Oregon State University SHIP

Group No.: G0038976
Voyager Gold 500_20 S4
Effective: 2021-2022

PacificSource HEALTH PLANS

7/6/2021 4846846

Welcome to your PacificSource Student plan. Your plan includes a wide range of benefits and services.

Using this Student Guide

This Student guide will help you understand how your plan works and how to use it.

If anything is unclear to you, our Customer Service team is available to answer your questions. Please give us a call, email us, or visit our website. We look forward to serving you and your family.

Governing Law

This plan must comply with both state and federal law, including required changes occurring after the plan's effective date. Therefore, coverage is subject to change as required by law. Unless federal law is found to apply, the validity and interpretation of this plan, and the rights and obligations of the Members, will be governed by the state's laws where your Policyholder's plan is issued.

This plan includes coverage for pediatric dental care, which is considered an Essential Health Benefit under the Affordable Care Act (ACA).

Additional Information

You may request information regarding premiums, cost sharing, Provider networks, utilization review, Appeals and Grievances, accreditation, benefits, pharmacy formulary, definitions of terms, and confidentiality policies. This information is available from our Customer Service team or on the PacificSource website.

PacificSource Customer Service Team

Medical
Phone (855) 274-9814
Email studenthealth@pacificsource.com

Dental
Phone (866) 373-7053
Email dental@pacificsource.com

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

PacificSource Headquarters

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Website

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Contract Year: September 11, 2021 – September 10, 2022

Provider Network: Voyager

Who is eligible?

International Students registered for a minimum of one on-campus credit at Oregon State University are required to enroll in the OSU Student Health Insurance Plan. All eligible Students are automatically enrolled and charged for the OSU Student Health Insurance Plan. Eligible dependents of those enrolled in the plan may participate on a voluntary basis.

	Student	Spouse	Per Child
International – Fall	$1,188.00	$1,118.00	$1,118.00
International – Winter	$1,188.00	$1,118.00	$1,118.00
International – Spring/Summer	$1,188.00	$1,118.00	$1,118.00
International – Summer	$906.00	$836.00	$836.00
INTO OSU – Fall	$1,188.00	$1,118.00	$1,118.00
INTO OSU – Winter	$1,188.00	$1,118.00	$1,118.00
INTO OSU – Spring/Summer	$1,188.00	$1,118.00	$1,118.00
INTO OSU – Summer	$906.00	$836.00	$836.00

The premiums above include a $70 administration fee, per student, charged by your school.

This plan has an Actuarial Value of 80.67% which satisfies the gold metal level of the ACA.

Student Health Center: OSU Student Health Services

If the member is a student of Oregon State University, the Student Health Center listed above is considered an in-network provider for covered services. Services provided by the Student Health Center are covered.

Deductible Per Contract Year	OSU Student Health Services	In-network and Out-of-network
Individual/Family	None	$500/$1,500
Out-of-Pocket Limit Per Contract Year	**OSU Student Health Services and In-network**	**Out-of-network**
Individual/Family	$6,000/$12,000	None

Note: Even though you may have the same benefit for in-network and out-of-network, your actual costs for services provided out-of-network may exceed this plan's out-of-pocket limit for out-of-network services. In addition, out-of-network providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company, and this amount is not counted toward the out-of-network out-of-pocket limit. Please see allowable fee in the Definitions section of your student guide.

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

Service/Supply	OSU Student Health Services Member Pays	In-network Member Pays	Out-of-network Member Pays
Preventive Care			
Well baby/Well child care, ages birth - 21	Not available	No deductible, 0%	After deductible, 40%
Preventive physicals	No deductible, 0%	No deductible, 0%	After deductible, 40%
Preventive STD screening	No deductible, 0%	No deductible, 0%	After deductible, 40%
Well woman visits	No deductible, 0%	No deductible, 0%	After deductible, 40%
Preventive mammograms	Not available	No deductible, 0%	After deductible, 40%
Immunizations	No deductible, 0%	No deductible, 0%	After deductible, 40%
Preventive colonoscopy	Not available	No deductible, 0%	After deductible, 40%
Professional Services			
Office and home visits	No deductible, 0%	After deductible, 20%	After deductible, 40%
Naturopath office visits	Not available	After deductible, 20%	After deductible, 40%
Specialist office and home visits	No deductible, 0%	After deductible, 20%	After deductible, 40%
Telemedicine visits	Not available	No deductible, $10	After deductible, 40%
Newborn nurse home visits	Not available	After deductible, 0%	After deductible, 0%
Office procedures and supplies	No deductible, 20%	After deductible, 20%	After deductible, 40%

Service/Supply	OSU Student Health Services Member Pays	In-network Member Pays	Out-of-network Member Pays
Surgery	Not available	After deductible, 20%	After deductible, 40%
Outpatient rehabilitation services	No deductible, 20%	After deductible, 20%	After deductible, 40%
Chiropractic manipulation/Spinal manipulation (18 visits per benefit year)	No deductible, 20%	After deductible, 20%	After deductible, 40%
Acupuncture	No deductible, 20%	After deductible, 20%	After deductible, 40%
Hospital Services			
Inpatient room and board	Not available	After deductible, 20%	After deductible, 40%
Inpatient rehabilitation services	Not available	After deductible, 20%	After deductible, 40%
Skilled nursing facility care	Not available	After deductible, 20%	After deductible, 40%
Outpatient Services			
Outpatient surgery/services	Not available	After deductible, 20%	After deductible, 40%
Diagnostic imaging – advanced	Not available	After deductible, 20%	After deductible, 40%
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	No deductible, 20%	After deductible, 20%	After deductible, 40%
Urgent and Emergency Services			
Urgent care center visits	Not available	After deductible, 20%	After deductible, 40%
Emergency room visits – medical emergency	Not available	After deductible, $150 plus 20%^	After deductible, $150 plus 20%^
Emergency room visits – non-emergency	Not available	After deductible, $150 plus 20%^	After deductible, $250 plus 20%^
Ambulance, ground	Not available	After deductible, 20%	After deductible, 20%
Ambulance, air	Not available	After deductible, 20%	After deductible, 20%+
Maternity Services**			

Service/Supply	OSU Student Health Services Member Pays	In-network Member Pays	Out-of-network Member Pays
Physician/Provider services (global charge)	Not available	After deductible, 20%	After deductible, 40%
Hospital/Facility services	Not available	After deductible, 20%	After deductible, 40%
Mental Health and Substance Use Disorder Services			
Office visits	No deductible, 0%	After deductible, 20%	After deductible, 40%
Inpatient care	Not available	After deductible, 20%	After deductible, 40%
Residential programs	Not available	After deductible, 20%	After deductible, 40%
Other Covered Services			
Allergy injections	No deductible, 20%	After deductible, 20%	After deductible, 40%
Durable medical equipment	No deductible, 20%	After deductible, 20%	After deductible, 40%
Home health services	Not available	No deductible, 0%	No deductible, 0%
Transplants	Not available	After deductible, 20%	After deductible, 40%
Temporomandibular joint	Not available	After deductible, 20%	After deductible, 40%
Impacted wisdom tooth extraction	Not available	After deductible, 20%	After deductible, 40%

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

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

** Medically necessary services, medication, and supplies to manage diabetes during pregnancy from conception through six weeks postpartum will not be subject to a deductible, copayment, or coinsurance.

+ Out-of-network air ambulance coverage is covered at 500 percent of the Medicare allowance. You may be held responsible for the amount billed in excess. Please see your student guide for additional information or contact our Customer Service team with questions.

Additional information

What is the deductible?

Your plan's deductible is the amount of money that you pay first, before your plan starts to pay. You'll see that many services, especially preventive care, are covered by the plan without you needing to meet the deductible. The individual deductible applies if you enroll without dependents. If you and one or more dependents enroll, the individual deductible applies for each member only until the family deductible has been met. There is no deductible when you use OSU Student Health Services.

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

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for covered medical expenses during the plan year. Once the out-of-pocket limit has been met, the plan will pay 100 percent of covered charges for the rest of that year. The individual out-of-pocket limit applies only if you enroll without dependents. If you and one or more dependents enroll, the individual out-of-pocket limit applies for each member only until the family out-of-pocket limit has been met. Be sure to check your student guide, as there are some charges, such as non-essential health benefits, penalties and balance billed amounts that do not count toward the out-of-pocket limit.

OSU Student Health Services expense and in-network provider expense apply together toward the out-of-pocket limit. Out-of-network provider expense applies to the out-of-network provider out-of-pocket limit.

Payments to providers

Payment to providers is based on the prevailing or contracted allowable fee for covered services. In-network providers accept the allowable fee as payment in full. Out-of-network providers are allowed to balance bill any remaining balance that your plan did not cover. Services of out-of-network providers could result in out-of-pocket expense in addition to the percentage indicated.

Preauthorization

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

Formulary: Oregon Drug List (ODL)

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

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

PacificSource Expanded (Preventive) No-cost Drug List

Your prescription benefit includes certain outpatient drugs as a preventive benefit at no deductible, $0/copay. This includes specific drugs that are taken regularly to prevent a disease or to keep a specific disease or condition from progressing. You can get a list of covered preventive drugs by contacting our Customer Service team or visit PacificSource.com and select Find a Drug.

Affordable Care Act Standard Preventive No-cost Drug List

Your prescription benefit includes preventive care drugs at no cost to you and are not subject to a deductible or MAC penalties. This benefit includes some drugs required by the Affordable Care Act, including tobacco cessation drugs. These drugs are identified on the drug list as Tier 0.

Contraceptives

Contraceptives approved by the Food and Drug Administration (FDA) are covered as recommended by the USPSTF, HRSA, and CDC. Any deductibles, copayments, and/or coinsurance amounts are waived if a generic is filled. When no generic exists, brand name contraceptives may be covered at no cost. If your provider prescribes a non-formulary contraceptive due to medical necessity, it may be subject to preauthorization for coverage at no charge.

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

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

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays	Tier 4 Member Pays
In-network Retail Pharmacy				
Up to a 30 day supply:	No deductible, the lesser of $30 or 50%	No deductible, the lesser of $100 or 50%	No deductible, the lesser of $200 or 50%	No deductible, the lesser of $200 or 50%
In-network Mail Order Pharmacy				

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays	Tier 4 Member Pays
Up to a 90 day supply:	No deductible, the lesser of $90 or 50%	No deductible, the lesser of $300 or 50%	No deductible, the lesser of $600 or 50%	No deductible, the lesser of $600 or 50%
Compound Drugs**				
Up to a 30 day supply:	No deductible, the lesser of $200 or 50%			
Out-of-network Pharmacy				
30 day max fill, no more than three fills allowed per year:	Not covered except for 5 day emergency supply			

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

Specialty Medications must be filled through an in-network specialty pharmacy and are limited to a 30 day supply.

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

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

The following shows the vision benefits (including vision exams, lenses, and frames when applicable) available under this plan when performed or prescribed by a licensed ophthalmologist or licensed optometrist. Coverage for pediatric services will end on the last day of the month in which the member turns 19. Medical deductible, copayment, and/or coinsurance for covered charges apply to the medical plan's out-of-pocket limit.

If charges for a service or supply are less than the amount allowed, the benefit will be equal to the actual charge. If charges for a service or supply are greater than the amount allowed, the expense above the allowed amount is the member's responsibility and will not apply toward the member's medical deductible or out-of-pocket limit.

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Members Age 18 and Younger		
Eye exam	No deductible, 0%	After deductible, 40%
Vision hardware	No deductible, 0% for one pair per year	After deductible, 40% for one pair per year
Members Age 19 and Older		
Eye exam	No deductible, $10	No deductible, 0% up to $25 then 100%
Single vision lenses	No deductible, $40	No deductible, 0% up to $10 then 100%
Bifocal lenses	No deductible, $40	No deductible, 0% up to $25 then 100%
Trifocal lenses	No deductible, $40	No deductible, 0% up to $55 then 100%
Lenticular lenses	No deductible, $40	No deductible, 0% up to $55 then 100%
Progressive lenses	No deductible, $105	No deductible, 0% up to $25 then 100%
Frames	No deductible, 0% up to $75 then 100%	
Contact Lenses (in lieu of glasses)		
Contact lenses	No deductible, 0% up to $131 then 100%	

Benefit Limitations: members age 18 and younger

- One vision exam every contract year.
- Vision hardware includes one pair of glasses (lenses and frames) or contacts (lenses and fitting) once per contract year.

Benefit Limitations: members age 19 and older

- One vision exam every contract year.
- Lenses: One pair every contract year.
- Frames: Once every contract year.
- Contact lenses: Once every contract year.

Exclusions

- Charges for services or supplies covered in whole or in part under any medical or vision benefits provided by an employer.
- Expenses covered under any workers' compensation law.
- Eye exams required as a condition of an academic program, employment, required by a labor agreement or government body.
- Medical or surgical treatment of the eye.
- Nonprescription lenses.
- Plano contact lenses.
- Replacement of lost, stolen, or broken lenses or frames.
- Services or supplies not listed as covered expenses.
- Services or supplies received before this plan's coverage begins or after it ends.
- Special procedures, such as orthoptics or vision training.
- Visual analysis that does not include refraction.

Important information about your vision benefits

Your plan includes coverage for vision services. To make the most of those benefits, it's important to keep in mind the following:

In-network Providers: PacificSource is able to add value to your vision benefits by contracting with a network of vision providers. Those providers offer vision services at discounted rates, which are passed on to you in your benefits.

Paying for Services: Our provider contracts require in-network providers to bill us directly whenever you receive covered services and supplies. Providers will verify your vision benefits.

In-network providers should not ask you to pay the full cost in advance. They may only collect your share of the expense up front, such as copayments and amounts over your plan's maximum benefit. If you are asked to pay the entire amount in advance, tell the provider you understand they have a

contract with PacificSource and they should bill PacificSource directly.

Sales and Special Promotions (sales and promotions are not considered insurance): Vision retailers often use coupons and promotions to bring in new business, such as free eye exams, two-for-one glasses, or free lenses with purchase of frames. Because in-network providers already discount their services through their contract with PacificSource, your plan's in-network benefits cannot be combined with any other discounts or coupons. You can use your plan's in-network benefits, or you can use your plan's out-of-network benefits to take advantage of a sale or coupon offer.

If you do take advantage of a special offer, the in-network provider may treat you as an uninsured customer and require full payment in advance. You can then send the claim to PacificSource yourself, and we will reimburse you according to your plan's out-of-network benefits.

Provider Network: Advantage Dental

This plan covers the following services when performed by a provider to the extent that they are operating within the scope of their license as required under law in the state of issuance, and when determined to be necessary, usual, and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury, including masticatory function (chewing of food).

In-network dentists contract with PacificSource to furnish dental services and supplies for a set fee. That fee is called the contracted allowable fee. In-network providers agree not to collect more than the contracted allowable fee. When you use an in-network provider, you will pay only the in-network provider amounts below. If you choose not to use an in-network provider, or don't have access to one, reimbursement is based on the allowable fee. If charges exceed the allowable fee, the excess charges are your responsibility.

This plan covers dental services for members age 18 and younger, as required under the Affordable Care Act. Coverage for pediatric services will end on the last day of the month in which the member turns 19.

Deductible Per Contract Year	In-network	Out-of-network
Individual/Family	See your Medical Schedule of Benefits	See your Medical Schedule of Benefits
Out-of-Pocket Limit Per Contract Year	**In-network**	**Out-of-network**
Individual/Family	See your Medical Schedule of Benefits	See your Medical Schedule of Benefits

Note: Even though you may have the same benefit for in-network and out-of-network, your actual costs for services provided out-of-network may exceed this plan's out-of-pocket limit for out-of-network services. In addition, out-of-network providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company, and that amount does not count toward your out-of-pocket limit. Please see allowable fee in the Definitions section of your student guide.

