immunizations (Facility or Office Visits), Well Woman Preventive Visits (Office Visits), Screening & Counseling Services (Office Visits) as illustrated under the Routine Physical Exam benefit type, Routine Cancer Screenings (Outpatient), Prenatal Care (Office Visits), Comprehensive Lactation Support and Counseling Services (Facility or Office Visits), Breast Pumps & Supplies, Family Contraceptive Counseling Services (Office Visits), Female Voluntary Sterilization (Inpatient and Outpatient), Pediatric Preventive Vision and Dental Service, Female Contraceptives Generic Prescription Drugs, Brand Prescription Drugs if no Generic equivalent, FDA-Approved Female Generic Emergency Contraceptives. In compliance with Oregon State Mandate(s) the Policy Year Deductible is also waived for: Maternal Diabetic Services from conception to **6 weeks** post-partum.

Deductibles & Maximums

| | |
|--|--|
| Annual Benefit Maximum | Unlimited |
| Annual Deductibles - Per visit or admission deductibles do not apply towards satisfying the plan Deductible. | The following Deductibles are applied before Covered Medical Expenses are payable: In-Network Provider: \$300 per Insured per Policy Year Out-of-Network Provider: \$600 per Insured per Policy Year |
| Coinsurance | Covered Medical Expenses are payable at the coinsurance percentage specified below, after any applicable deductible, up to an unlimited maximum benefit. |
| Annual Out of Pocket Maximums - Once the Individual Out-of-Pocket Limit has been satisfied, Covered Medical Expenses will be payable at 100% for the remainder of the Policy Year, up to any benefit maximum that may apply. Coinsurance, Deductibles, Co-pays and Prescription Drug expenses apply to the Out-of-Pocket Limit. Services that do not apply towards satisfying the Out-Of-Pocket Limit: expenses that are not Covered Medical Expenses; expenses for Designated Care penalties, and other expenses not covered by this Plan. | In-Network Provider: \$5,000 per Insured per Policy Year Out-of-Network Provider: \$10,000 per Insured per Policy Year |

| Inpatient Hospitalization Services | In-Network Provider | Out-of-Network Provider |
|--|---|--------------------------------|
| Room and Board Expense , Semi-private room. | After a \$250 Co-pay per admission, 80% of the Negotiated Charge | 50% of the Recognized Charge |
| Intensive Care Room and Board Expense | After a \$250 Co-pay per admission, 80% of the Negotiated Charge | 50% of the Recognized Charge |
| Non-Surgical Physicians , Charges for the non-surgical services of the attending Physician, or a consulting Physician. | 80% of the Negotiated Charge | 50% of the Recognized Charge |
| Miscellaneous Hospital Expense , Includes; among others; expenses incurred during a hospital confinement for: anesthesia and operating room; laboratory tests and x rays; oxygen tent; and drugs; medicines; and dressings. | 80% of the Negotiated Charge | 80% of the Recognized Charge |
| Surgical Expense (Inpatient & Outpatient) | In-Network Provider | Out-of-Network Provider |
| Surgical Expense | After a \$100 Co-pay per surgery, 80% of the Negotiated Charge | 50% of the Recognized Charge |
| Anesthesia Expense | 80% of the Negotiated Charge | 80% of the Recognized Charge |
| Ambulatory Surgical Expense | 80% of the Negotiated Charge | 50% of the Recognized Charge |
| Ambulatory Surgical Center | After a \$100 Co-pay, 80% of the Negotiated Charge | 50% of the Recognized Charge |

