



Linfield University

Group Number: G0047082

Navigator Platinum 500+25-50_20 S3

Effective: 2026-2027





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

Using this Certificate of Coverage (Herein Called Student Guide)

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

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

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.

If you are in need of a PacificSource Member ID card you may contact our Customer Service team or visit our website, [PacificSource.com/members/getting-care/id-card](https://www.pacificsource.com/members/getting-care/id-card).

PacificSource Customer Service

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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PacificSource Website

[pacificsource.com/students](https://www.pacificsource.com/students)

CONTENTS

MEDICAL BENEFIT SUMMARY	A
PRESCRIPTION DRUG BENEFIT SUMMARY	F
VISION BENEFIT SUMMARY	H
PEDIATRIC DENTAL BENEFIT SUMMARY.....	J
UNDERSTANDING HOW YOUR BENEFITS ARE PAID.....	1
BENEFIT YEAR	1
YOUR DEDUCTIBLE	1
YOUR COPAYMENT	1
YOUR COINSURANCE	1
YOUR OUT-OF-POCKET LIMIT.....	2
ESSENTIAL HEALTH BENEFITS.....	2
UNDERSTANDING MEDICAL AND DENTAL NECESSITY.....	2
UNDERSTANDING EXPERIMENTAL, INVESTIGATIONAL, OR UNPROVEN SERVICES.....	2
ELIGIBLE PROVIDERS.....	3
COVERED SERVICES.....	3
PREVENTIVE CARE SERVICES	3
PROFESSIONAL SERVICES	4
AMBULANCE SERVICES.....	7
BLOOD TRANSFUSIONS	7
BREAST PROSTHESES	8
COCHLEAR IMPLANTS	8
CONTRACEPTIVES AND CONTRACEPTIVE DEVICES/FAMILY PLANNING.....	8
DIABETIC EQUIPMENT, SUPPLIES, AND TRAINING.....	8
DIAGNOSTIC AND THERAPEUTIC RADIOLOGY/LABORATORY AND DIALYSIS – (NON-ADVANCED).....	8
DIAGNOSTIC IMAGING – ADVANCED	9
DURABLE MEDICAL EQUIPMENT.....	9
ELEMENTAL ENTERAL FORMULA.....	10
EMERGENCY ROOM – PROVIDER AND FACILITY.....	10
HOME HEALTHCARE SERVICES.....	11
HOSPICE CARE SERVICES.....	11
INFERTILITY SERVICES	11
INPATIENT SERVICES	11

MATERNITY SERVICES	12
OUTPATIENT SERVICES	13
PEDIATRIC DENTAL SERVICES.....	13
CLASS I SERVICES (COVERED FOR MEMBERS AGE 18 AND YOUNGER).....	13
CLASS II SERVICES (COVERED FOR MEMBERS AGE 18 AND YOUNGER).....	14
CLASS III SERVICES (COVERED FOR MEMBERS AGE 18 AND YOUNGER).....	14
PRESCRIPTION DRUGS	15
TEMPOROMANDIBULAR JOINT SERVICES (TMJ)	19
TRANSPLANT SERVICES	19
VISION SERVICES.....	20
WOMEN'S HEALTH AND CANCER RIGHTS	20
BENEFIT EXCLUSIONS.....	21
UTILIZATION REVIEW	26
PRIOR AUTHORIZATION	26
CASE MANAGEMENT	27
INDIVIDUAL/SUPPLEMENTAL BENEFITS.....	28
USING THE PROVIDER NETWORK.....	28
LINFELD STUDENT HEALTH CENTER	28
IN-NETWORK PROVIDERS.....	28
YOUR PRIMARY CARE PROVIDER.....	29
SHARED DECISION MAKING.....	29
FINDING AN IN-NETWORK PROVIDER	30
OUT-OF-NETWORK PROVIDERS.....	30
COVERAGE WHILE TRAVELING	32
EPIDEMIC.....	33
TERMINATION OF PROVIDER CONTRACTS	33
BENEFIT DETERMINATIONS AND CLAIMS PAYMENT.....	34
COORDINATION OF BENEFITS.....	36
THIRD PARTY LIABILITY	40
COMPLAINTS, GRIEVANCES, AND APPEALS	42
QUESTIONS, CONCERNS, OR COMPLAINTS.....	42
GRIEVANCE PROCEDURES.....	42
APPEAL PROCEDURES.....	43
HOW TO SUBMIT GRIEVANCES OR APPEALS	44
BECOMING COVERED	45

ELIGIBILITY	45
EFFECTIVE DATE OF COVERAGE	45
ENROLLING AFTER THE INITIAL ENROLLMENT PERIOD	46
GENERAL PLAN PROVISIONS	46
TERM AND TERMINATION – COVERAGE	47
RESOURCES FOR INFORMATION AND ASSISTANCE	47
FEEDBACK AND SUGGESTIONS	49
RIGHTS AND RESPONSIBILITIES	49
PRIVACY AND CONFIDENTIALITY	50
PLAN ADMINISTRATION	50
DEFINITIONS	51

Benefit Year: August 15, 2026 – August 14, 2027

Provider Network: Navigator

Who is eligible?