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

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Class I Services (Covered for enrolled individuals age 18 and younger.)		
Examinations	No deductible, 0%	After deductible, 30%
Bitewing films, full mouth x-rays, cone beam x-rays, and/or panorex	No deductible, 0%	After deductible, 30%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Dental cleaning (prophylaxis and periodontal maintenance)	No deductible, 0%	After deductible, 30%
Fluoride (topical or varnish applications)	No deductible, 0%	After deductible, 30%
Sealants	No deductible, 0%	After deductible, 30%
Space maintainers	No deductible, 0%	After deductible, 30%
Athletic mouth guards	No deductible, 0%	After deductible, 30%
Brush biopsies	No deductible, 0%	After deductible, 30%
Class II Services (Covered for enrolled individuals age 18 and younger.)		
Fillings	No deductible, 30%	After deductible, 50%
Simple extractions	No deductible, 30%	After deductible, 50%
Periodontal scaling and root planing	No deductible, 30%	After deductible, 50%
Full mouth debridement	No deductible, 30%	After deductible, 50%
Class III Services (Covered for enrolled individuals age 18 and younger.)		
Complicated oral surgery	No deductible, 50%	After deductible, 50%
Pulp capping	No deductible, 50%	After deductible, 50%
Pulpotomy	No deductible, 50%	After deductible, 50%
Root canal therapy	No deductible, 50%	After deductible, 50%
Periodontal surgery	No deductible, 50%	After deductible, 50%
Tooth desensitization	No deductible, 50%	After deductible, 50%
Crowns	No deductible, 50%	After deductible, 50%
Dentures	No deductible, 50%	After deductible, 50%
Bridges	No deductible, 50%	After deductible, 50%
Replacement of existing prosthetic device	No deductible, 50%	After deductible, 50%
Implants	No deductible, 50%	After deductible, 50%
Orthodontia for medically necessary reasons for enrolled individual's age 18 and younger	No deductible, 50%	After deductible, 50%
Miscellaneous (Covered for enrolled individuals age 18 and younger.)		
Emergency office visit	No deductible, 50%	After deductible, 50%

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

Additional information

What is the deductible?

Your plan's deductible is the amount of money that you pay first, before your plan starts to pay. You'll see that some services are covered by the plan without you needing to meet the deductible. Your medical and dental deductible are combined. See your Medical Schedule of Benefits for your deductible amount. The individual deductible applies if you enroll without dependents. If you and one or more dependents enroll, the individual deductible applies for each member only until the family deductible has been met.

Deductible expense applies only to out-of-network providers.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for approved medical and pediatric dental expenses during the contract year. Once the out-of-pocket limit has been met, the plan will pay 100 percent of allowed amounts for covered services for the rest of that contract year. Non-essential health benefits, penalties, and balance billed amounts over the allowable fee do not accumulate toward the out-of-pocket limit.

Your medical and dental out-of-pocket are combined. See your Medical Schedule of Benefits for your out-of-pocket limit.

Predetermination

Coverage of certain dental services and surgical procedures are by review. When a planned dental service exceeds $300, PacificSource recommends a predetermination to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Predeterminations are not a guarantee of payment and do not change your out-of-pocket expense.

BECOMING COVERED

ELIGIBILITY

Requirements for Enrollment

See the Policyholder for eligibility requirements to determine if you and your family members are eligible to enroll in this plan. No family or household members other than those determined eligible by the Policyholder can enroll under this plan.

The Policyholder will use its established eligibility criteria and initial enrollment period for this plan, which will be provided to PacificSource. The Policyholder will only send PacificSource enrollment information for those Students and family members eligible to enroll on this plan.

International Students registered for a minimum of one on-campus credit at Oregon State University are required to enroll in the OSU Student Health Insurance Plan. All eligible Students are automatically enrolled and charged for the OSU Student Health Insurance Plan. Eligible dependents of those enrolled in the plan may participate on a voluntary basis.

You must not be entitled to benefits under Medicare Part A or B nor be enrolled in a Medicare Choice or Advantage plan.

Family Members

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

- Your legal Spouse or your Domestic Partner.
- Your, your Spouse's, or your Domestic Partner's Dependent Children under age 26 regardless of the child's place of residence, marital status, or financial dependence on you.
- Your, your Spouse's, or your Domestic Partner's unmarried Dependent Children age 26 or over who are mentally or physically disabled. To qualify as dependents, they must have been continuously unable to support themselves since turning age 26 because of a mental or physical disability. PacificSource requires documentation of the disability from the child's Provider, and will review the case before determining eligibility for coverage.

No family or household members other than those listed above are eligible to enroll under your coverage.

ENROLLING NEW FAMILY MEMBERS

To enroll new family members that become eligible for coverage after your effective date, complete and submit an enrollment change as instructed by your school. PacificSource may ask for legal documentation to confirm the status of the Dependent.

Requests for enrollment of a new family member due to a qualifying event must be received as instructed by your school within 31 days of the qualifying event. A claim for maternity care is not considered notification for the purpose of enrolling a newborn child.

If additional premium is required, it is charged from the date of the qualifying event. Premium for the first 31 days of coverage and any additional premium is due 31 days from the date billing for the required premium is received by you. PacificSource may ask for legal documentation to confirm the status of the dependent.

Qualifying events

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

- Birth of a newborn Dependent Child;
- Placement of an adopted or foster child;
- Marriage or domestic partnership;
- Guardianship; or
- Qualified medical child support order (QMCSO).

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

ENROLLING AFTER THE INITIAL ENROLLMENT PERIOD

Special Enrollment Periods

You and/or your family members may decline coverage during your initial enrollment period. To do so, you must submit a completed qualifying waiver provided by your school before your school's required deadline. You and/or your family members may enroll in this plan later if you qualify under the Special Enrollment Rules below.

- Special Enrollment Rule #1

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

- Special Enrollment Rule #2

  If you acquire new family members due to a qualifying event, you may be able to enroll your newly eligible family members at that time. For more information, see Enrolling New Family Members section.

- Special Enrollment Rule #3

  If you or your family members become eligible for a premium assistance subsidy under Medicaid or a state Children's Health Insurance Program (CHIP), you may be able to enroll yourself and/or your family members at that time. To do so, you must request enrollment within 60 days of the date you and/or your family members become eligible for such assistance. Coverage will begin on the first day of the month after becoming eligible for such assistance.

Medical Leave of Absence

Students with a College/University approved medical leave can have up to one term extension of benefits per academic career. For example, if the Student leaves mid-Fall, coverage can be extended through the Winter term only.

EFFECTIVE DATE OF COVERAGE

Coverage for each Student who enrolls is effective on the first day of the period in which you are eligible and premium has been paid. See Policyholder for premium payment requirements for you and your family members to enroll in this plan.

International and INTO OSU Students- Fall term coverage runs from September 11, 2021 through December 18, 2021. Waiver or Enrollment deadline is October 15, 2021.

International and INTO OSU Students- Winter term coverage runs from December 19, 2021 through March 19, 2022. Waiver or Enrollment deadline is January 14, 2022.

International and INTO OSU Students- Spring/Summer term coverage runs from March 20, 2022 through September 10, 2022. Waiver or enrollment deadline is April 15, 2022.

International and INTO OSU Students- Summer only coverage runs from June 12, 2022 through September 10, 2022. Waiver or enrollment deadline is July 8, 2022.

GENERAL PLAN PROVISIONS

This plan is renewable at the option of the Policyholder. In the event this plan is terminated, coverage will end at 11:59:59 p.m. local time on the date of termination.

Time limit on certain defenses. After two years from the date of issue of this plan, no misstatements, except fraudulent misstatements, made by the member during enrollment for such plan shall be used to void this plan or to deny a claim for loss incurred or disability, commencing after the expiration of such two year period.

No claim for loss incurred or disability, commencing after two years from the date of issue of this plan, shall be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of coverage of this plan.

Representations not warranties. In the absence of fraud, all statements made by the Policyholder or Member will be considered representations and not warranties. No statement made for the purpose of effecting insurance will void the insurance or reduce benefits unless it is contained in a written document signed by the Policyholder or the Member, a copy of which has been furnished to that person.

Members have the sole right to choose their healthcare Providers. PacificSource is not liable for quality of healthcare. PacificSource is not responsible for the quality of care a person receives since all those who provide care do so as independent contractors. PacificSource cannot be held liable for any claim for damages or injuries you experience while receiving health services or supplies.

Recovery of Overpayment. If a benefit payment is made by PacificSource, to or on behalf of a Member, which exceeds the benefit amount such Member is entitled to receive in accordance with the terms of this plan, PacificSource has the right to require the return of the overpayment on request and to reduce, by the amount of the overpayment, any future benefit payment made to or on behalf of the Member that is covered under this plan. Such right does not affect any other right of recovery that PacificSource may have with respect to such overpayment.

Disclosure of Protected Health Information (PHI). PacificSource may, at the request of the Policyholder, disclose PHI or electronic PHI (ePHI) relating to the Members on this plan to the Policyholder to allow the Policyholder to perform Plan Administration functions as that term is defined by Health Insurance Portability and Accountability Act (HIPAA).

Only employees or agents of the Policyholder who may receive or have access to PHI are those who require the information in order to resolve claims, referral, or other benefit issues on behalf of the Members; or those who require it to resolve enrollment and payment issues on behalf of this plan; and only those for whom such work is part of their job description. The Policyholder shall have a process in place prior to the receipt of any PHI for the sole purpose of investigating and resolving any suspected incidents where PHI has been improperly accessed, used, or disclosed by the Policyholder’s employee or agent.

The Policyholder certifies and agrees to the following:

- The Policyholder has sufficient administrative, physical and technical safeguards in place to protect the privacy of the PHI from any unauthorized use or disclosure in compliance with all applicable state and federal laws;
- No PHI shall be used or disclosed other than as permitted or required by this plan or as required by law;
- Ensure that any agent agrees to the same restrictions and conditions that apply to the Policyholder with respect to such PHI;
- No PHI shall be used in employment-related actions or in connection with any other benefit or employee benefit plan of the Policyholder;
- The Policyholder has a written policy for investigating and appropriately reporting any security incidents that relate to PHI to PacificSource;
- The Policyholder shall make available PHI in accordance with HIPAA;
- The Policyholder shall make available PHI for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- The Policyholder shall make available the information required to provide an accounting of disclosure in accordance with HIPAA;
- The Policyholder shall make its internal practices, books, and records relating to the use and disclosure of PHI received from this plan available to the Secretary for purposes of determining compliance by this plan with the provisions of HIPAA;
- That, if feasible, Policyholder shall return or destroy all PHI received from this plan that the Policyholder still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- The Policyholder shall ensure that the adequate separation between employees who need access to PHI to perform their assigned job functions and those who do not is established and enforced.

Rescissions. PacificSource may Rescind a Member's coverage if the Member, or the person seeking coverage on their behalf, performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of a material fact. The Member will be given 30 days prior written notice of any Rescission of coverage, and offered an opportunity to Appeal that decision.

TERM AND TERMINATION – COVERAGE

- **Students.** Insurance for a Student will end on the first of the following events:
  - the date this plan terminates;
  - the last day for which any required premium has been paid;
  - the date on which the Student withdraws from the school because of entering the armed forces of any country. Premiums will be refunded, on a pro-rata basis, when application is made within 30 days from withdrawal;
  - the date an international Student withdraws from the school or the day they receive an approved medical withdrawal from the school; or
  - the date the Student is no longer in an eligible Student classification.

If withdrawal from school is for reasons other than entering the armed forces, no premium refund will be made. Students will be covered for the term for which they are enrolled and for which premium has been paid.

- **Dependents.** Insurance for a Student's family member will end when insurance for the Student ends. Coverage will end prior to that time in the event of one of the following:
  - the date the Student fails to pay any required premium;
  - the date family members are no longer eligible under this plan;
  - for a Dependent Child, on the last day of the month of the child's 26th birthday;
  - for a Spouse, the date the marriage ends in divorce or annulment; or
  - for a Domestic Partner, the date of termination of the domestic partnership (the Student must provide written notice of such termination to PacificSource).

Any Student who requests to terminate coverage prior to the end of the Contract Year shown on the Medical Schedule of Benefits may be terminated on the last day of the month prior to PacificSource receiving the request for termination and will not be eligible for a refund of premium.

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

UNDERSTANDING HOW YOUR BENEFITS ARE PAID

This section of the Student guide contains information to help you understand the benefits of the plan and how certain aspects of your plan work, including Deductibles, Copayments, Coinsurance, and annual out-of-pocket limit amounts. Many terms used in this Student guide are defined in the Definitions section of this Student guide. You can identify such terms by their being capitalized.

CONTRACT YEAR

A contract year is a 12 month period beginning on the date the insurance contract is issued or the anniversary of the date the insurance contract was issued. Many benefits and provisions in this plan are calculated on a Contract Year basis. Each year these provisions renew and may change, and you must satisfy the new or revised amounts for that year. For your Contract Year, please see the Medical Schedule of Benefits.

YOUR DEDUCTIBLE

Except for certain services that do not require satisfaction of the Deductible, PacificSource will only begin to pay benefits for Covered Services once a Member satisfies the Deductible by incurring a specific amount of expenses during the Contract Year. The amount that accrues to the Deductible is the Allowable Fee.

Your expenses for the following do not count towards the Deductible and will be your responsibility:

- Charges over the Out-of-network Allowable Fee for services of Out-of-network Providers;
- Charges for non-Covered Services; and
- Charges for any Coinsurance or Copayments.

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

YOUR COPAYMENT

This plan may include a Copayment on certain services or supplies each time you receive a specified service or supply. Copayments are fixed dollar amounts. Any Copayment required will be the lesser

of the fixed dollar amount or the Allowable Fee for the service or supply. The Provider will collect any Copayment.

YOUR COINSURANCE

After a Member has satisfied the individual Deductible or the family Deductible, if any applies, this plan may include a Coinsurance payment on certain services or supplies each time the Member receives a specified service or supply until the Member meets any applicable out-of-pocket limit. Coinsurance is a percentage of the Allowable Fee. Any Coinsurance required will be based on the lesser of the billed charges or the Allowable Fee. The Provider will bill you and collect any Coinsurance payment.

Please note that Out-of-network Providers can bill you for amounts that exceed the Out-of-network Allowable Fee, in addition to the Coinsurance amount.

YOUR ANNUAL OUT-OF-POCKET LIMIT

This plan has an out-of-pocket limit provision to protect you from excessive healthcare expenses. The Schedule of Benefits shows your plan's annual out-of-pocket limits for In-network and/or Out-of-network Providers. If you incur Covered Services over those amounts, this plan will pay 100 percent of the Allowable Fee for eligible charges for the remainder of the Contract Year.

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

- Charges over the Out-of-network Allowable Fee for services of Out-of-network Providers;
- Charges for non-Covered Services;
- Incurred charges that exceed amounts allowed under this plan; and
- Charges for the difference in cost between brand name medication and generic equivalent as explained under Prescription Drug List Tiers section.

ESSENTIAL HEALTH BENEFITS

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

Understanding Medical Necessity

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

Be careful – just because a treatment is prescribed by a healthcare professional does not mean it is Medically Necessary under the terms of this plan. This plan provides medical coverage only when such care is Medically Necessary to treat an Illness or Injury or the service qualifies as Preventive Care. All treatment is subject to review for Medical Necessity. Review of treatment may involve preauthorization, concurrent review of the continuation of treatment, post-treatment review, or any combination of these. A second opinion (at no cost to the Member when requested by PacificSource) may be required for a Medical Necessity determination.