Continued on next page

Schedule of Benefits (continued)

| Outpatient Benefits | In-Network Provider | Out-of-Network Provider |
|---|---|--|
| Physician's Office Visit Expense. Co-pay is due at time of visit and is in addition to the plan deductible. | 100% of the Negotiated Charge after a \$25 Co-pay per visit | 50% of the Recognized Charge after a \$40 Co-pay per visit |
| Preventative Care Services, Including but not limited to routine physical exams, immunizations and diagnostic X-ray & lab for routine physical exams. | 100% of the Negotiated Charge | 50% of the Recognized Charge |
| Laboratory and X-Ray Expense | 80% of the Negotiated Charge | 50% of the Recognized Charge |
| Emergency Room Visit Expense. <u>Important Note:</u> Please note that as Out-of-Network Providers do not have a contract with PacificSource, the provider may not accept payment of your cost share (your deductible and co-insurance) as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. The co-pay is in addition to the plan deductible. | 80% of the Negotiated Charge after \$250 Co-pay per visit (Co-pay waived if admitted) | 80% of the Recognized Charge after \$250 Copay per visit (Co-pay waived if admitted) |
| Urgent Care Expense. <u>Please note:</u> A covered person should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition. The covered person should go directly to the emergency room of a hospital or call 911 for ambulance and medical assistance. The Co-pay is in addition to the plan deductible. | 100% of the Negotiated Charge after a \$30 Co-pay per visit | 50% of the Recognized Charge after a \$50 Co-pay per visit |
| Advanced Diagnostic Imaging (ie MRI, CT, PET) Expense | 80% of the Negotiated Charge after \$100 Co-pay | 50% of the Recognized Charge |
| Ambulance Expense | 80% of the Negotiated Charge after \$100 Co-pay per trip | 80% of the Recognized Charge after \$100 Co-pay per trip |
| Therapy Expense, For the following types of therapy provided on an outpatient basis: Physical Therapy, Chiropractic Care, Speech Therapy, or Occupational Therapy. | 80% of the Negotiated Charge after a \$25 Co-pay per visit | 50% of the Recognized Charge after a \$40 Co-pay per visit |
| Durable Medical Equipment Expense | 80% of the Negotiated Charge | 50% of the Recognized Charge |
| Diagnostic Testing for Learning Disabilities Expense | 80% of the Negotiated Charge | 50% of the Recognized Charge |
| Treatment for Learning Disabilities Expense | 100% of the Negotiated Charge after a \$25 Co-pay per visit | 50% of the Recognized Charge |
| Allergy Testing and Treatment Expense, Includes laboratory tests, physician office visits to administer injections, prescribed medications for testing and treatment of the allergy, and other medically necessary supplies and services. | 80% of the Negotiated Charge | 50% of the Recognized Charge |
| Impacted Wisdom Teeth Expense | 80% of the Actual Charge | 80% of the Actual Charge |
| Dental Injury Expense | 80% of the Actual Charge | 80% of the Actual Charge |
| Diabetic Testing Supplies Expense, Including test strips, diabetic test agents, glucose tablets, lancets/lancing devices, and alcohol swabs and blood glucose monitors. | 80% of the Negotiated Charge | 50% of the Recognized Charge |
| Mental Health Benefits | In-Network Provider | Out-of-Network Provider |
| Inpatient Expense, Charges incurred while confined as a full-time inpatient in a hospital or residential treatment facility for the treatment of mental and nervous disorders. Prior review and approval must be obtained from PacificSource. | 80% of the Negotiated Charge after \$100 Co-pay per admission | 50% of the Recognized Charge |
| Outpatient Expense, Charges for marriage and family therapies are not covered. | 100% of the Negotiated Charge after a \$25 Co-pay per visit | 50% of the Recognized charge |
| Alcoholism and Drug Addiction Treatment | In-Network Provider | Out-of-Network Provider |
| Inpatient Expense, For the treatment of alcohol and drug addiction. | 80% of the Negotiated Charge after a \$100 Co-pay per admission | 50% of the Recognized Charge |
| Outpatient Expense, For the treatment of alcohol and drug addiction. | 100% of the Negotiated Charge after a \$25 Co-pay per visit | 50% of the Recognized Charge |
| Maternity Benefits | In-Network Provider | Out-of-Network Provider |
| Maternity Expense, For the care of the covered person. | 80% of the Negotiated Charge | 50% of the Recognized Charge |
| Well Newborn Nursery Care Expense, For the routine care of a covered newborn child. See page 8 for additional information on this benefit. | 80% of the Negotiated Charge | 50% of the Recognized Charge |