All Students are required to carry medical insurance coverage comparable to that offered through the school's Student Health Insurance Plan. Unless specifically waived with proof of coverage with another plan, Students will automatically be covered under the Student Health Insurance Plan, and the premiums charged to their account with the school.

	Per Session
Undergraduate - Fall	\$2,130.00
Undergraduate - Winter	\$2,638.00
Undergraduate - Spring/Summer	\$2,130.00

This plan has an Actuarial Value of 88.56% which satisfies the platinum metal level of the ACA.

Deductible Per Benefit Year	In-network	Out-of-network
Individual	\$500	\$900
Out-of-Pocket Limit Per Benefit Year	In-network	Out-of-network
Individual	\$3,500	\$10,500

Note: In-network deductible and out-of-pocket limit accumulate separately from the out-of-network deductible and out-of-pocket limit. 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 may in certain situations bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company (called balance billing). Balance billing amounts are not counted toward the out-of-network out-of-pocket limit. For additional information about balance billing or allowable fees, see 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 Pays	Member
Preventive Care				

Service/Supply	In-network	Member Pays	Out-of-network Pays	Member
Well baby/Well child care, ages birth - 21	No deductible, 0%		After deductible, 50%	
Preventive physicals	No deductible, 0%		After deductible, 50%	
Preventive STD screening	No deductible, 0%		After deductible, 50%	
Well woman visits	No deductible, 0%		After deductible, 50%	
Preventive mammograms	No deductible, 0%		After deductible, 50%	
Immunizations	No deductible, 0%		After deductible, 50%	
Preventive colonoscopy	No deductible, 0%		After deductible, 50%	
Professional Services				
PCP office and home visits	First three visits no deductible, \$5. Subsequent visits, no deductible, \$25*.		After deductible, 50%	
Naturopath office visits	No deductible, \$25		After deductible, 50%	
Specialist office and home visits	No deductible, \$50		After deductible, 50%	
Telehealth visits	First three visits no deductible, \$5. Subsequent visits, no deductible, \$25*.		After deductible, 50%	
Newborn nurse home visits	No deductible, 0%		After deductible, 50%	
Office procedures and supplies	After deductible, 20%		After deductible, 50%	
Surgery	After deductible, 20%		After deductible, 50%	
Outpatient rehabilitation and habilitation services	No deductible, \$25		After deductible, 50%	
Acupuncture (12 visits per benefit year)	No deductible, \$25		After deductible, 50%	
Chiropractic manipulation/Spinal manipulation (20 visits per benefit year)	No deductible, \$25		After deductible, 50%	
Hospital Services				
Inpatient room and board	After deductible, 20%		After deductible, 50%	

Service/Supply	In-network	Member Pays	Out-of-network Pays	Member
Inpatient rehabilitation and habilitation services	After deductible, 20%		After deductible, 50%	
Skilled nursing facility care	After deductible, 20%		After deductible, 50%	
Outpatient Services				
Outpatient surgery/services	After deductible, 20%		After deductible, 50%	
Diagnostic imaging – advanced	After deductible, 20%		After deductible, 50%	
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	No deductible up to \$400, then after deductible, 20%		After deductible, 50%	
Urgent and Emergency Services				
Urgent care center visits	No deductible, \$25		After deductible, 50%	
Emergency room visits – medical emergency	No deductible, \$200^		No deductible, \$200^	
Emergency room visits – non-emergency	No deductible, \$200^		No deductible, \$200^	
Ambulance, ground	After deductible, 20%		After deductible, 20%	
Ambulance, air	After deductible, 20%		After deductible, 20%	
Maternity Services**				
Physician/Provider services (global charge)	After deductible, 20%		After deductible, 50%	
Hospital/Facility services	After deductible, 20%		After deductible, 50%	
Mental Health and Substance Use Disorder Services				
Office visits	First three visits no deductible, \$5. Subsequent visits, no deductible, \$20*.		No deductible, \$20	
Inpatient care	After deductible, 20%		After deductible, 20%	
Residential programs	After deductible, 20%		After deductible, 20%	
Other Covered Services				
Allergy injections	After deductible, 20%		After deductible, 50%	
Durable medical equipment +	After deductible, 20%		After deductible, 50%	

Service/Supply	In-network	Member Pays	Out-of-network Pays	Member
Home health services		After deductible, 20%		After deductible, 50%
Transplants		After deductible, 20%		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.

^ Copay applies to ER physician and facility charges only. Copay waived if admitted into hospital.