Some Medically Necessary services are not Covered Services. Medically Necessary services and supplies that are specifically excluded from coverage under this plan can be found in the Benefit Exclusions section.

If you ever have a question about your plan benefits, contact our Customer Service team.

Understanding Experimental, Investigational, or Unproven Services

This plan does not cover services or treatments that are Experimental, Investigational, or Unproven.

To ensure you receive the highest quality care at the lowest possible cost, we review new and emerging technologies and medications on a regular basis. Our internal committees make decisions about PacificSource coverage of these methods and medications based on literature reviews, standards of care and coverage, consultations, and review of evidence-based criteria. You and your Provider may request information regarding our criteria for determining these services or treatments.

Eligible Providers

This plan provides benefits only for Covered Services and supplies rendered by a Provider, Hospital, Specialized Treatment Facility, Durable Medical Equipment Supplier, or other licensed healthcare Providers. The services or supplies provided by individuals or companies that are not specified as eligible Providers are not eligible for reimbursement under the benefits of this plan. To be eligible, the Providers must be practicing within the scope of their licenses.

Contracting for Outside Services

Members may freely contract to obtain any healthcare services outside the plan on any terms the Members choose.

COVERED SERVICES

This section of the Student guide contains information about the benefits provided under the plan. The following list of benefits is exhaustive. You are responsible for all charges for services that are not a Covered Service. With the exception of Preventive Care services and professional services, the benefits are listed alphabetically for your convenience.

As described in the prior section, these services and supplies may require you to satisfy a Deductible, make a Copayment, and/or pay Coinsurance. They may be subject to additional limitations or maximum dollar amounts (maximum dollar amounts do not apply to Essential Health Benefits). For an expense to be eligible for payment, you must be a Member of this plan on the date the expense is incurred and eligible Providers practicing within the scope of their licenses must render the services. A treatment or service may be Medically Necessary, yet not be a Covered Service. For more information about exclusions, see the Benefit Exclusions section.

PREVENTIVE CARE SERVICES

This plan covers Preventive Care services in accordance with the age limits and frequency guidelines according to the recommendations of the United States Preventive Services Task Force (USPSTF) – the A and B list of preventive services, the Health Resources and Services Administration (HRSA), and by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. If one of these bodies adopts a new or revised recommendation, this plan has up to one year before coverage of the related services must be available and effective under this plan.
For a list of the services that fall within this benefit, please visit the USPSTF website at uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations or the HRSA website at hrsa.gov/womens-guidelines-2016 (note that these websites may change). For Members who do not have Internet access or have additional questions, please contact our Customer Service team at the number shown at the beginning of this Student guide for a complete description of the preventive services lists. Below are some of the services that fall within this benefit. In addition to the Affordable Care Act (ACA) required benefits as explained above, the list also includes state mandated benefits.

Colorectal Cancer Screening

This plan covers examinations and laboratory tests for a preventive colonoscopy, including removal of polyps during the screening procedure if a positive result on any fecal test assigned either a grade A or B, a fecal occult blood test, a flexible sigmoidoscopy, or a double contrast barium enema for Members age 50 and over or who are under age 50 and at high risk for colon cancer. For more information on Essential Health Benefit Preventive Care drugs coverage, see the Prescription Drugs section. A colonoscopy that is not required to be covered as preventive under ACA, or is performed for the evaluation or treatment of a known medical condition, is paid at no cost share when provided by an In-network Provider, unless this plan qualifies for an HSA. For HSA qualified plans, nonpreventive colonoscopies will be covered under the diagnostic benefit and is subject to cost sharing.

Immunizations

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

Preventive Physicals

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

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

Prostate Cancer Screening

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

Tobacco Cessation Program Services

This plan covers Tobacco Cessation Program services when provided by an In-network Provider.

Well Baby/Well Child Care

This plan covers well baby/well child care examinations. Only laboratory tests and other routine screening procedures related to the well baby/well child care exam are covered by this benefit. Diagnostic and therapeutic radiology and lab work outside the scope of the preventive physical will be subject to the standard cost sharing.

- Benefits are limited as follows:
  - At birth: One standard in-Hospital exam
  - Ages 0-2: 12 additional exams during the first 36 months of life
  - Ages 3-21: One exam per Contract Year

Well Woman Care

This plan covers Women's Healthcare Services for Members as required by ACA and when performed by a Provider or Women's Healthcare Provider. Services include, but not limited to,

preventive mammograms including 3D, preventive gynecological exams, pelvic exam, pap smears, breast exams, and the maternity related services required to be covered as preventive under the ACA. For diagnostic mammograms, see the Diagnostic and Therapeutic Radiology/Laboratory and Dialysis – (Non-Advanced) section.

Members have the right to seek care from obstetricians and gynecologists for Covered Services without preapproval or preauthorization.

PROFESSIONAL SERVICES

Audiological Tests

This plan covers audiological (hearing) tests.

Biofeedback

This plan covers biofeedback services to treat migraine headaches or urinary incontinence when provided by an eligible Provider.

- Benefits are limited as follows: Lifetime Maximum of 10 sessions.

Cardiac Rehabilitation

This plan covers Cardiac Rehabilitation.

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

Child Abuse Medical Assessments

This plan covers child abuse medical assessments which includes the taking of a thorough medical history, a complete physical examination and interview by or under the direction of a Provider trained in the evaluation, diagnosis, and treatment of child abuse. Child abuse medical assessments are covered when performed at a community assessment center. Community assessment center means a neutral, child-sensitive community-based facility or service Provider to which a child from the community may be referred to receive a thorough child abuse medical assessment for the purpose of determining whether the child has been abused or neglected.

Chiropractic Manipulation/Spinal Manipulation and Acupuncture Care

This plan covers services for chiropractic manipulation/spinal manipulation and acupuncture care.

Benefits are limited as follows: A combined benefit for all chiropractic manipulation/spinal manipulation and acupuncture care is limited to 18 visits per Contract Year.

Clinical Trials (Approved)

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

Cosmetic or Reconstructive Surgery

This plan provides cosmetic or reconstructive services in the following situations:

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

Some cosmetic or reconstructive surgeries require preauthorization. You can search for procedures and services that require preauthorization on our website at Authgrid.PacificSource.com (select Commercial for the line of business).

Cosmetic or reconstructive surgery is provided for one attempt and must take place within 18 months after the Injury, surgery, scar, or defect first occurred unless determined otherwise through Medical Necessity evaluation.

Craniofacial Anomalies

This plan covers dental and orthodontic services for the treatment of craniofacial anomalies when Medically Necessary to restore function. Coverage includes, but not limited to, physical disorders identifiable at birth that affect the bony structure of the face or head, such as a cleft palate, cleft lip, craniosynostosis, craniofacial microsomia and Treacher Collins syndrome. Coverage is limited to the least costly clinically appropriate treatment. Cosmetic procedures and procedures to improve on the normal range of functions are not covered.

Dietary or Nutritional Counseling

This plan covers services for diabetic education and management of anorexia nervosa or bulimia nervosa if provided by a qualified Provider or as required under ACA for obesity as determined by Medical Necessity evaluation.

Foot Care

This plan covers routine foot care for Members with diabetes mellitus.

Gender Affirmation

This plan covers Medically Necessary gender affirming surgery and related procedures, including hormone therapy, and requires preauthorization.

Genetic Counseling

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

Injectable Drugs and Biologicals

This plan covers injectable drugs and biologicals when administered by a Provider and Medically Necessary for diagnosis or treatment of Illness or Injury. For information about drugs or biologicals that can be self-administered or are dispensed to a Member, see the Prescription Drugs section. This benefit does not include immunizations (see the Preventive Care Services section), drugs, or biologicals that can be self-administered or are dispensed to a Member.

Injury of the Jaw or Natural Teeth

This plan covers the services of a Provider to treat Injury of the jaw or natural teeth. Except for the initial examination, such services require preauthorization.

Newborn Nurse Home Visiting Services

This plan covers newborn nurse home visiting services for a newborn child up to the age of six months.

Office Visits and Urgent Care Visits

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

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

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

Pediatric Dental Care Requiring General Anesthesia

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

- Benefits are limited as follows: One visit per Contract Year and is subject to preauthorization.

Surgery

This plan covers surgery and other outpatient services performed in a Providers office or an Ambulatory Surgical Center. Some surgeries require preauthorization. You can search for procedures and services that require preauthorization on our website at Authgrid.PacificSource.com (select Commercial for the line of business).

Telemedicine

This plan covers Medically Necessary telemedical health services when provided by a healthcare professional.

AMBULANCE SERVICES

This plan covers services of a state certified ground or air ambulance to the nearest facility capable of treating the condition, when other forms of transportation will endanger your health. There is no coverage for services that are for personal or convenience purposes. Air ambulance service is covered only when ground transportation is medically or physically inappropriate. Reimbursement to out-of-network air ambulance services are based on 500 percent of the Medicare allowance. In some cases, the Medicare allowance may be significantly lower than the Provider's billed amount. The Provider may hold you responsible for the amount they bill in excess of the Medicare allowance, as well as applicable cost sharing. Non-emergency ground or air ambulance between facilities requires preauthorization.

BLOOD TRANSFUSIONS

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

BREAST PROSTHESES

This plan covers removal, repair, or replaces of breast prostheses due to a contracture or rupture, but only when the original prosthesis was for a Medically Necessary Mastectomy. Preauthorization by PacificSource is required, and eligibility for benefits is subject to the following criteria:

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

COCHLEAR IMPLANTS

This plan covers single or bilateral cochlear implants when Medically Necessary, including programming and reprogramming.

CONTRACEPTIVES AND CONTRACEPTIVE DEVICES/FAMILY PLANNING

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

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

This plan covers tubal ligation and vasectomy procedures.

DIABETIC EQUIPMENT, SUPPLIES, AND TRAINING

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

- Some supplies may require preauthorization. You can search for procedures and services that require preauthorization on our website at Authgrid.PacificSource.com (select Commercial for the line of business).
- Diabetic supplies other than insulin and syringes (such as lancets, test strips, and glucostix).
- Insulin pumps.
- Diabetic insulin and syringes are covered under your Prescription Drug benefit. Formulary lancets and test strips are also available under your Prescription Drug benefit in lieu of those covered supplies under the medical plan.
- Outpatient and self-management training and education for the treatment of diabetes. The training must be provided by a licensed healthcare professional with expertise in diabetes.
- Medically Necessary Telemedicine, via two-way electronic communication, provided in connection with the treatment of diabetes.

DIAGNOSTIC IMAGING – ADVANCED

This plan covers Medically Necessary advanced diagnostic imaging for the diagnosis of Illness or Injury. For the purposes of this benefit, advanced diagnostic imaging includes CT scans, MRIs, PET scans, CATH labs, and nuclear cardiology studies. In all situations and settings (excluding emergency room services), benefits require preauthorization and are subject to the Deductibles, Copayments, and/or Coinsurance stated in your Medical Schedule of Benefits for Outpatient Services – Diagnostic Imaging – Advanced. Please note that the Copayment for these services is per test. For

example, if separate MRIs are performed on different regions of the back, there will be a Copayment charged for each region imaged.

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

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

A mammogram related to the ongoing evaluation or treatment of a medical condition is not considered to be a preventive service and is paid under this benefit.

Please see the Medical Schedule of Benefits for cost sharing information on benefits (other than colonoscopy which is at no cost share for In-network Provider) that fall under this category.

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

Absent a Contracted Allowable Fee amount based on the Medicare allowable, benefits for Members who are receiving renal dialysis are limited to 125 percent of the current Medicare allowable amount for In-network and Out-of-network Providers. In all situations and settings, benefits are subject to the Deductibles, Copayments, and/or Coinsurance stated in your Medical Schedule of Benefits for Outpatient Services – Diagnostic and therapeutic radiology/lab and dialysis.

DURABLE MEDICAL EQUIPMENT

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

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

- Benefits are limited as follows:
  - The cost of Durable Medical Equipment that is not considered an Essential Health Benefit is covered up to $5,000 per Contract Year. Examples of Essential Health Benefits are prosthetics and Orthotic Devices, oxygen and oxygen supplies, diabetic supplies, wheelchairs, breast pumps, and medical foods for the treatment of inborn errors of metabolism.
  - Benefits will be paid toward either the purchase or the rental of the equipment for the period needed, whichever is less. Repair or replacement of equipment is also covered when necessary, subject to all conditions and limitations of the plan. If the cost of the purchase, rental, repair, or replacement is over $1,000, preauthorization by PacificSource is required.
  - Only expenses for Durable Medical Equipment, or prosthetic and Orthotic Devices that are provided by a PacificSource contracted Provider or a Provider that satisfies the criteria of the Medicare fee schedule for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and Other Items and Services are eligible for reimbursement.
  - Medically Necessary treatment for sleep apnea and other sleeping disorders is covered when preauthorized by PacificSource. Coverage of oral devices includes charges for consultation, fitting, adjustment, follow-up care, and the appliance. The appliance must be prescribed by a

Provider specializing in evaluation and treatment of obstructive sleep apnea, and the condition must meet criteria for obstructive sleep apnea.

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

ELEMENTAL ENTERAL FORMULA

This plan covers Medically Necessary nonprescription elemental enteral formula ordered by a Provider for home use to treat severe intestinal malabsorption disorder and the formula comprises a predominant or essential source of nutrition.

EMERGENCY ROOM – PROVIDER AND FACILITY

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

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

HOME HEALTH SERVICES

This plan covers Home Health Services, including home infusion services that cannot be self-administered, when provided by a licensed home health agency. Private duty nursing is not covered.

HOSPICE CARE SERVICES

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

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

- Benefits are limited as follows:
  - Hospice Care: The plan does not cover services of a primary caregiver such as a relative, friend, or private duty nurse. Care is provided for a terminally ill Member for an initial period of six months. An additional six months of care may be provided when determined Medically Necessary.
  - Respite care: Care is subject to a maximum of five consecutive days and to a Lifetime Maximum benefit of 30 days. The Member must be enrolled in a hospice program to be eligible for respite care benefits.

INFERTILITY DIAGNOSTIC SERVICES

This plan covers Infertility diagnostic services when Medically Necessary. Covered Services include office visits and diagnostic procedures related to the diagnosis of Infertility. For more information, see the Benefit Exclusions section.

This plan covers Infertility services when Medically Necessary. Office visits and diagnostic procedures related to the diagnosis of Infertility are Covered Services. Treatment of Infertility is not a Covered Service.

INPATIENT SERVICES

Hospital Services

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

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

Inpatient Habilitation

This plan covers inpatient Habilitation Services when Medically Necessary to help a person keep, learn, or improve skills and functioning for daily living. These services must be consistent with the condition being treated, and must be part of a written treatment program prescribed by a Provider and are subject to preauthorization and concurrent review by PacificSource.

- Benefits are limited as follows: Up to a maximum of 30 days per Contract Year subject to Medical Necessity unless Medically Necessary to treat a mental health diagnosis. Treatment for head or spinal cord injuries are covered when criteria for individual benefits are met.

Inpatient Rehabilitation

This plan covers inpatient Rehabilitation Services when Medically Necessary to keep, restore, or improve skills and function for daily living that have been lost or impaired due to Illness, Injury or disability.

- Benefits are limited as follows: Up to a maximum of 30 days per Contract Year subject to Medical Necessity unless Medically Necessary to treat a mental health diagnosis. Treatment for head or spinal cord injuries are covered when criteria for individual benefits are met. Recreation therapy is only covered as part of an inpatient admission.