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Schedule of Benefits (continued)

| Additional Benefits | In-Network Provider | Out-of-Network Provider |
|---|--|-------------------------------|
| Pap Smear Screening Expense | 100% of the Negotiated Charge | 50% of the Recognized Charge |
| Mammogram Expense | 100% of the Negotiated Charge | 50% of the Recognized Charge |
| Family Planning Expense , Includes charges incurred for services and supplies that are provided to prevent pregnancy. See page 7 for additional information on this benefit. | 100% of the Negotiated Charge | 50% of the Recognized Charge |
| Routine Screening Expense , Includes charges for Chlamydia, Sexually Transmitted Disease (STD), Prostate, and Colorectal Cancer screenings. | 100% of the Negotiated Charge | 50% of the Recognized Charge |
| Rehabilitation Facility Expense | 80% of the Negotiated Charge | 50% of the Recognized Charge |
| Human Organ Transplant Expense | 80% of the Negotiated Charge | 50% of the Recognized Charge |
| Elective Abortion Expense | 100% of the Negotiated Charge (Deductible waived) | 100% of the Recognized Charge |
| Transgender Surgery Expense , No dollar max. Covered to medical necessity. | 80% of the Negotiated Charge | 50% of the Recognized Charge |
| Acupuncture Expense | 80% of the Negotiated Charge after \$30 Co-pay per visit | 50% of the Recognized Charge |

| Prescription Medications | In-Network Provider & Out-of-Network Provider Pharmacy |
|---|--|
| <p>Prescription Drug Expense 30 Day Supply. Contraceptives (that do not have a generic alternate) covered at 100%. <i>Please Note:</i> You are required to pay in full at the time of service for all Prescriptions dispensed at a Out-of-Network Pharmacy.</p> <p>To learn more about your prescription benefits visit psuweeklyscolars.myahpcare.com. <i>Note: Specialty prescription drugs can only be obtained through Caremark.</i></p> <p>Please visit PacificSource.com/drug-list for more information about your covered prescription & preventative drug options.</p> <p>Mail Order Pharmacy Service PacificSource partners with CVS Caremark Mail Service. Order up to a 90-day supply of covered medications and have them delivered to you, with no standard shipping charge. Visit: pacificsource.com/member/mail-order-rx.aspx to learn more and get started.</p> | <p>In-Network Pharmacy: 100% of the Negotiated Charge following a \$25 Co-pay for each Generic, \$50 Co-pay for each Preferred Brand Name, \$75 Co-pay for each Non-Preferred Brand Name, and 20% Coinsurance up to \$250 for each Specialty Prescription Drug</p> <p>Out-of-Network Pharmacy: 100% of the Recognized Charge following a \$25 Co-pay for each Generic, \$50 Co-pay for each Preferred Brand Name, \$75 Co-pay for each Non-Preferred Brand Name, and 20% Coinsurance up to \$250 for each Specialty Prescription Drug</p> <p>100% of the Negotiated Charge following a \$50 Co-pay for each Generic, \$100 Co-pay for each Preferred Brand Name or \$150 Co-pay for each Non-Preferred Brand Name Prescription Drug.</p> |

For more details about these benefits, please see the Benefit Descriptions section on the following pages.



Benefit Descriptions

- **Preventive Care Services:** Benefits include expenses for a routine physical exam by a physician, physician assistant, or nurse practitioner. If charges for a routine physical exam given to a child who is a covered dependent are covered under any other benefit section, those charges will not be covered under this section.