Skilled Nursing Facilities and Convalescent Homes

This plan covers Medically Necessary Skilled Nursing Facilities and Convalescent Homes and are subject to admission notification and concurrent review.

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

MATERNITY SERVICES

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

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

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

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

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

This plan covers Medically Necessary crisis intervention, diagnosis, and treatment of mental health conditions and Substance Use Disorders the same as any other Illness. For more information on services not covered by your plan, see the Benefit Exclusions section.

Providers Eligible for Reimbursement

A Mental Health and/or Substance Use Disorder Healthcare Provider is eligible for reimbursement if:

- The Mental Health and/or Substance Use Disorder Healthcare Provider is authorized for reimbursement under the laws of your plan’s state of issuance; and
- The Mental Health and/or Substance Use Disorder Healthcare Provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities; and
- The patient is staying overnight at the Mental Health and/or Substance Use Disorder Healthcare Facility (see the Definitions section) and is involved in a structured program at least eight hours per day, seven days per week; or
- The Mental Health and/or Substance Use Disorder Healthcare Provider is providing a Covered Service under this plan.

Eligible Mental Health and/or Substance Use Disorder Healthcare Providers are:

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

Medical Necessity and Appropriateness of Treatment

- As with all medical treatment, mental health and Substance Use Disorders treatment is subject to review for Medical Necessity and/or appropriateness. Review of treatment may involve pre-service review, concurrent review of the continuation of treatment, post-treatment review, or a combination of these. PacificSource will notify the Member and Member's Provider when a treatment review is necessary to make a determination of Medical Necessity.
- Medication management by a Provider (such as a psychiatrist) does not require review.
- Treatment of Substance Use Disorders and related disorders is subject to placement criteria established by the American Society of Addiction Medicine, Third Edition (ASAM).

Mental Health Parity and Addiction Equity Act of 2008

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

OTHER COVERED SERVICES, SUPPLIES, AND TREATMENTS

Inborn Errors of Metabolism

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

Maxillofacial Prosthetic Services

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

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

Orthognathic (Jaw) Surgery

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

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

Sleep Studies

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

Traumatic Brain Injury

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

Wisdom Teeth

This plan covers medical expenses for services of a Provider for removal of one or more impacted wisdom teeth.

OUTPATIENT SERVICES

Applied Behavioral Analysis (ABA) for Autism, Asperger's or Pervasive Development Disorder

This plan covers ABA according to PacificSource's guidelines for Medical Necessity. Preauthorization and a treatment plan are required.

Outpatient Habilitation

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

- Benefits are limited as follows: Up to a combined maximum of 30 visits per Contract Year subject to review for Medical Necessity, unless Medically Necessary to treat a mental health diagnosis. Treatment of neurodevelopmental problems, and other problems associated with pervasive developmental disorders are covered when criteria for individual benefits are met.

Outpatient Rehabilitation

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

- Benefits are limited as follows: Limited to a maximum of 30 visits per Contract Year subject to review for Medical Necessity, unless Medically Necessary to treat a mental health diagnosis. Treatment of neurodevelopmental problems and other problems associated with pervasive

developmental disorders for which Rehabilitation Services would be appropriate may be considered for benefits when criteria for individual benefits are met.

Services for speech therapy are only covered 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.

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

PEDIATRIC DENTAL SERVICES

All services in this section are covered only for Members age 18 and younger.

Coverage for pediatric services will end on the last day of the month in which the Member turns 19. Frequency limits are as required under the Affordable Care Act (ACA).

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

- **Examinations (routine or other diagnostic exams)** are limited to two examinations per Contract Year. Separate charges for review of a proposed treatment plan or for diagnostic aids, such as study models and diagnostic lab tests (other than brush biopsies), are not covered. Problem focused examinations are covered.
- **Complete full mouth series of x-rays, a cone beam x-ray, or panorex** are limited to one complete full mouth series of x-rays, cone beam x-ray, or panorex in any 60 month period and further limited to one bitewing set in a six month period. When an accumulative charge for additional Periapical X-rays in a one year period matches that of a complete full mouth series of x-rays, no further benefits for Periapical X-rays, cone beam x-rays, complete full mouth series of x-rays, or panorex are available for the remainder of the year.
- **Dental cleaning (Prophylaxis and Periodontal Maintenance)** are limited to a combined total of two procedures per Contract Year. The limitation for dental cleaning applies to any combination of Prophylaxis and/or Periodontal Maintenance in the Contract Year. A separate charge for periodontal charting is not a Covered Service. Periodontal Maintenance is not covered when performed within three months of Periodontal Scaling and Root Planing and/or Curettage.
- **Fluoride (topical or varnish applications)** is limited to a combined total of four applications per Contract Year.
- **Application of sealants** are limited to one application in a 36 month period to permanent molars and bicuspids, except for visible evidence of clinical failure.
- **Space maintainers** are covered.
- **Athletic mouth guards** are limited to one per lifetime if the Member is still enrolled in secondary school.
- **Brush biopsies** used to aid in the diagnosis of oral cancer are covered.

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

- **Composite Resin or similar Restoration (fillings) in a posterior (back) tooth** are limited to the amount that would be paid for a corresponding Amalgam Restoration. PacificSource will pay for a filling on a tooth surface only once every 24 months, up to four surfaces per tooth.

- **Simple extractions of teeth** and other minor oral surgery procedures are covered.
- **Periodontal Scaling and Root Planing and/or Curettage** is limited to only one procedure per quadrant in any 24 month period. For the purpose of this limitation, eight or fewer teeth existing in one arch will be considered one quadrant.
- **Full mouth debridement** is limited to once every 24 months. This procedure is only covered if the teeth have not received a Prophylaxis in the prior 24 months and if an evaluation cannot be performed due to the obstruction by plaque and calculus on the teeth. This procedure is not covered if performed on the same date as a dental cleaning (Prophylaxis or Periodontal Maintenance).

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

- **Complicated oral surgery procedures**, such as the removal of impacted teeth, frenulectomy, and frenulosplasty are covered.
- **Pulp capping** is covered only when there is an exposure to the pulp. These are direct pulp caps. Coverage for indirect pulp caps are covered as part of the Restoration fee and are not covered as a separate charge.
- **Pulpotomy** is covered only for deciduous teeth.
- **Root canal therapy** is covered.
- **Periodontal surgery** is limited to procedures accompanied by a periodontal diagnosis and history of conservative (non-surgical) periodontal treatment.
- **Tooth desensitization** is covered as a separate procedure from other dental treatment.
- **General anesthesia** administered by a Provider in their office when used in conjunction with approved oral surgery procedures is covered.
- **Administration of nitrous oxide** is covered.
- **Oral pre-medication anesthesia for conscious sedation** is covered.
- **Crowns** and other cast or laboratory-processed Restorations are limited to the Restoration of any one tooth every 60 months. If a tooth can be restored with a material such as Amalgam or Composite Resin, covered charges are limited to the cost of Amalgam or non-laboratory Composite Resin Restoration even if another type of Restoration is selected by the patient and/or Provider.
- **Initial cast partial denture, full denture, immediate denture, or overdenture** are limited to the cost of a standard full or cast partial denture. Charges for denture adjustments and repairs are covered. Benefits for subsequent rebases and relines are provided only once every 12 months. Cast Restorations for partial denture Abutment teeth or for splinting purposes are not covered unless the tooth in and of itself requires a Cast Restoration.
- **Initial fixed bridges or removable cast partials** are covered.
- **Replacement of an existing Prosthetic Device** is covered only when the device being replaced is unserviceable, cannot be made serviceable, and has been in place for at least 60 months.
- **Crowns, onlays, bridges**. The completion date is the cementation date (seat date) regardless of the type of cement utilized.
- **Implants**. Surgical placement and removal of implants are limited to once per lifetime per tooth space. Benefits include final crown and implant Abutment over a single implant, final

implant-supported bridge Abutment, and implant Abutment or pontic. An alternative benefit per arch of a conventional full or partial denture for the final implant-supported full or partial denture Prosthetic Device is available.

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

PRESCRIPTION DRUGS

This plan covers certain prescription medications included on your Drug List. Please refer to PacificSource.com/find-a-drug for an up-to-date list of drugs and other information about your prescription benefit including quantity limits and preauthorization requirements. If you have any questions about your coverage, please contact our Customer Service team.

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

Prescription Drug List Tiers

PacificSource's Prescription Drug List (also known as formulary) includes drugs that are used to treat all medically recognized conditions that are not otherwise excluded by your benefits. All formulary drugs are placed on one of five tiers. Due to pricing fluctuations in the market a drug may be added, removed, or moved to a higher or lower tier. The lower the tier number the lower your cost will be. Tier 0 has no cost and Tier 4 has the highest cost. We will notify you prior to making any change that may impact your care.

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

Please see the Prescription Drug Schedule of Benefits for cost sharing information.

Drug Discount Programs

Some medications may qualify for third party Copayment assistance programs that could lower your out-of-pocket costs for those products. For any such medication where third party Copayment assistance is used, the Member shall not receive credit toward their Deductible or out-of-pocket limit for any Copayment or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

Mail Order Pharmacy

This plan includes mail order service for Prescription Drugs. Questions about mail order may be directed to our Customer Service team. A mail service order form is available on our website, PacificSource.com/members/individuals/prescription-drug-information.

Specialty Drugs

Specialty Drugs are designated with SP on the Drug List available on our website. Specialty Drugs often require special handling, storage, and instructions. PacificSource contracts with a Specialty Pharmacy for these high-cost medications and biotech drugs (oral and injectable). A pharmacist-led care team provides individual follow-up care and support to covered Members with prescriptions for Specialty Drugs by providing them strong clinical support, as well as the best overall value for these specific medications. The care team also provides comprehensive disease education and counseling, assesses patient health status, and offers a supportive environment for patient Inquiries.

Fills of Specialty Drugs are limited to a 30 day supply, require preauthorization, and must be filled through our exclusive network Specialty Pharmacies. More information is available on our website, PacificSource.com/members/individuals/prescription-drug-information/find-pharmacy.

No Duplication of Services

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

Diabetic Supplies

Refer to your Drug List, available on our website, to see which diabetic supplies are covered under your prescription benefit. Some diabetic supplies, such as glucose monitoring devices, may only be covered under your medical benefit. Diabetic testing supplies are subject to plan quantity limits. For more information, see the Diabetic Equipment, Supplies, and Training section.

Contraceptives

Contraceptives approved by the FDA are covered as required under state law and as recommended by the USPSTF, HRSA, and CDC. Any Deductibles, Copayments, and/or Coinsurance amounts are waived if a generic is filled. When no generic exists, brand name contraceptives may be covered at no cost. If your Provider prescribes a non-formulary contraceptive due to Medical Necessity, it may be subject to preauthorization for coverage at no charge.

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

Anticancer Medications

Orally administered and self-administered anticancer medications used to kill or slow the growth of cancerous cells are available when prescribed and may be subject to preauthorization. Please see the Prescription Drug Schedule of Benefits for cost sharing information.

Formulary Changes

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

Medication Synchronization

To ensure your medication is effective, it’s important to take it exactly as prescribed. This can be challenging if you take multiple medications that refill at different times and require many trips to the pharmacy. Through our medication synchronization program, your ongoing prescriptions can be coordinated so refills are ready at the same time. If you wish to have your medication refills synchronized, please ask your Provider or pharmacist to contact our Pharmacy Services team at

(844) 877-4803, or email pharmacy@pacificsource.com. We will work with your Providers to evaluate your options and develop your synchronization plan.

Prescription Limitations and Exclusions

- This plan only covers drugs prescribed by eligible Providers prescribing within the scope of their professional licenses. This plan does not cover the following:
  - Over-the-counter drugs or other drugs that federal law does not prohibit dispensing without a prescription. For related provisions, see the Contraceptives and Contraceptive Devices/Family Planning section. Select 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 prescription 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 may require preauthorization, please refer to the medical authorization grid on our website, Authgrid.PacificSource.com (select Commercial for the line of business).
  - Some immunizations may be covered under either your medical or pharmacy benefit. Vaccines covered under the pharmacy benefit include, but not limited to: influenza, hepatitis B, herpes zoster (shingles), and pneumococcal. Most other immunizations must be provided by your Provider under your medical benefit.
  - Some drugs and all devices to treat erectile or sexual dysfunction unless defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.
  - Vitamins, minerals, and dietary supplements except for prescription prenatal vitamins, fluoride products, and for drugs 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 Provider 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.
- Certain drugs have quantity limits (QL), which means we will generally not pay for quantities above posted limits. An up-to-date list of drugs requiring quantity limit exceptions along with all of our requirements is available on our website.
- For most prescriptions, you may refill your prescription only after 75 percent of the previous supply has been taken. This is calculated by the number of days that have elapsed since the previous fill and the days' supply entered by the pharmacy. PacificSource will not approve early refills, except under the following circumstances:
  - The request is for ophthalmic solutions or gels, refillable after 70 percent of the previous supply has been taken.
  - The Member will be on vacation in a location that does not allow for reasonable access to a network pharmacy for subsequent refills.

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

Formulary Exception and Coverage Determination Process

Requests for formulary exceptions can be made by the Member or Provider by contacting our Pharmacy Services team. Standard exception requests are determined within 72 hours, expedited requests are determined within 24 hours following receipt of the request. Formulary exceptions and coverage determinations must be based on Medical Necessity, and information must be submitted to support the Medical Necessity including all of the following:

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

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

TEMPOROMANDIBULAR JOINT SERVICES (TMJ)

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

TRANSPLANT SERVICES

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

- Benefits are limited as follows:
  - Except for corneal transplants which do not require preauthorization, transplant supplies, treatments, services and evaluations, including pre-transplant evaluations, require preauthorization.
  - Transplants of human body organs and tissues.
  - Transplants of animal, artificial, or other non-human organs and tissues are not covered.
  - Limited travel and housing expenses are covered for the Member and one caregiver are limited to $5,000 per transplant. Travel and living expenses are not covered for the donor.
  - Testing of related or unrelated donors for a potential living related organ donation is payable at the same percentage that would apply to the same testing of an insured recipient.
  - Expense for acquisition of cadaver organs is covered, payable at the same percentage and subject to the same limitations, if any, as the transplant itself.

- Medical services required for the removal and transportation of organs or tissues from living donors are covered. Coverage of the organ or tissue donation is payable at the same percentage as the transplant itself if the recipient is a PacificSource Member.
- If the donor is not a PacificSource Member, only those complications of the donation that occur during the initial hospitalization are covered, and such complications are covered only to the extent that they are not covered by another health plan or government program. Coverage is payable at the same percentage as the transplant itself.
- If the donor is a PacificSource Member, complications of the donation are covered as any other Illness would be covered.
- Transplant related services, including human leukocyte antigen (HLA) typing, sibling tissue typing, and evaluation costs, are considered transplant expenses and accumulate toward any transplant benefit limitations and are subject to PacificSource's Provider contractual agreements. For more information, see Payment of Transplant Benefits.

Payment of Transplant Benefits

If a transplant is performed at an in-network Center of Excellence transplantation facility, covered charges of the facility are subject to plan Deductibles (Coinsurance and Copayment amounts after Deductibles are waived). If our contract with the facility includes the services of the medical professionals performing the transplant, those charges are also subject to plan Deductibles (Coinsurance and Copayment amounts after Deductibles are waived). If the professional fees are not included in our contract with the facility, then those benefits are provided according to your Medical Schedule of Benefits.

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

VISION SERVICES

This plan covers vision exams, lenses, and frames when performed or prescribed by Providers practicing within the scope of their licenses.

If charges for a service or supply are less than the Allowable Fee, the benefit will be equal to the actual charge. If services are provided out-of-network and the Provider's billed charges are greater than the Allowable Fee, Balance Billing will apply. Out-of-network expenses above the Allowable Fee will be the Member's responsibility and will not apply toward the Member's medical plan Deductible or out-of-pocket limit.

Adult

This plan covers preventive vision examinations and hardware, including lenses, frames and/or contact lenses for Members age 19 and older.

Pediatric

Coverage for pediatric services will end on the last day of the month in which the Member turns 19.

This plan covers preventive vision examinations and hardware including lenses, frames, and/or contact lenses for Members age 18 and younger.

Please see the Vision Schedule of Benefits for cost share information and benefit details.

WOMEN'S HEALTH AND CANCER RIGHTS

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

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

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

Post-Mastectomy Care

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

BENEFIT EXCLUSIONS

This plan does not cover the following:

- Abdominoplasty for any indication.
- Academic skills training. This exclusion does not apply if the program, training, or therapy is part of a treatment plan for a pervasive developmental disorder.
- Aesthetic dental procedures – Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.
- Any amounts in excess of the Allowable Fee for a given service or supply.
- Athletic activities – Any injuries sustained while competing or practicing for a professional or semiprofessional athletic contest.
- Aversion therapy.
- Biofeedback (other than as specifically noted under the Covered Services 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, or Injury, or other insurers covering the incident (such as workers' compensation insurers, automobile insurers, and general liability insurers).
- Chelation therapy including associated infusions of vitamins and/or minerals, except as Medically Necessary for the treatment of selected medical conditions and medically significant heavy metal toxicities.
- Computer or electronic equipment for monitoring asthmatic, similar medical conditions, or related data.
- Connector bar or stress breaker.
- Cosmetic/reconstructive services and supplies – Services and supplies, including drugs, rendered primarily for cosmetic/reconstructive purposes (does not apply to Emergency Services).

Cosmetic/reconstructive services and supplies are those performed primarily to improve the body's appearance and not primarily to restore impaired function of the body, unless the area needing treatment is a result of a Congenital Anomaly or gender dysphoria.

- Court-ordered sex offender treatment programs.
- Day care or Custodial Care – Care and related services designed essentially to assist a person in maintaining activities of daily living. (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 this plan's hospice benefit. For related provisions, see Skilled Nursing Facility Services Convalescent Homes in the Inpatient Services section, Home Health Services, and Hospice Care Services sections.
- Dental examinations and treatment for Members age 19 and older – 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 Hospital Services in the Inpatient Services section.
- Denture replacement made necessary by loss, theft, or breakage.
- 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) 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 nonmedical purposes and/or marketed to the general public.
- Equipment used primarily in athletic or recreational activities. This includes exercise equipment for stretching, conditioning, strengthening, or relief of musculoskeletal problems.
- Experimental, Investigational, or Unproven – This plan does not cover services, supplies, protocols, procedures, devices, chemotherapy, drugs or medicines, or the use thereof that are Experimental, Investigational, or Unproven for the diagnosis and treatment of the Member. This limitation also excludes treatment that, when and for the purpose rendered have not yet received full US government agency approval for other than Experimental, Investigational, Unproven, or clinical testing. Limitations also exclude medical practice not of generally accepted in your plan's

state of issuance, or is not approved for reimbursement by the Centers for Medicare and Medicaid Services.

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 exercises and eye refraction, therapy, and procedures – Orthoptics, vision therapy, and procedures intended to correct refractive errors.
- Fitness or exercise programs and health or fitness club memberships.
- Foot care (routine) – Services and supplies for corns and calluses of the feet, conditions of the toenails other than infection, hypertrophy, or hyperplasia of the skin of the feet, and other routine foot care, except in the case of Members being treated for diabetes mellitus.
- Gingivectomy, gingivoplasty, or crown lengthening in conjunction with crown preparation or fixed bridge services done on the same date of service.
- 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 work.
- Indirect pulp caps are to be included in the Restoration process, and are not a separate Covered Service.
- Instructional or educational programs, except diabetes self-management programs when Medically Necessary.
- Intra and extra coronal splinting – Devices and procedures for intra and extra coronal splinting to Stabilize mobile teeth.
- Jaw – Services or supplies for developmental or degenerative abnormalities of the jaw, malocclusion, dental implants, or improving placement of dentures.
- Mail order or Internet/web based dental Providers are not eligible Providers.
- Maintenance supplies and equipment not unique to medical care.
- Mattresses and mattress pads unless Medically Necessary to heal pressure sores.
- Mental health treatments for conditions defined in the current edition of Diagnostic and Statistical Manual of Mental Disorders, 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 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 mental health disorder; stress management, parenting skills, or family education; and assertiveness training.

- Modifications to vehicles or structures to prevent, treat, or accommodate a medical condition.
- Motion analysis, including videotaping and 3-D kinematics, dynamic surface and fine wire electromyography, including Provider review.
- Myeloablative high dose chemotherapy, except when the related transplant is specifically covered under the transplantation provisions of this plan.
- Naturopathic supplies.
- Nicotine related disorder treatment, other than those covered through Tobacco Cessation Program services.
- Obesity 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 for when Medically Necessary for in the restoration or improvement of speech following a traumatic brain Injury or for Members diagnosed with a pervasive developmental disorder.
- Orthodontic services – Repair or replacement of orthodontic appliances furnished under this plan.
- Orthodontic services – Treatment of misalignment of teeth and/or jaws, or any ancillary services expressly performed because of orthodontic treatment, except as provided for treatment of cleft palate/cleft lip whose treatment began prior to turning age 19, and was not completed prior to turning age 19.
- Orthognathic surgery – Services and supplies to augment or reduce the upper or lower jaw, except to repair an Accidental Injury or for removal of a malignancy, including reconstruction of the jaw.
- Orthopedic shoes and shoe modifications.
- Over-the-counter nonprescription drugs, unless included on your Drug List or is otherwise listed as a Covered Service in this Student guide. Does not apply to tobacco cessation medications covered under USPSTF guidelines.
- Panniculectomy (removal of panniculus, or excess skin, from lower abdomen) for any indication.
- Periodontal probing, charting, and re-evaluations.
- Periodontal Splinting, night guards, or appliances used to increase vertical dimensions, restore the occlusion, or correct habits such as tongue thrust and grinding teeth. Periodontal splinting including crowns and bridgework used in conjunction with periodontal splinting.
- Personal items such as telephones, televisions, and guest meals during a stay at a Hospital or other inpatient facility.
- Photographic images of the teeth.
- Physical or eye examinations required for administrative purposes such as participation in athletics 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.
- Pulpotomies on permanent teeth.
- Recreation therapy – outpatient.
- Rehabilitation – Functional capacity evaluations, work hardening programs, vocational rehabilitation, community reintegration services, and driving evaluations and driving training programs.
- Removal of clinically serviceable Amalgam Restorations to be replaced by other materials free of mercury, except with proof of allergy to mercury.
- Replacement costs for worn or damaged Durable Medical Equipment that would otherwise be replaceable without charges under warranty or other agreement.
- 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 Services section.
- Self-help health or instruction or training programs.
- Sensory integration training. This exclusion does not apply if the program, training, or therapy is part of a treatment plan for a pervasive developmental disorder.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth.
- 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 or supplies not listed as a Covered Service, unless required under federal or state law.
- Services required by state law as a condition of maintaining a valid driver license or commercial driver license.
- Services, supplies, and equipment not involved in diagnosis or treatment but provided primarily for the comfort, convenience, alteration of the physical environment, or education of a Member. This includes appliances like adjustable power beds sold as furniture, air conditioners, air purifiers, room humidifiers, heating and cooling pads, home blood pressure monitoring equipment, light boxes, conveyances other than conventional wheelchairs, whirlpool baths, spas, saunas, heat lamps, tanning lights, and pillows.
- Sexual disorders – Services or supplies for the treatment of erectile or sexual dysfunction, unless defined in the current edition of Diagnostic and Statistical Manual of Mental Disorders.
- Sinus lift grafts to prepare sinus site for implants.

- 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.
- Stress-breaking or habit-breaking appliances unless Medically Necessary.
- Support groups.
- Tooth transplantation – Services and supplies provided in connection with tooth transplantation, including re-implantation from one site to another, splinting, and/or stabilization. This exclusion does not relate to the re-implantation of a tooth into its original socket after it has been avulsed.
- 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 Dentally Necessary, according to acceptable dental practice, or treatment not likely to have a reasonably favorable prognosis.
- Treatment not Medically Necessary – Services or supplies that are not Medically Necessary for the diagnosis or treatment of an Illness or Injury.
- Treatment of any Illness or Injury resulting from an illegal occupation or attempted felony, or treatment received while in the custody of any law enforcement other than with the local supervisory authority while pending disposition of charges.
- Treatment of any work-related Illness or Injury except as described in On-the-Job Illness or Injury and Workers' Compensation.
- Treatment prior to enrollment.
- 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 any act of war, or any war declared or undeclared, or while in the service of the armed forces.

UTILIZATION REVIEW

PacificSource has a utilization review program to determine coverage. The Utilization Review program is administered by our Health Services team for preauthorization and concurrent reviews (prior authorizations and inpatient stays) for medical and behavioral health. Questions regarding Medical Necessity, possible Experimental, Investigational, or Unproven services, appropriate setting, and appropriate treatment are forwarded to the PacificSource Medical Director for review and Benefit Determination.

If you would like information on how we reached a particular utilization review Benefit Determination, please contact our Health Services team by phone at (541) 684-5584 or (888) 691-8209, or by email at healthservices@pacificsource.com.

PREAUTHORIZATION

Coverage of certain healthcare services and Surgical Procedures requires a Benefit Determination by PacificSource before the services are performed. This process is called preauthorization.

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

Your Provider can request preauthorization from the PacificSource Health Services team. If your Provider will not request preauthorization for you, you may contact us yourself. In some cases, we may ask for more information or require a second opinion (at no cost to the Member when requested by PacificSource) before authorizing coverage.

Because of the changing nature of medicine, PacificSource continually reviews new technologies and standards of healthcare practice. Therefore, procedures and services requiring preauthorization is subject to change. You can search for procedures and services that require preauthorization on our website at Authgrid.PacificSource.com (select Commercial for the line of business). Our preauthorization search tool is not intended to suggest that all items listed are covered by the benefits in this plan.

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

If your treatment is not preauthorized, you can still seek treatment, but you will be held responsible for the expense if it is not Medically Necessary or not covered by this plan. Remember, any time you are unsure if an expense will be covered, contact our Customer Service team.

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

In a medical emergency, services and supplies necessary to determine the nature and extent of the Emergency Medical Condition and to Stabilize the Member are covered without preauthorization requirements.

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

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

CASE MANAGEMENT

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

Case managers are experienced licensed healthcare professionals with specialized skills to respond to the complexity of a Member's healthcare needs. When case management services are

implemented, a case manager will work in collaboration with a Member's Provider and the PacificSource Medical Director to enhance the quality of care, maximize available health plan benefits, and propose individual supplemental benefits. PacificSource reserves the right to employ a third party to assist with, or perform the function of, case management.

INDIVIDUAL/SUPPLEMENTAL BENEFITS

An individual/supplemental benefit may be available if PacificSource approves coverage for services or supplies that are not a Covered Service under this plan (for example, continuation of home health physical therapy beyond the benefit limit, if Medical Necessity determines that continuation would prevent a Hospital stay). PacificSource may cover these supplemental benefits through case management if PacificSource determines that supplemental benefits are Medically Necessary and will result in an overall reduction in covered costs and improved quality of care. The decision to allow supplemental benefits will be made by PacificSource on a case-by-case basis. PacificSource and the Member's attending Provider must concur in the request for supplemental benefits in lieu of specified Covered Services before supplemental benefits will be covered. PacificSource's determination to cover and pay for supplemental benefits for a Member does not set a precedent for coverage of continued or additional supplemental benefits for a Member. No substitution will be made without the consent of the insured.

USING THE PROVIDER NETWORK

This section explains how your plan benefits differ when you use OSU Student Health Services, In-network and Out-of-network Providers. This information is not meant to prevent you from seeking treatment from any Provider if you are willing to take increased financial responsibility for the charges incurred. Your network name is listed on your PacificSource Member ID card and at the beginning of your Schedule of Benefits. The Schedule of Benefits identifies the different tiers of Providers, and the different reimbursement levels and cost sharing for those different tiers (for example, a Student Health Center or clinic, In-network Providers, and Out-of-network Providers).

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

Under this plan, you are free to seek care, including Women's Healthcare Services, from any Provider without a referral. You may, however, be required to comply with certain procedures, including obtaining preauthorization for certain services or following a pre-approved treatment plan.

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

OSU STUDENT HEALTH SERVICES

The Policyholder has a student health clinic that provides services to Students. Many services are covered by the Student health fee and thus available to you at no charge. Contact OSU Student Health Services for more information about services available to you. See the Medical Schedule of Benefits, under the 'OSU Student Health Services' column in this guide, for benefit information.

IN-NETWORK PROVIDERS

In-network Providers contract with PacificSource to provide services and supplies for a Contracted Allowable Fee. In-network Providers bill PacificSource directly, and we pay them directly. When you receive Covered Services or supplies from an In-network Provider, you are only responsible for any applicable Deductible, Copayment, and/or Coinsurance amount. To ensure the highest level of benefits, access care from an In-network Provider including specialists and Hospitals.

PacificSource contracts directly and/or indirectly with In-network Providers throughout our networks' Service Area. We also have agreements with nationwide Provider networks. These Providers outside our Service Area are also considered PacificSource In-network Providers under your plan.

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

Risk-sharing Arrangements

By agreement, an In-network Provider may not bill a Member for any amount in excess of the Contracted Allowable Fee. However, the agreement does not prohibit the Provider from collecting Deductibles, Copayments, Coinsurance, and amounts for non-Covered Services from the Member. If PacificSource was to become insolvent, an In-network Provider agrees to continue to provide Covered Services to a Member for the duration of the period for which premium was paid to PacificSource on behalf of the Member. Additional information on PacificSource's risk-sharing arrangements is available by contacting our Customer Service team.

FINDING IN-NETWORK PROVIDER INFORMATION

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

- On the PacificSource website, pacificsource.com/osu, go to Find a Doctor to easily look up In-network Providers, specialists, behavioral health Providers, and Hospitals. You can also print your own customized directory.
- Contact our Customer Service team. Our team can answer your questions about specific Providers and can mail you a directory free of charge.

OUT-OF-NETWORK PROVIDERS

When you receive services or supplies from an Out-of-network Provider, your out-of-pocket expense is likely to be higher than if you had used an In-network Provider. If the same services or supplies are available from an In-network Provider, you may be responsible for more than the applicable Deductibles, Copayments, and/or Coinsurance amounts.

Allowable Fee for Out-of-network Providers

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

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

In PacificSource's Service Areas, the Allowable Fee for professional services is based on PacificSource's standard Out-of-network Provider reimbursement rate. Outside the PacificSource Service Area and in areas where our Members do not have reasonable access to an In-network Provider through one of our third party Provider networks, the Allowable Fee, depending upon the service and supply, can be based on data collected from PacificSource or other nationally recognized databases. If the service is based on the Usual, Customary, and Reasonable charge (UCR), PacificSource will utilize the 85th percentile. UCR is based on data collected for a geographic area.

Provider charges for each type of service are collected and ranked from lowest to highest. Charges at the 85th position in the ranking are considered to be the 85th percentile.