A routine physical exam is a medical exam given by a physician, physician assistant, or nurse practitioner, for a reason other than to diagnose or treat a suspected or identified injury or sickness. Included as part of the exam are:

- Routine vision and hearing screenings given as part of the routine physical exam.
- X-rays, lab, and other tests given in connection with the exam, and
- Materials for the administration of immunizations for infectious disease and testing for tuberculosis.

In addition to any state regulations or guidelines regarding mandated Routine Physical Exam services, Covered Medical Expenses include services rendered in conjunction with,

- Screening and counseling services, such as:
 - Interpersonal and domestic violence;
 - Sexually Transmitted Diseases; and
 - Human Immune Deficiency Virus (HIV) infections.
- Screening for gestational diabetes.
- X-rays, lab and other tests given in connection with the exam.
- Immunizations for infectious diseases and the materials for administration of immunizations that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- If the plan includes dependent coverage, for covered newborns, an initial hospital check up.

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

- Services that have a rating of 'A' or 'B' from the 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.

A and B list for preventive services can be found at:

www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations

The list of Women's preventive services can be found at:

www.hrsa.gov/womensguidelines

Important Note: For details on the frequency and age limits that apply to Routine Physical Exams and Routine Cancer Screenings, a covered person may contact his or her physician, by logging onto InTouch for Members: psuweeklyscolars.com or calling the toll-free number on the back of the ID card.

- **Screening and Counseling Services:** Covered Medical Expenses include charges made by a physician in an individual or group setting for the following:
 - **Obesity:** Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:
 - Preventive counseling visits and/or risk factor reduction intervention;
 - Medical nutrition therapy;
 - Nutritional counseling; and
 - Healthy diet counseling visits provided in connection

with Hyperlipidemic (high cholesterol) and other known factors for cardiovascular and diet-related chronic disease.

Services in this category are subject to a combined limit of 26 individual or group visits by a recognized provider per Policy Year with exception to Dietary and Nutritional counseling for eating disorders (i.e. Bulimia and Anorexia), that have no visitation limit.

- **Misuse of Alcohol and/or Drugs:** Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.
- **Use of Tobacco Products:** Tobacco cessation program services are covered at no charge only when provided by a PacificSource approved program. Specific nicotine replacement therapy will be covered according to the program's description. Tobacco cessation related medication will be covered to the same extent this policy covers other prescription medications.

Note: Office visits for tobacco cessation do not have a visit limit.

Tobacco product means a substance containing tobacco or nicotine including:

- Cigarettes;
- Cigars;
- Smoking tobacco;
- Chewing tobacco;
- Snuff;
- Smokeless tobacco; and
- Candy-like products that contain tobacco.

Limitations: Unless specified above, not covered under this Screening and Counseling Services benefit are charges incurred for:

- Services which are covered to any extent under any other part of this Plan.

- **Family Planning Expense:** For females with reproductive capacity, Covered Medical Expenses include those charges incurred for services and supplies that are provided to prevent pregnancy. All services and supplies covered under this benefit must be approved by the Food and Drug Administration (FDA). Coverage includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist. Such counseling services are Covered Medical Expenses when provided in either a group or individual setting.

The following contraceptive methods are covered expenses under this benefit:

- **Voluntary Sterilization:** Covered expenses include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants. Covered expenses under this Preventive Care benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.

Limitations: Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this Plan;

- Services which are for the treatment of an identified illness or injury;
- Services that are not given by a physician or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Any contraceptive methods that are only “reviewed” by the FDA and not “approved” by the FDA;
- Male contraceptive methods or devices;
- The reversal of voluntary sterilization procedures, including any related follow-up care.

○ **Important Note:** Brand-Name Prescription Drug or Devices will be covered at 100% of the Negotiated Charge, including waiver of Annual Deductible if a Generic Prescription Drug or Device is not available in the same therapeutic drug class or the prescriber specifies Dispense as Written.