PacificSource's payment to Out-of-network Providers (Allowable Fee) may be derived from several sources, depending on the service or supply and the Service Area where it is provided. To calculate our payment to Out-of-network Providers, we determine the Allowable Fee, then subtract the Out-of-network Provider benefits as shown in the Out-of-network Provider column of your Schedule of Benefits.

Balance Billing

Our Allowable Fee is often less than the Out-of-network Provider's charge. In that case, the difference between the Allowable Fee and the Provider's billed charge is also your responsibility; this difference is called Balance Billing. That amount does not count toward this plan's out-of-pocket limit. It also does not apply toward any cost sharing required by the plan.

Balance Billing Protection

There are certain circumstances under which your out-of-pocket expenses will not be greater if you are treated by an Out-of-network Provider at an in-network medical facility due to Balance Billing protection:

- An Out-of-network Provider or facility providing Emergency Services.
- An Out-of-network Provider at an in-network facility providing Emergency Services or other inpatient or outpatient services.

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

Example of Provider Payment

The following illustrates how payment could be made for the same service in two different settings: with an In-network Provider and with an Out-of-network Provider. This is only an example; your plan's benefits may be different:

	In-network Provider	**Out-of-network Provider**
Provider's usual charge	$120	$120
Billed charge after negotiated Provider discounts	$100	$120
PacificSource's Allowable Fee	$100	$100
Allowable Fee less Member's Coinsurance	$80	$50
Percent of payment	80%	50%
PacificSource's payment	**$80**	**$50**
Member's responsibility:		
Coinsurance	20%	50%
Member's amount of Allowable Fee	$20	$50
Difference between Allowable Fee and billed charge after discounts	$0	$20
Member's total responsibility to the Provider	**$20**	**$70**

COVERAGE WHILE TRAVELING

Finding an In-network Provider

If you are away from home, but *within* the Service Area, you may find an In-network Provider by using the PacificSource directory at pacificsource.com/osu or by contacting our Customer Service team.

If you are *outside* of the Service Area, go to the link above and follow the instructions to find In-network Providers outside the Service Area. The listed Providers are part of nationwide Provider networks with whom we have agreements. Providers on these networks are considered in-network when *and only when* you are outside your Service Area.

Non-Emergency Care While Traveling

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

Non-emergency care outside of the United States is covered. This plan's benefits are available for non-emergency care outside the United States, subject to the provisions of this plan.

- If an In-network Provider is available in your area, your plan's In-network Provider benefits will apply if you use an In-network Provider.
- If an In-network Provider is available but you choose to use an Out-of-network Provider, your plan's Out-of-network Provider benefits will apply.
- When abroad, your plan's In-network Provider benefits will apply for Covered Services.

Out-of-network Provider for Emergency Services

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

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

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

Epidemic

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

TERMINATION OF PROVIDER CONTRACTS

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

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

You may be entitled to continue care with an individual Provider, whose contract was terminated without cause, for a limited period of time at the in-network cost share. Continuation of care will not be available if you are no longer covered under this plan, the Provider will not accept the Contracted

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

If you do not qualify for continuation of care, the Provider becomes an Out-of-network Provider on the date the contract with PacificSource terminates. Any services you receive from them will be paid at the percentage shown in the out-of-network column of your Schedule of Benefits. To avoid unexpected costs, be sure to verify each time you see your Provider that they are still in-network.

Active Course of Treatment

If the contract of a Provider who is providing to you an active course of treatment, as defined in 45 CFR 156.230, is terminated without cause, you may be able to continue to receive services from the Provider at the in-network benefit level for a limited period of time. The services may be paid at in-network cost sharing until the earliest of the following:

- Treatment is complete; or
- 90 days after you were notified that the contract ended or the date your request for continuity of care was received or approved, whichever is earlier.

CLAIMS PAYMENT

How to File a Claim

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

If you receive care from an Out-of-network Provider, the Provider may submit the claim to PacificSource for you. If not, you are responsible for sending the claim to us for processing. Your claim must include a copy of your Provider's itemized bill, including the Provider name and address, the Provider tax identification number and national Provider identifier, procedure codes, and diagnosis codes. It must also include your name, PacificSource Member ID number, and the patient's name. If you were treated for an Accidental Injury, please include the date, time, place, and circumstances of the Accident.

All claims for benefits should be turned in to PacificSource within 90 days of the date of service. If you are unable to submit a claim within 90 days, present the claim with an explanation for consideration for coverage. We will never pay a claim that was submitted more than a year after the date of service.

Proofs of Loss

PacificSource, upon receipt of a notice of claim, will furnish to the Member such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished by PacificSource within 15 days after the giving of such notice, the Member shall be deemed to have complied with the requirements of this plan as to proof of loss. Upon receipt of the forms for proof of loss, the Member then must submit the proofs of loss within 90 days of the date of the loss or as soon as reasonably possible. Proofs of loss include written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

All medical claims should be sent to:

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

All dental claims should be sent to:

PacificSource Health Plans
Attn: Dental Claims
PO Box 7068
Springfield, OR 97475-0068

Claim Handling Procedures

Claim Determination – PacificSource will make a claim determination within the time period noted in the chart below for the specific type of claim, unless additional information is necessary to process the claim. If we do not receive the necessary information within 15 days of the delay notice, we will either deny the claim or notify you every 45 days while the claim remains under investigation. No extension is permitted for Urgent Care Claims.

Type of Notice	Concurrent Care Claim	Urgent Care Claim	Pre-service Claim	Post-service Claim
Initial determination by PacificSource	24 hours	48 hours	2 business days	30 calendar days
If PacificSource requires additional information, PacificSource will make request within	24 hours	48 hours	2 business days	30 calendar days
Provider or Member must provide requested additional information within	24 hours	48 hours	5 business days	15 calendar days
Once PacificSource receives the information, decision will be made and written notice sent within	24 hours	48 hours	2 business days	30 calendar days

Payment of Claims – PacificSource may pay benefits to the Member, the Provider, or both jointly. Neither the benefits of this plan nor a claim for payment of benefits under the plan are assignable in whole or in part to any person or entity.

Adverse Benefit Determinations – PacificSource will notify you in writing of a decision to deny, modify, reduce, or terminate payment, coverage authorization or provision of healthcare services or benefits, including the admission to or continued stay in a healthcare facility.

Review of Adverse Benefit Determinations – An Adverse Benefit Determination applied for on a pre-service, post-service, or concurrent care basis may be Appealed in accordance with the plan's Appeals procedures. For more information, see the Complaints, Grievances, and Appeals section.

Questions about Claims

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

Benefits Paid in Error

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

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

COORDINATION OF BENEFITS

This is a summary of only a few of the provisions of your healthcare plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules.

Double Coverage

It is common for family members to be covered by more than one healthcare plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one healthcare plan, state law permits your insurers to follow a procedure called coordination of benefits to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered healthcare expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, contact our Customer Service team or the Division of Financial Regulation.

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the primary or secondary benefit payer. The primary plan always pays first when you have a claim.

Any plan that does not contain your state's COB rules will always be primary.

When This Plan is Primary

If you or a family member are covered under another plan in addition to this one, we will be primary when:

Your Own Expenses

- The claim is for your own healthcare expenses, unless you are covered by Medicare and both you and your Spouse or Domestic Partner are retired.

Your Spouse's or Domestic Partner's Expenses

- The claim is for your Spouse or your Domestic Partner, who is covered by Medicare, and you are not both retired.

Your Child's Expenses

- The claim is for the healthcare expenses of your child who is covered by this plan; and
- You are married and your birthday is earlier in the year than your Spouse's or your Domestic Partner's, or you are living with another individual, regardless of whether or not you have ever

been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the birthday rule; or

- You are separated or divorced and you have informed us of a court decree that makes you responsible for the child's healthcare expenses; or
- There is no court decree, but you have custody of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

We will always be secondary when you are also covered by a system of socialized medicine or when another insurance plan or insurance program outside the United States provides benefits for the Covered Services.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits in accordance with the terms of your plan, just as if you had no other healthcare coverage under any other plan.

How We Pay Claims When We Are Secondary

We will be secondary whenever the rules do not require us to be primary.

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An allowable expense is a healthcare expense covered by one of the plans, including Copayments, Coinsurance, and Deductibles.

- If there is a difference between the amounts the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the Provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the primary plan, whichever is higher. Health maintenance organizations (HMOs) and preferred Provider organizations (PPOs) usually have contracts with their Providers.
- We will determine our payment by calculating the amount we would have paid if we had been primary, and apply that calculated amount to any allowable expense that is left unpaid by the primary plan. We may limit our payment by any amount so that, when combined with the amount paid by the primary plan, the total benefits paid do not exceed the total allowable expense for your claim. We will credit any amount we would have paid in the absence of your other healthcare coverage toward our own plan Deductibles.
- If the primary plan covers similar kinds of healthcare expenses, but allows expenses that we do not cover, we may pay for those expenses.
- We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain preauthorization, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

Questions about Coordination of Benefits?
Contact the Division of Financial Regulation.

THIRD PARTY LIABILITY

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

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

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

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

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

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

PacificSource regularly engages in activities to identify and recover claims payments which should not have been paid or applied to Deductible amounts (for example, claims which are duplicate claims, errors, or fraudulent claims). If PacificSource makes a payment to you that you are not entitled to, or pays a person who is not eligible for payment, PacificSource may recover the payment.

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

- In the case where PacificSource becomes aware of an incorrect payment that was made due to an error, misstatement, misrepresentation, omission, or concealment other than insurance fraud by the healthcare Provider or another person, the 12 month time limit begins on the date PacificSource has actual knowledge of the invalid claim, claim overpayment, or other incorrect payment. Regardless of the date upon which PacificSource obtains actual knowledge of an invalid claim, claim overpayment, or other incorrect payment, PacificSource may not request reimbursement more than 24 months after the payment.

Motor Vehicle and Other Accidents

In accordance with state law, and notwithstanding the information above, you must provide PacificSource notice, by personal service or by registered or certified mail, if you make a claim or bring legal action for damages for injuries against any other person arising from a motor vehicle Accident. If PacificSource elects to seek reimbursement out of any recovery from such a claim or legal action, PacificSource will provide you with written notice to that effect by personal service or by registered or certified mail within 30 days of receipt of notice from you of such claim or legal action. Further, in such situations, PacificSource will take no action to reduce payments or subrogate until you receive full compensation for your injuries and the reimbursement or subrogation is paid only from the total amount of the recovery in excess of the amount that fully compensates you for your injuries.

If you are involved in a motor vehicle Accident or other Accident, your related healthcare expenses are not covered by this plan if they are covered by any other type of insurance plan.

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

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

This plan does not cover any work-related Illness or Injury that is caused by any for-profit activity, whether through employment or self-employment. The only exceptions are if:

- You are an owner, partner, or principal; are injured in the course of self-employment; and are otherwise exempt from the applicable state or federal workers' compensation insurance;
- The appropriate state or federal workers' compensation insurance program has determined that coverage is not available for your Injury; or
- You are employed with an Oregon based group, and have timely filed an application for coverage with the State Accident Insurance Fund or other Workers' Compensation carrier, and are waiting for determination of coverage from that entity.

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

Surrogacy Health Services

PacificSource is entitled to reimbursement for any paid claims out of the compensation a Member receives or is entitled to receive under a surrogacy agreement. A Member who enters into a surrogacy agreement must reimburse PacificSource for Covered Services related to conception, pregnancy, delivery, or postpartum care that are received in connection with the surrogacy agreement. PacificSource is entitled to reimbursement for any paid claims out of the compensation a Member receives or is entitled to receive under a surrogacy agreement. A Member who enters into a

surrogacy agreement must inform PacificSource of that agreement within 30 days of entering that agreement and provide a copy of the agreement to PacificSource.

COMPLAINTS, GRIEVANCES, AND APPEALS

QUESTIONS, CONCERNS, OR COMPLAINTS

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

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

GRIEVANCE PROCEDURES

If you or your Authorized Representative are dissatisfied with the availability, delivery, or the quality of healthcare services; or claims payment, handling, or reimbursement for healthcare services, you may file a Grievance in writing. Grievances are not Adverse Benefit Determinations and do not establish a right to internal or External Review for a resolution to a Grievance.

PacificSource will attempt to address your Grievance, generally within 30 days of receipt. For more information, see the How to Submit Grievances or Appeals section.

APPEAL PROCEDURES

If you believe PacificSource has improperly reduced or terminated a healthcare item or service, or failed or refused to provide or make a payment in whole or in part for a healthcare item or service that is based on any of the reasons listed below, you or your Authorized Representative may Appeal the decision. The request for Appeal must be made in writing and within 180 days of your receipt of our Adverse Benefit Determination. For more information, see the How to Submit Grievances or Appeals section. You may Appeal if there is an Adverse Benefit Determination based on a:

- Denial of eligibility for or termination of enrollment in a healthcare plan;
- Rescission or cancellation of your plan;
- Imposition of a third party liability, network exclusion, annual benefit limit, or other limitation on otherwise Covered Services or items;
- Determination that a healthcare item or service is Experimental, Investigational, Unproven, not a Dental Necessity, or Medically Necessary, effective, or appropriate; or
- Determination that a course or plan of treatment you are undergoing is an active course of treatment for the purpose of continuity of care.

PacificSource staff involved in the initial Adverse Benefit Determination will not be involved in the Internal Appeal.

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

If you request review of an Adverse Benefit Determination, PacificSource will continue to provide coverage for the disputed benefit, pending outcome of the review, if you are currently receiving

services or supplies under the disputed benefit. If PacificSource prevails in the Appeal, you may be responsible for the cost of coverage received during the review period. The decision at the External Review level is binding unless other remedies are available under state or federal law.

Request for Expedited Response: If there is a clinical urgency to do so, you or your Authorized Representative may request in writing or orally, an expedited response to an internal or External Review of an Adverse Benefit Determination. To qualify for an expedited response, your attending Provider must attest to the fact that the time period for making a non-urgent Benefit Determination could seriously jeopardize your life, health, your ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the healthcare service or treatment that is the subject of the request. If your Appeal qualifies for an expedited review and would also qualify for External Review (see External Independent Review), you may request that the internal and External Reviews be performed at the same time.

External Independent Review: If your dispute with PacificSource relates to an Adverse Benefit Determination that a course or plan of treatment is not Medically Necessary; is Experimental, Investigational, or Unproven; is not an active course of treatment for purposes of continuity of care; or is not delivered in an appropriate healthcare setting and with the appropriate level of care, you or your Authorized Representative may request an External Review by an independent review organization. PacificSource must receive a signed Authorization To Use/Disclose Protected Health Information form within five business days of your external independent review request. This form is located on our website, PacificSource.com/resources/documents-and-forms. For more information, see the How to Submit Grievances or Appeals section.

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

PacificSource may, at its discretion and with your consent, waive the requirements of compliance with the Internal Appeal process and have a dispute referred directly to External Review. You shall be deemed to have exhausted the Internal Appeal if PacificSource fails to strictly comply with its Appeal process and with state and federal requirements for Internal Appeal.

If the independent review organization reverses our decision, we will apply their decision quickly. However, if the independent review organization stands by our decision, there is no further Appeal available to you.

If PacificSource fails to comply with the decision of the independent review organization assigned under Oregon law, you have a private right of action against PacificSource for damages arising from an Adverse Benefit Determination subject to the External Review.

If you have questions regarding Oregon's External Review process, you may contact:

Division of Financial Regulation
Call (503) 947-7984 or (888) 877-4894

Timelines for Responding to Appeals

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

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

Information Available with Regard to an Adverse Benefit Determination

The final Adverse Benefit Determination will include:

- A reference to the specific internal rule or guideline PacificSource used in the Adverse Benefit Determination; and
- An explanation of the scientific or clinical judgment for the Adverse Benefit Determination, if the Adverse Benefit Determination is based on Medical Necessity, Dental Necessity, Experimental, Investigational, Unproven treatment, or a similar exclusion.