- **Therapy Expense:** Covered Medical Expenses include charges incurred by a covered person for the following types of therapy provided on an outpatient basis:
 - Physical Therapy,
 - Chiropractic Care,
 - Speech Therapy,
 - Inhalation Therapy,
 - Cardiac Rehabilitation, or
 - Occupational Therapy.

Expenses for Chiropractic Care are Covered Medical Expenses, if such care is related to neuromusculoskeletal conditions arising from: the lack of normal nerve, muscle, and/or joint function.

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 up to one year post injury 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.

Covered Medical Expenses for chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy, radiation therapy, tests and procedures, physiotherapy (for rehabilitation only after a surgery), and expenses incurred at a radiological facility. Covered Medical Expenses also include expenses for the administration of chemotherapy and visits by a health care professional to administer the chemotherapy.

Benefits for these types of therapies are payable for Covered Medical Expenses, on the same basis as any other sickness.

- **Allergy Testing and Treatment Expense:** Benefits include charges incurred for diagnostic testing and treatment of allergies and immunology services.

Covered Medical Expenses include, but are not limited to, charges for the following:

- Laboratory tests,
- Physician office visits, including visits to administer injections, prescribed medications for testing and treatment of the allergy, including any equipment used in the administration of prescribed medication, and
- Other medically necessary supplies and services.

- **Maternity Expense:** Covered Medical Expenses include inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.

Any decision to shorten such minimum coverage shall be made by the attending Physician, in consultation with the mother. In such cases, Covered Medical Expenses may include home visits, parent education, and assistance and training in breast or bottle-feeding.

Prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures of a high-risk pregnancy, Maternity Expenses, and Complications of Pregnancy are payable on the same basis as any other Sickness.

- **Prenatal Care:** Prenatal care will be covered for services received by a pregnant female in a physician's, obstetrician's, or gynecologist's office but only to the extent described below. Coverage for prenatal care under this benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

- **Comprehensive Lactation Support and Counseling Services:** Covered Medical Expenses will include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the post-partum period by a certified lactation support provider. The “post-partum period” means the 60 day period directly following the child's date of birth. Covered expenses incurred during the post-partum period also include the purchase of non-hospital grade breast feeding equipment.

Lactation support and lactation counseling services are covered expenses when provided in either a group or individual setting.

- **Well Newborn Nursery Care Expense:** Benefits include charges for routine care of a covered person's newborn child as follows:
 - Hospital charges for routine nursery care during the mother's confinement,
 - Physician's charges for circumcision, and
 - Physician's charges for visits to the newborn child in the hospital and consultations.

- **Pap Smear Screening Expense:** Covered Medical Expenses include one routine annual Pap smear screening (or an alternative cervical cancer screening test when recommended by a physician or a health care provider), and an FDA approved human papillomavirus screening test for women age 18 and older.

- **Mammogram Expense:** Covered Medical Expenses include coverage for mammograms for screening or diagnostic purposes upon referral of a nurse practitioner, certified nurse-midwife, physician assistant, or a physician. Benefits will be paid for Expenses incurred for the following:
 - 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

- **Human Organ Transplant Expense:** The organ or tissue donation and facility is covered. Travel and housing expenses for the recipient and one caregiver are limited to \$5,000 per transplant. Preauthorization required for all transplant expenses.

Exclusions and Limitations

IMPORTANT NOTICE: This is a brief description of the limitations and exclusions of this policy. For more detailed information, you may request the Student Guide from Academic HealthPlans at psuweekklyscholars.myahpcare.com.