Upon request and free of charge, PacificSource will provide you with any additional documents, records, or information that is relevant to the Adverse Benefit Determination.

HOW TO SUBMIT GRIEVANCES OR APPEALS

Grievances and Appeals can be submitted in writing by you or your Authorized Representative. Before submitting a Grievance or Appeal, we suggest you contact our Customer Service team with your concerns. You can reach us by phone or email using the contact information found on the first page of this Student guide. Issues can often be resolved at this level. Otherwise, you may file a Grievance or Appeal by contacting:

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

Email studenthealth@pacificsource.com with Grievance or Appeal as the subject

Fax (541) 225-3628

Assistance Outside PacificSource

You have the right to file a Complaint or seek other assistance from the Division of Financial Regulation. Assistance is available by contacting:

Division of Financial Regulation
Consumer Advocacy Unit
PO Box 14480
Salem, OR 97309-0405

Call (503) 947-7984 or (888) 877-4894

Email: DFR.InsuranceHelp@oregon.gov

Website dfr.oregon.gov

RESOURCES FOR INFORMATION AND ASSISTANCE

Assistance

PacificSource Members who do not speak English, have literacy difficulties, or have physical or mental disabilities that impede their ability to file an Appeal may contact our Customer Service team for assistance.

Information Available from PacificSource

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

- A directory of In-network Providers under your plan;
- Information about your Drug List (also known as a formulary);
- A copy of our annual report on Complaints and Appeals;
- A summary of Adverse Benefit Determinations and Grievance processes;
- Information about our policy for protecting the confidentiality of your health information;
- Information about the cost of premiums and Member cost sharing requirements;
- An annual statement of all benefit payments made by PacificSource for a Member's coverage, including payments that have been counted against any applicable benefit limitations;
- A description (consistent with risk-sharing information required by the Centers for Medicare and Medicaid Services) of any risk-sharing arrangements we have with Providers;
- A description of our efforts to monitor and improve the quality of healthcare services including accreditation status with a national managed care accreditation organization and Health Effectiveness Data and Information Set (HEDIS) data results;
- Information about how we check the credentials of our network Providers and how you can obtain the names and qualifications of your Providers;
- Information about our preauthorization, Predetermination, and utilization review procedures; and
- Information about any healthcare plan offered by PacificSource.

Information Available from the Division of Financial Regulation about PacificSource

The following consumer information is available from the Division of Financial Regulation:

- The results of all publicly available accreditation surveys;
- A summary of our health promotion and disease prevention activities;
- Samples of the written summaries delivered to PacificSource Policyholders;
- An annual summary of Grievances and Appeals against PacificSource;
- An annual summary of our utilization review policies;
- An annual summary of our quality assessment activities; and
- An annual summary of the scope of our Provider network and accessibility of healthcare services.

You can request this information by contacting:

Division of Financial Regulation
Consumer Advocacy Unit
PO Box 14480
Salem, OR 97309-0405

Call (503) 947-7984 or (888) 877-4894

Email: DFR.InsuranceHelp@oregon.gov

Website dfr.oregon.gov

FEEDBACK AND SUGGESTIONS

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

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

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

RIGHTS AND RESPONSIBILITIES

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

Your Rights as a Member:

- You have a right to receive information about PacificSource, our services, our Providers, and your rights and responsibilities.
- You have a right to expect clear explanations of your plan benefits and exclusions.
- You have a right to be treated with respect and dignity.
- You have a right to impartial access to healthcare without regard to race, religion, gender, national origin, or disability.
- You have a right to honest discussion of appropriate or Medically Necessary treatment options. You are entitled to discuss those options regardless of how much the treatment costs or if it is covered by this plan.
- You have a right to the confidential protection of your healthcare records and personal information.
- You have a right to voice Complaints about PacificSource or the care you receive, and to Appeal decisions you believe are wrong.
- You have a right to participate with your Provider in decision-making regarding your care.
- You have a right to know why any tests, procedures, or treatments are performed and any risks involved.
- You have a right to refuse treatment and be informed of any possible medical or dental consequences.
- You have a right to refuse to sign any consent form you do not fully understand, or cross out any part you do not want applied to your care.
- You have a right to change your mind about treatment you previously agreed to.
- You have a right to make recommendations regarding PacificSource Health Plans' Member rights and responsibilities policy.

Your Responsibilities as a Member:

- You are responsible for reading this Student guide and all other communications from PacificSource, and for understanding your plan's benefits. You are responsible for contacting our Customer Service team if anything is unclear to you.
- You are responsible for making sure your In-network Provider obtains preauthorization for any services that require it before you are treated.
- You are responsible for providing PacificSource with all the information required to provide benefits under your plan.
- You are responsible for giving your Provider complete health information to help accurately diagnose and treat you.
- You are responsible for telling your Providers you are covered by PacificSource and showing your PacificSource Member ID card when you receive care.
- You are responsible for being on time for appointments, and calling your Provider ahead of time if you need to cancel.
- You are responsible for any fees the Provider charges for late cancellations or no shows.
- You are responsible for contacting PacificSource if you believe you are not receiving adequate care.
- You are responsible for supplying information to the extent possible that PacificSource needs in order to administer your benefits or your Providers need in order to provide care.
- You are responsible for following plans and instructions for care that you have agreed to with your Providers.
- You are responsible for understanding your health problems and participating in developing mutually agreed upon goals, to the degree possible.

PRIVACY AND CONFIDENTIALITY

PacificSource has strict policies in place to protect the confidentiality of your personal information, including healthcare records. Detailed information is available at PacificSource.com/privacy.

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 Authorized 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 request receipt of confidential communications in a different manner or at a different address, you will need to complete and return the form provided at PacificSource.com/resources/documents-and-forms.

PLAN ADMINISTRATION

Insurance Contract

This plan is fully insured. Benefits are provided under a blanket group insurance contract between the Policyholder and PacificSource Health Plans. Under the blanket group insurance contract, PacificSource – not the Policyholder – is responsible for paying claims. However, the Policyholder and PacificSource share responsibility for administering the plan's eligibility and enrollment

requirements. The Policyholder has given PacificSource authority to determine eligibility for benefits under the plan and to interpret the terms of the plan.

Our address is:

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

Legal Procedures

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

DEFINITIONS

Wherever used in this plan, the following definitions apply to the masculine and feminine, and singular and plural forms of the terms. Other terms are defined where they are first used in the text.

Abutment is a tooth used to support a Prosthetic Device (bridges, partials, or overdentures). With an implant, an Abutment is a device placed on the implant that supports the implant crown.

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

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, 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 maximum amount PacificSource will reimburse Providers. In-network Providers are paid the Contracted Allowable fee and Out-of-network Providers are paid the Out-of-network Allowable Fee.

- **Contracted Allowable Fee** is an amount PacificSource agrees to pay an In-network Provider for a given service or supply through direct or indirect contract.
- **Out-of-network Allowable Fee** is the dollar amount established by PacificSource for reimbursement of charges for specific services or supplies provided by Out-of-network Providers. PacificSource uses several sources to determine the Out-of-network Allowable Fee. Depending on the service or supply and the geographical area in which it is provided, the Out-of-network Allowable Fee may be based on data collected from the Centers for Medicare and Medicaid Services (CMS), contracted vendors, other nationally recognized databases, or PacificSource, as documented in PacificSource's payment policy.

An Out-of-network Provider may charge more than the limits established by the Out-of-network Allowable Fee. Charges that are eligible for reimbursement, but exceed the Out-of-network Allowable Fee, are the Member's responsibility. For more information, see the Out-of-network Providers section.

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

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

Alveolectomy is the removal of bone from the socket of a tooth.

Amalgam is a silver-colored material used in restoring teeth.

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

Appeal means a written or verbal request from a Member or, if authorized by the Member, the Member's Authorized Representative, to change a previous decision made under this plan concerning:

- Access to healthcare benefits, including an Adverse Benefit Determination made pursuant to utilization management;
- Claims payment, handling, or reimbursement for healthcare services;
- Rescissions of the Member's benefit coverage; and
- Other matters as specifically required by law.

Approved Clinical Trials are Phase I, II, III, or IV clinical trials for the prevention, detection, or treatment of cancer or another life-threatening condition or disease. The trial must be:

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

Authorized Representative is an individual who by law or by the consent of a person may act on behalf of the person. An Authorized Representative *must* have the Member complete and execute an Authorization to Use or Disclose PHI form and a Designation of Authorized Representative form, both of which are available at pacificsource.com/osu, and which will be supplied to you upon request.

These completed forms must be submitted to PacificSource before PacificSource can recognize the Authorized Representative as acting on behalf of the Member.

Balance Billing means the difference between the Allowable Fee and the Provider's billed charge. Out-of-network Providers may bill the Member this amount unless otherwise stated in the Allowable Fee for Out-of-network Providers**.**

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

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

Benefit Determination means the activity taken to determine or fulfill 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 Necessity 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 post-service review of services.

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

Cast Restoration includes crowns, inlays, onlays, and other Restorations made to fit a patient's tooth that are made at a laboratory and cemented onto the tooth.

Coinsurance means a defined percentage of the Allowable Fee for certain Covered Services and supplies the Member receives. It is the percentage the Member is responsible for, not including Copayments and Deductibles.

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

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

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

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

sixth toes or fingers, or defects of metabolism, and other conditions that are medically diagnosed to be Congenital Anomalies.

Contract Year means a 12 month period beginning on the date the insurance contract is issued or the anniversary of the date the insurance contract was issued. If changes are made to the insurance contract on a date other than the anniversary of issuance, a new Contract Year may start on the date the changes become effective if so agreed by PacificSource and the Policyholder. A Contract Year may or may not coincide with a calendar year.

Copayment (also referred to as Copay) is a fixed, up-front dollar amount the Member is required to pay for certain Covered Services.

Covered Service means a service or supply for which benefits are payable under this plan subject to applicable Deductibles, Copayments, Coinsurance, out-of-pocket limit, or other specific limitations.

Curettage is the scraping and cleaning of the walls of a real or potential space, such as a gingival pocket or bone, to remove pathological material.

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

Deductible means the portion of the healthcare expense for a Covered Service that must be paid by the Member before the benefits of this plan are applied. A plan may include more than one Deductible.

Dentally Necessary or Dental Necessity means those services and supplies that are required for diagnosis or treatment of Illness or Injury and that are:

- Consistent with the symptoms or diagnosis and treatment or prevention of the condition;
- Consistent with generally accepted standards of good dental practice in the policy's state of issuance, or expert consensus Provider opinion published in peer-reviewed dental literature, or the results of clinical outcome trials published in peer-reviewed dental literature;
- As likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any other service or supply, both as to the disease or Injury involved and the patient's overall health condition;
- Not for the convenience of the Member or a Provider of services or supplies; and
- The least costly of the alternative services or supplies that can be safely provided.

The fact that a Provider may recommend or approve a service or supply does not, of itself, make the charge a Covered Service.

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

Domestic Partner means an individual that meets the following definition:

- **Registered Domestic Partner** means an individual, age 18 or older, who is joined in a domestic partnership, and whose domestic partnership is legally registered in any state.
- **Unregistered Domestic Partner** means an individual of same or opposite gender who is joined in a domestic partnership with the Student and meets the following criteria:

- Is age 18 or older;
- Not related to the Student by blood closer than would bar marriage in the state where they have permanent residence and are domiciled;
- Shares jointly the same permanent residence with the Student for at least six months immediately preceding the date of application to enroll and intent to continue to do so indefinitely;
- Has an exclusive domestic partnership with the Student and has no other Domestic Partner;
- Does not have a legally binding marriage nor has had another Domestic Partner within the previous six months; and
- Was mentally competent to consent to contract when the domestic partnership began and remains mentally competent.

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

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

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

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

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

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

Emergency Services means:

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

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

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

- Ambulatory patient services;
- Emergency Services;
- Hospitalization;
- Laboratory services;
- Maternity and newborn care;
- Mental health and Substance Use Disorder services, including behavioral health treatment;
- Pediatric services, including oral and vision care;
- Prescription Drugs;
- Preventive and wellness services and chronic disease management; and
- Rehabilitation and Habilitation Services and devices.

Experimental, Investigational, or Unproven means services, supplies, protocols, procedures, devices, chemotherapy, drugs or medicines, or the use thereof, that are Experimental, Investigational, or Unproven for the diagnosis and treatment of Illness or Injury.

- Experimental, Investigational, or Unproven services and supplies include, but not limited to, services, supplies, procedures, devices, chemotherapy, drugs or medicines, or the use thereof, which at the time they are rendered and for the purpose and in the manner they are being used:
  - Have not yet received full U.S. government agency required approval (for example, FDA) for other than Experimental, Investigational, Unproven, or clinical testing;
  - Are not of generally accepted medical practice in your plan's state of issue or as determined by medical advisors, medical associations, and/or technology resources;
  - Are not approved for reimbursement by the Centers for Medicare and Medicaid Services;
  - Are furnished in connection with medical or other research; or
  - Are considered by any governmental agency or subdivision to be Experimental, Investigational, Unproven, not considered reasonable and necessary, or any similar finding.
- When making decisions about whether treatments are Experimental, Investigational, or Unproven, PacificSource relies on the above resources as well as:
  - Expert opinions of specialists and other medical authorities;
  - Published articles in peer-reviewed medical literature;
  - External agencies whose role is the evaluation of new technologies and drugs; and
  - External Review by an independent review organization.

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

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

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

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

Grievance means:

- A written Complaint submitted by a Member or an Authorized Representative of a Member regarding:
  - The availability, delivery, or quality of a healthcare service; or
  - Claims payment, handling, or reimbursement for healthcare services and, unless the Member has not submitted a request for an Internal Appeal, the Complaint is not disputing an Adverse Benefit Determination.

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

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

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

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

- Home health aide services;
- Hospice therapy;

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

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

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

Illness includes a physical or mental condition that results in a Covered Service. 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 Provider that directly or indirectly holds a Provider contract or agreement with PacificSource.

Infertility means:

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

Injury means bodily trauma or damage that is independent of disease or infirmity. The damage must be caused through external and Accidental means and does not include muscular strain sustained while performing a physical activity. For information regarding muscular strain, see Illness in this section.

Inquiry means a written request for information or clarification about any subject matter related to the Member's healthcare plan.

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

Lifetime Maximum means the maximum benefit that will be provided toward the expenses incurred by any one person while the person is covered by a PacificSource insurance plan issued to you. If any Covered Service is deemed to be an Essential Health Benefit as determined by the Secretary of the U.S. Department of Health and Human Services, Lifetime Maximum dollar limits will not apply to that Covered Service in accordance with the standards established by the Secretary.

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

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

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

- Consistent with the symptoms or diagnosis and treatment of the condition;
- Consistent with generally accepted standards of good medical practice in your plan's state of issuance, or expert consensus Provider opinion published in peer-reviewed medical literature, or the results of clinical outcome trials published in peer-reviewed medical literature;
- As likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any other service or supply, both as to the Illness or Injury involved and the patient's overall health condition;
- Not for the convenience of the Member or a Provider of services or supplies; and
- The least costly of the alternative services or supplies that can be safely provided. When specifically applied to a Hospital inpatient, it further means that the services or supplies cannot be safely provided in other than a Hospital inpatient setting without adversely affecting the patient's condition or the quality of medical care rendered.

Services and supplies intended to diagnose or screen for a medical condition in the absence of signs or symptoms, or of abnormalities on prior testing, including exposure to infectious or toxic materials or family history of genetic disease, are not considered Medically Necessary under this definition. For more information, see screening tests in the Benefit Exclusions section.

Member means a person covered by this plan.

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

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

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

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

Mental or Nervous Conditions means all disorders defined in the current edition of Diagnostic and Statistical Manual of Mental Disorders.

Orthotic Devices means rigid or semi rigid devices supporting a weak or deformed leg, foot, arm, hand, back, or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back, or neck. It includes orthopedic appliances or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body. Orthotic Devices are usually customized for an individual's use and are not appropriate for anyone else. Examples of

Orthotic Devices include, but not limited to, Ankle Foot Orthosis (AFO), Knee Ankle Foot Orthosis (KAFO), Lumbosacral Orthosis (LSO), and foot orthotics.

Out-of-network Provider means a Provider that does not directly or indirectly hold a Provider contract or agreement with PacificSource.

Periapical X-ray is an x-ray of the area encompassing or surrounding the tip of the root of a tooth.

Periodontal Maintenance is a periodontal procedure for patients who have previously been treated for periodontal disease. In addition to cleaning the visible surfaces of the teeth (as in Prophylaxis) surfaces below the gum line are also cleaned. This is a more comprehensive service than a regular cleaning (Prophylaxis).

Periodontal Scaling and Root Planing means the removal of plaque and calculus deposits from the root surface under the gum line.

Physical/Occupational Therapy is comprised of the services provided by (or under the direction and supervision of) a licensed physical or occupational therapist. Physical/Occupational Therapy includes emphasis on examination, evaluation, and intervention to alleviate impairment and functional limitation and to prevent further impairment or disability.

Policyholder is the plan administrator that offers this plan to its eligible Students and Student family members.

Post-service Claim means a request for benefits that involves healthcare services you have already received.

Pre-service Claim means a request for benefits that requires approval by PacificSource in advance (preauthorization) in order for a benefit to be paid.

Predetermination means an estimate provided before dental treatment starts that tells you if treatment is covered, the amount PacificSource will pay, the amount for which you will be responsible, and any alternate treatment options covered by your dental plan. A Predetermination is not a guarantee of payment and is based on benefits available at the time requested.

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

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.

Prophylaxis is a cleaning and polishing of all teeth.

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

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

Pulpotomy is the removal of a portion of the pulp, including the diseased aspect, with the intent of maintaining the vitality of the remaining pulpal tissue by means of a therapeutic dressing.

Radiographic Image means any x-ray or computerized image of the teeth and jaws that provide information for detecting, diagnosing, and treating conditions that can threaten oral and general health. It includes cone beam x-rays, bitewing x-rays, periapical x-rays, intraoral x-rays, extraoral x-rays, panoramic x-rays, and cephalometric x-rays.

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

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

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

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

- The drug, device, or service being tested in the clinical trial unless the drug, device, or service would be covered for that indication by the plan if provided outside of a clinical trial;
- Items or services required for the provisions of the drug, device, or service being tested in the clinical trial;
- Items or services required for the clinically appropriate monitoring of the drug, device, or service being tested in the clinical trial;
- Items or services required for the prevention, diagnosis, or treatment of complications arising from the provision of the drug, device, or service being tested in the clinical trial;
- Items or services that are provided to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- Items or services provided by a clinical trial sponsor free of charge to in the clinical trial; or
- Items or services that are not covered by this plan if provided outside of the clinical trial.

Schedule of Benefits is a summary of the plan 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 plan.

Service Area is Oregon, Idaho, Montana and Washington.

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

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

Specialty Drugs are high dollar oral, injectable, infused, or inhaled biotech medications prescribed for the treatment of chronic and/or genetic disorders with complex care issues that have to be

managed. The major conditions these drugs treat include, but not limited to: cancer, HIV/AIDS, hemophilia, hepatitis C, multiple sclerosis, Crohn's disease, rheumatoid arthritis, and growth hormone deficiency.

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

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

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

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

Student means an individual that 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.

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

Surgical Procedure means any of the following listed operative procedures:

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

Telemedicine is the use of technology for exchange of information when Medically Necessary.

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

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

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

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

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

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

Women's Healthcare Services means organized services to provide healthcare to women, inclusive of the women's preventive services required by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. The services include, but not limited to, maternity care, reproductive health services, gynecological care, general examination, and Preventive Care as medically appropriate, and medically appropriate follow-up visits for these services. Women's Healthcare Services also include any appropriate healthcare service for other health problems, discovered and treated during the course of a visit to a Women's Healthcare Provider for a Women's Healthcare Service, which is within the Providers scope of practice. For purposes of determining a woman's right to directly access health services covered by the plan, maternity care, reproductive health, and preventive services include: Contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breastfeeding, and complications of pregnancy.

Contact us.

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

Your privacy is important to us.

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

Discrimination is Against the Law

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

PacificSource:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at (888) 977-9299.

If you believe that PacificSource has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 7068, Springfield, OR 97475-0068, (888) 779-9299, TTY: 711, Fax (541) 684-5264, or email CRC@pacificsource.com. Please indicate you wish to file a civil rights grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Customer Service Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Amharic	ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የPacificSource Health Plans ሽፋን አስፈላጊ መረጃ አለው።በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖችን ፈልጉ። የጤናን ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት። (888) 977-9299 ይደውሉ።
Arabic	يحوي هذا الاشعار معلومات هامة. يحوي هذا الاشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال PacificSource Health Plans ابحث عن التواريخ الهامة في هذا الاشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصور على المعلومات والمساعدة بلغتك (888) 977-9299 من دون أي تكلفة. اتصل بـ

Bantu-Kirundi	Iyi notice ifise akamaro k’ingenzi. Iyi notice ifise akamaro kingene utegerezwa gusaba canke ivyerekeye PacificSource Health Plans, ucuraba ko ibikenewe kuriyi notice, ushobora gufata umwanzuro ukungene wokurikirana ubuzima bwawe uburihiye. Kandi ukongera kugira uburenganzira bwo kwigenga kuronka amakuru n’ubufasha mu rurimi gwawe atacyo utanze. Hamagara (888) 977-9299.
Cambodian-Mon-Khmer	បសចកតីជូនែំណឹងបនេះ ម្ននព័ែ៌ម្ននយ៉ា ងសំខាន់ ។ បសចកតីជូនែំណឹងបនេះ ម្ននព័ែ៌ម្ននយ៉ា ងសំខាន់ អ្ំពីេបឹង៉ងរេ ឬ ការ៉ា រ់ង រស់អ្នកតាមរយៈ PacificSource Health Plans។ សូមដសែងរកកាលរបិចេេសំខាន់ចាំច់ ជាកនុងបសចកតីជូនែំណឹងបនេះ ។ អ្នកប្រដែលជាប្ែូវការរបចេញសកមមភាព ែល់កំណែ់ថ្ងៃជាក់ចាស់នានា បែេមបីនឹងរកាេុកការ៉ា រ់ង សុខភាពរស់អ្នក ឬប្ាក់ជំនួយបចញថ្ងៃ ។ អ្នកម្ននសិេធិេួលព័ែ៌ម្ននបនេះ និងជំនួយជាកនុងភាសារស់អ្នកជោយមិនអ្ស់លុយប េើយ ។ សូមេូរស័ពទ (888) 977-9299[។
Chinese	本通知含有重要的訊息。本通知對於您透過 PacificSource Health Plans 所提出的申請或保險有重要的訊息。請在本通知中查看重要的日期。您可能要在特定的截止日期之前採取行動，以保留您的健康保險或有助於省錢。您有權利免費以您的母語得到幫助和訊息 請致電 (888) 977-9299。
Cushite-Oromo	Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa PacificSource Health Plans tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta’an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda’a. Kaffaltii irraa bilisa haala ta’een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa (888) 977-9299 tii bilbilaa.
French	Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de PacificSource Health Plans. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l’aide dans votre langue à aucun coût. Appelez (888) 977-9299.
German	Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch PacificSource Health Plans. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter (888) 977-9299.
Italian	Questo avviso contiene informazioni importanti sulla tua domanda o copertura attraverso PacificSource Health Plans. Cerca le date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama (888) 977-9299.
Japanese	この通知には重要な情報が含まれています。この通知には、PacificSource Health Plans の申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。(888) 977-9299までお電話ください。

Korean	본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 PacificSource Health Plans 을 통한 커버리지 에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 리가 있습니다. (888) 977-9299 로 전화하십시오.
Laotian	ການແຈ້ງການນ້ ມ ໍ ຂ້ ມ ູ ນ ໍ ສ າ ຄ ັ ນ. ການແຈ ້ ງການນ ້ ມ ໍ ຂ ້ ມ ູ ນ ່ ທ ໍ ສ າ ຄ ັ ນ ກ ່ ຽ ວ ກ ັ ບ ໍ ຄ ວ າ ຮ ້ ອ ງ ສ ະ ໝ ັ ກ ຫ ຼ ື ການຄ ້ ມ ຄ ອ ງ ຂ ອ ງ ທ ່ ານ ໂ ດ ຍ ຜ ່ ານ PacificSource Health Plans. ເ ປ ໍ ບ ງ ໍ ສ າ ລ ັ ບ ກ ່ ານ ບ ໍ ສ າ ຄ ັ ນ ໃ ນ ແ ຈ ້ ງ ການນ ້ . ທ ່ ານ ອ າ ດ ຈ າ ເ ປ ັ ນ ຕ ້ ອ ງ ໃ ຊ ້ ເ ວ ລ າ ໍ ດ າ ເ ນ ນ ການ ໂ ດ ຍ ກ ່ ານ ບ ໍ ສ າ ມ າ ດ ຈ ະ ເ ຮ ັ ດ ສ ໍ າ ເ ລ ັ ດ ໄ ດ ້ ຖ ້ າ ທ ່ ານ ສ ະ ໜ ອ ງ ຂ ໍ ຂ ໍ ມ ູ ນ ຂ ່ າ ວ ສ ານ ນ ້ ແ ລ ະ ການຊ ່ ວ ຍ ເ ຫ ຼ ື ອ ໃ ນ ພ າ ສ າ ຂ ອ ງ ທ ່ ານ ກ ່ ອ ນ ທ ี ่ ຈ ะ ໄ ດ ້ ຮ ັ ບ ໍ ຂ ້ ມ ู ນ ຂ ่ า ว ส า น น ้ แ ล ะ ก า ร ช ่ ว ย เ ห ล ื อ ห ร ื อ ใ น ภ า ษ า ข อ ง ท ่ า น ก ่ อ น ท ี ่ จ ะ ม ี ค ่ า ใ ช ้ จ ่ า ย . ใ ห (888) 977-9299.
Nepali	यो स चनामा ू महत्त्वप र ्ू ू जानकारी छ । यो स चनामा ू तपाईकं ो आवे िन वा PacificSource Health Plans का माध्यमबाटप्राप्त हुने सदु विाबारे महत्त्वपर् ू ्ू जानकारी छ । यो सचू नामा भएका महत्त्वपर् ू ्ू दमदतहरू ख्याल ि नुहु ोस् । तपाईलं े पाइरहके ो स्वास् ्य दबमा पाइरहन वा तपाईकं ो खचुको भक्तानीमा ु सहायता पाउन के ही समयकारवाही ि न -सीमामा काम- ु पनु े हनसक्छु । तपाईलं े यो जानकारी र सहायता आफ्नो मातभृ ाषामा दन शल् ु क पाउनु तपाईकं ो अदिकार: हो (888) 977-9299 मा फोन ि नुहु ोस् ।
Norweigen	Denne kunngjøringen har viktig informasjon. Kunngjøringen inneholder viktig informasjon om programmet eller dekning gjennom PacificSource Health Plans. Se etter viktige datoer i denne kunngjøringen. Du må kanskje ta affære ved visse frister for å beholde helse-dekning eller økonomisk bistand. Du har rett til å få denne informasjonen og hjelp i ditt spark uten kostnad. Ring (888) 977-9299.
Pennsylvania Dutch	Die Bekanntmaching gebt wichdichi Auskunft. Die Bekanntmaching gebt wichdichi Auskunft baut dei Application oder Coverage mit PacificSource Health Plans. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmde Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix. Kannscht du (888) 977-9299 uffrufe
Persian	این اعلامیه حامی اطلاعات مهم میباشد. این اعلامیه حامی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما مربوط به PacificSource Health Plans به تاریخ های مهم در این اعلامیه توجه نمایید. شما . ممکن است تا به تاریخ های مشخصی برای حفظ پوشش مزایای یا برای کمک به مخارج مزایای ملزوم به انجام کارهایی شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید 977-9299 (888) باشید
Punjabi	ਇਸ ਨੋ ਜਿਸ ਜਵਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੋ ਜਿਸ ਜਵਚ PacificSource Health Plans ਵਲੋਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਿਆਰੇ ਮਹਿੱ ਤਵਪ ਰਨ ਜਾਣਕਾਰੀ ਹੈ . ਇਸ ਨੋ ਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਲਈ ਵੇਖੋ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱ ਚ ਮਦਦ ਦੇ ਇਛੁਿੱ ਕ ਹੋ ਤਾਂ ਤੁਹਾਨ ੂੰ ਅੰ ਤਮ ਤਾਜਰਖ਼ ਤੋਂ ਪਜਹਲਾਂ ਕੁਿੱ ਝ ਖਾਸ ਕਦਮ ਚੁਿੱ ਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ. ਤੁਹਾਨ ੂੰ ਮੁਫ਼ਤ ਜਵਚ 'ਤੇ ਆਪਣੀ ਭਾਸਾ ਜਵਿੱ ਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪਰਾਪਤ ਕਰਨ ਦਾ ਅਜਿਕਾਰ ਹੈ. ਕਾਲ (888) 977-9299
Romanian	Prezenta notificare conține informații importante. Această notificare conține informații importante privind cererea sau acoperirea asigurării dumneavoastre de sănătate prin PacificSource Health Plans. Căutați datele cheie din această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la (888) 977-9299.

Russian	Настоящее уведомление содержит важную информацию. Это уведомление содержит важнуюинформацию о вашем заявлении или страховом покрытии через PacificSource Health Plans. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону (888) 977-9299.
Serbo-Croatian	U ovom obavještenju su sadržane važne informacije. U ovom obavještenju su sadržane važne informacije o Vašoj prijavi ili osiguranju preko PacificSource Health Plans. Pogledajte nalaze li se u ovom obavještenju neki ključni datumi. Možda ćete morati poduzeti određenje radnje u datom roku kako biste i dalje zadržali svoje osiguranje ili pomoć pri plaćanju. Imate pravo da ove informacije, kao i pomoć, dobijete besplatno na svom jeziku. Nazovite (888) 977-9299.
Spanish	Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de PacificSource Health Plans. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al (888) 977-9299.
Tagalog	Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng PacificSource Health Plans. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa (888) 977-9299.
Thai	ประกาศนี้มีข้อมูลสาคัญประกาศนี้มีข้อมูลที่สาคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน PacificSource Health Plans ดูกาหนดการในประกาศนี้คุณอาจจะต้องดาเนินการภายในกาหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่ายคุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่ายโทร (888) 977-9299.
Ukrainian	Це повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про Ваше звернення щодо страхувального покриття через PacificSource Health Plans. Зверніть увагу на ключові дати, вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону (888) 977-9299.
Vietnamese	Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin nộp hoặc hợp đồng bảo hiểm qua chương trình PacificSource Health Plans. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình hoàn toàn miễn phí. Xin gọi số (888) 977-9299.