Plan benefits are subject to all applicable state and federal laws and regulations, which are subject to change. 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 setting, then this Plan will only pay what it would have been for the procedure on an outpatient basis. This Plan neither covers nor provides benefits for the following:

Types of Treatment – This Student Policy 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.
- Any amounts in excess of the allowable fee for a given service or supply.
- Aversion therapy.
- Benefits not stated – Services and supplies not specifically described as benefits under this Student Policy and/or any endorsement attached hereto.
- Biofeedback (other than as specifically noted under the Covered Medical Expenses – Other Covered Medical Services, Supplies, and Treatments section).
- Charges for phone consultations, missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims unless otherwise contracted. Charges over the usual, customary, and reasonable fee (UCR) – Any amount in excess of the UCR for a given service or supply.
- Charges that are the responsibility of a third party who may have caused the illness, injury, or disease or other insurers covering the incident (such as workers' compensation insurers, automobile insurers, and general liability insurers).
- Chelation therapy including associated infusions of vitamins and/or minerals, except as medically necessary for the treatment of selected medical conditions and medically significant heavy metal toxicities.
- Computer or electronic equipment for monitoring asthmatic, diabetic, or similar medical conditions or related data.
- Connector bar or stress breaker.
- 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 (does not apply to emergency services). Cosmetic/reconstructive services and supplies are those performed primarily to improve the body's appearance and not primarily to restore impaired function of the body, unless the area needing treatment is a result of a congenital anomaly or gender dysphoria.
- Court-ordered sex offender treatment programs.
- Day care or custodial care – 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 rehabilitation or habilitation services that are covered under Professional Services section.). Custodial care is only covered in conjunction with respite care allowed under the Student Guide's hospice benefit.
- 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. Please reference the dental policy for more information.

- Diabetic shoes and shoe modifications.
- Diagnostic casts – Gnathological recordings, occlusal equilibration procedures, or similar procedures.
- Drugs and biologicals that can be self-administered (including injectables), other than 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 nonmedical purposes or marketed to the general public.
- Expense incurred by a covered person; not a United States citizen; for services performed within the student's home country; if the student's home country has a socialized medicine program.
- Expense incurred for injury resulting from the play or practice of intercollegiate sports, athletics and intramurals.
- Experimental or investigational procedures – See Student Guide for details.
- Eye examinations (routine) members age 19 and older (not covered after max benefit reached).
- Eye glasses/Contact Lenses 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 (not covered after max benefit reached).
- Eye exercises and eye refraction, therapy, and procedures – Orthoptics, vision therapy, and procedures intended to correct refractive errors.
- Family planning – Services and supplies for artificial insemination, in vitro fertilization, treatment of infertility, or surgery to reverse voluntary sterilization, and treatment of erectile or sexual dysfunction unless medically necessary. See Student Guide for details.
- 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.
- Genetic (DNA) testing – DNA and other genetic tests, except for those tests identified as medically necessary for the diagnosis and standard treatment of specific diseases.
- Growth hormone injections or treatments, except to treat documented growth hormone deficiencies.
- Hearing Aids for individuals 19 and older except as noted in the Student Guide.
- Homeopathic medicines or homeopathic supplies.
- Hypnotherapy.
- Immunizations when recommended for or in anticipation of exposure through work.
- Indirect pulp caps are to be included in the restoration process, and are not a separate covered benefit.
- Instructional or educational programs, except diabetes self-management programs unless medically necessary.

Exclusions and Limitations (continued)

- 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.
- Marital/partner counseling.
- Massage, 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 that are not attributable to a mental health diagnosis as noted in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition (DSM-IV) or the DSM of Mental Disorders, Fifth Edition (DSM-5).
- 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.
- Narcosynthesis.
- Naturopathic supplies.
- Nicotine related disorders, other than those covered through tobacco cessation program services.
- Obesity or weight reduction control – Surgery or other related services or supplies provided for weight reduction control or obesity (including all categories of obesity), 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.
- 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.
- Orthopedic shoes and shoe modifications.
- Orthognathic surgery – Surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship to the facial bones, except as specified in the Professional Services section.
- Orthopedic 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.
- Precision attachments.
- Private nursing service.
- Programs that teach a person to use medical equipment, care for family members, or self-administer drugs or nutrition (except for diabetic education benefit).
- Psychoanalysis 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.
- Removal of clinically serviceable amalgam restorations to be replaced by other materials free of mercury, except with proof of allergy to mercury.
- Replacement costs for worn or damaged durable medical equipment that would otherwise be replaceable without charges under warranty or other agreement.
- 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 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.
- Scheduled and/or non-emergent medical care outside of the United States.
- 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 for which no charge is made, 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 services provided by the member, or by any licensed medical professional that is directly related to the member by blood or marriage.
- Services or supplies received after enrollment in this Student Policy ends.
- 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).
- Sinus lift grafts to prepare sinus site for implants.
- Sex reassignment – Procedures, services or supplies related to a sex reassignment unless medically necessary.
- 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.
- Speech therapy – Except if medically necessary as part of a treatment plan.
- Stress-breaking or habit-breaking appliances unless medically necessary.
- Support groups.

Continued on next page

Exclusions and Limitations (continued)

- Surgery to reverse voluntary sterilization.
- Transplants – Except as noted in the Student Guide.
- 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.
- 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.
- Treatment after insurance ends – Services or supplies a member receives after the member's coverage under this plan ends. The only exception is for Class III Services ordered and fitted before enrollment ends and are placed within 31 days after enrollment ends.
- Treatment not medically necessary – Services or supplies that are not medically necessary for the diagnosis or treatment of an illness, injury, or disease.
- Treatment of any illness, injury, or disease resulting from an illegal occupation or attempted felony, or treatment received while in the custody of any law enforcement other than with local supervisory authority while pending disposition of charges.
- Treatment of any confirmed work-related illness, injury, or disease, except in the following circumstances:
 - You are the owner, partner, or principal; 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 Student Policy, such as inpatient stays or admission to a hospital, skilled nursing facility or specialized facility that began before the patient's coverage under the Student Guide.
- Unwilling to release information – Charges for services or supplies for which a member is unwilling to release medical or eligibility information necessary to determine the benefits payable under this plan.
- Vocational rehabilitation, functional capacity evaluations, work-hardening programs, community reintegration services, and driving evaluations and training programs, except as medically necessary in the restoration or improvement of speech following a traumatic brain injury or for members diagnosed with 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.

Definitions

Wherever used in this policy, the following definitions apply to the terms listed below, and the masculine includes the feminine and the singular includes the plural. Other terms are defined where they are first used in the text.

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

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

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

Appeal means a written or verbal request from an enrollee or, if authorized by the enrollee, the enrollee's authorized 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;

- Matters pertaining to the contractual relationship between an Enrollee and PacificSource;
- Rescissions of enrollee's benefit coverage by PacificSource; and
- Other matters as specifically required by law.

Authorized representative is an individual who by law or by the consent of a person may act on behalf of the person. An authorized representative must have the enrollee complete and execute an Authorization to Use / Disclose PHI form and a Designation of Authorized Representative form, both of which are available at www.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 enrollee.

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

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

Definitions (continued)

Contracted Allowable Fee is an amount PacificSource agrees to pay an In-Network Provider for a given service or supply through direct or indirect contract.

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

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

Covered Expense is an expense for which benefits are payable under this Plan subject to applicable deductible, co-payment, co-insurance, out-of-pocket maximum, 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 means the covered student's spouse residing with the covered student or the person identified as a domestic partner in the "Affidavit of Domestic Partnership" which is completed and signed by the covered student, and the covered student's child. The term "child" includes a covered student's step-child, adopted child, and a child for whom a petition for adoption is pending. The term "dependent" does not include a person who is an eligible student or a member of the armed forces.

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

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.
- That is a behavioral health crisis.

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

Enrollee means a covered student while coverage under this Plan is in effect.

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 medical services to members while traveling throughout the United States.

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

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

In-network provider means a physician, healthcare professional, dentist, oral surgeon, endodontist, orthodontist, periodontist, pedodontist, denturist, dental hygienist, hospital, medical facility, or supplier of medical supplies that directly or indirectly holds a provider contract or agreement with PacificSource.

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.

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 Oregon, 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 enrollee 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.

Medical supplies means items of a disposable nature that may be essential to effectively carry out the care a physician has ordered for the treatment or diagnosis of an illness, injury, or disease.

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

Member means an individual insured under a PacificSource health plan.

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

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

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.

Plan means the Student Health Insurance Plan, sponsored by Portland State University as documented by the Policy and PacificSource Health Plans.

Continued on next page

Definitions (continued)

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, Naturopathic Physician, Licensed Massage Therapist, and Pharmacist.

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

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

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

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

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.

Student means a student or scholar of the Policyholder who is insured under this Plan and meets College/University eligibility guidelines.

Student Health Center means the health center on campus that provides services to students, many of which are covered by the Policyholders student health fee and are provided at no cost to the student.

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

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

Usual, customary, and reasonable fee (UCR) is the dollar amount established by PacificSource for reimbursement of eligible charges for specific services or supplies provided by out-of-network providers. PacificSource uses several sources to determine UCR. Depending on the service or supply and the geographical area in which it is provided, UCR may be based on data collected from the Centers for Medicare and Medicaid Services (CMS), other nationally recognized databases, or PacificSource, as documented in PacificSource's payment policy. An Out-of-Network Provider may charge more than the limits established by the definition of UCR. Charges that are eligible for reimbursement but exceed the UCR are the enrollee's responsibility.

Emergency Assistance Services: Academic Emergency Services

Academic Emergency Services:
855-873-3555 (Toll-free within the U.S.)
1 (610) 263-4660 (Outside the U.S.)
E-mail: assistance@ahpcare.com
aes.myahpcare.com

As a participant in the student health plan, you have access to the emergency travel services and benefits when you are traveling over 100 miles from home or outside your home country.

Emergency Medical Evacuation, Repatriation and Emergency Family Assistance Services

- Emergency Medical Evacuation, Unlimited
- Medically Advisable Repatriation, Unlimited
- Return of Deceased Remains, Unlimited
- Visit by Family Member or Friend, up to \$5,000 with 3 day hospitalization
- Return of Dependent Children, up to \$5,000, if left unattended
- Emergency Return Home, up to \$2,500, in the event of death of the student
- Return of Personal Belongings, up to \$1,000 in the event of evacuation or death
- Accidental Death and Dismemberment, \$25,000

Medical, Travel, Safety, and Legal Assistance

- Pre-travel information portal
- Physician referrals outside of the U.S.
- Medical monitoring during an emergency evacuation to ensure adequate care
- Prescription assistance
- Luggage lost in transit

- Passport replacement assistance
- Emergency travel arrangements
- Emergency translation assistance and/or interpreter referral
- Legal referral

Additional Benefits

- Security/Political Evacuation Coverage
- Natural Disaster Evacuation Coverage
- Emergency Reunion 3 Day Threshold

Academic Emergency Services are available to you 24 hours a day, 7 days a week. Simply call the number above to get access to knowledgeable assistance coordinators who will help you navigate any unfamiliar cultures or circumstances.

All services must be arranged and paid through the Academic Services program provider in order for the benefits to apply. There is no claims process for reimbursement of self-paid expenses, unless otherwise noted in program. Terms, limitations, and conditions apply to all services and benefits. Academic Services and AD&D coverage are underwritten by 4 Ever Life International Limited and administered by Worldwide Insurance Services, LLC, separate and independent from Academic HealthPlans.

This material is for information only and is not an offer or invitation to contract. Health insurance plans contain exclusions, limitations and benefit maximums. Providers are independent contractors and are not agents of PacificSource. Provider participation may change without notice. PacificSource does not provide care or guarantee access to health services. Information is believed to be accurate as of the production date; however, it is subject to change.

NOTICE: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or who conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

IMPORTANT NOTE

The Portland State University Scholar Health Insurance Plan is underwritten by PacificSource Health Plans and administered by Academic HealthPlans.