*First three visits per benefit year combined for Professional Services – Office and home visits, Telehealth visits, and Mental Health and Substance Use Disorder Services – Office visits.

+ Cochlear implants will not be subject to a deductible.

** 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.

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.

Note that there is a separate category for in-network and out-of-network when it comes to meeting your deductible. Only in-network expense applies to the in-network deductible and only out-of-network expense applies to the out-of-network deductible.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for covered services during the benefit 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 benefit year. 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.

Note that there is a separate category for in-network and out-of-network when it comes to meeting your out-of-pocket limit. Only in-network expense applies to the in-network out-of-pocket limit and only out-of-network expense applies to the out-of-network out-of-pocket limit.

Payments to providers

Payment to providers is based on the prevailing or allowable fee for covered services. In-network providers accept the allowable fee as payment in full. Services of out-of-network providers could result in out-of-pocket expense in addition to the percentage indicated.

Prior authorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Discrimination is against the law

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

Benefit Year: August 15, 2026 – August 14, 2027

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](https://www.pacificsource.com/find-a-drug).

The amount you pay for covered prescriptions at in-network pharmacies applies toward your plan's in-network medical out-of-pocket limit, the amount you pay for covered prescriptions at out-of-network pharmacies applies toward your plan's out-of-network out-of-pocket limit which is shown on the Medical Benefit Summary. 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 benefit 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](https://www.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 when filled at an in-network pharmacy. 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 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 exception review 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, \$20*	No deductible, \$35*	No deductible, \$55*	No deductible, \$80
In-network Mail Order Pharmacy				
Up to a 90 day supply:	No deductible, \$60*	No deductible, \$105*	No deductible, \$165*	No deductible, \$240
Compound Drugs**				
Up to a 30 day supply:	No deductible, \$55			
Out-of-network Pharmacy				
30 day maximum fill, no more than three fills allowed per year:	No deductible, 90%			

*Prescription insulin is not subject to a deductible and is limited to \$35 copay per 30 day supply when filled at an in-network pharmacy.

**Compounded medications are subject to a prior authorization process. Compounds are generally covered only when all commercially available formulary products have been exhausted and all the ingredients in the compounded 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 out-of-pocket limit. Does not apply to formulary tobacco cessation and preventive bowel prep kits covered under USPSTF guidelines.

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

Benefit Year: August 15, 2026 – August 14, 2027

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. Copayment and/or coinsurance for covered charges apply to the medical plan's 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%	No deductible, 0% up to \$40 then 100%
Vision hardware	No deductible, 0%	No deductible, 0% up to \$75 then 100%
Members Age 19 and Older		
Eye exam	No deductible, 0%	No deductible, 0%

Benefit Limitations: members age 18 and younger

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

Benefit Limitations: members age 19 and older

- One vision exam every benefit 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.
- Lens tint, for members age 19 and older.
- Lenses, frames, or contact lenses, for members age 19 and older.
- Medical or surgical treatment of the eye.
- Non-prescription lenses.
- Plano contact lenses.
- Services or supplies not listed as covered services.

- Services or supplies received before this plan's coverage begins or after it ends.
- Special procedures, such as orthoptics or vision training.
- Special supplies, such as sunglasses and subnormal vision aids, for members age 19 and older.
- 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.

Benefit Year: August 15, 2026 – August 14, 2027

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).

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 Benefit Year		All Providers
Individual		See your Medical Benefit Summary
Out-of-Pocket Limit Per Benefit Year		All Providers
Individual		See your Medical Benefit Summary
Note: You may be responsible for any charges that are over the allowable fee. 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	All Providers Member Pays
Class I Services (Covered for members age 18 and younger.)	
Examinations	No deductible, 0%
Bitewing films, full mouth x-rays, cone beam x-rays, and/or panorex	No deductible, 0%
Dental cleaning (prophylaxis and periodontal maintenance)	No deductible, 0%
Fluoride (topical or varnish applications)	No deductible, 0%
Sealants	No deductible, 0%
Space maintainers	No deductible, 0%
Athletic mouth guards	No deductible, 0%
Brush biopsies	No deductible, 0%

Service/Supply

All Providers Member Pays

Class II Services (Covered for members age 18 and younger.)

Fillings	After deductible, 20%
Simple extractions	After deductible, 20%
Periodontal scaling and root planing	After deductible, 20%
Full mouth debridement	After deductible, 20%

Class III Services (Covered for members age 18 and younger.)

Complicated oral surgery	After deductible, 40%
Pulp capping	After deductible, 40%
Pulpotomy	After deductible, 40%
Root canal therapy	After deductible, 40%
Periodontal surgery	After deductible, 40%
Tooth desensitization	After deductible, 40%
Crowns	After deductible, 40%
Dentures	After deductible, 40%
Bridges	After deductible, 40%
Replacement of existing prosthetic device	After deductible, 40%
Implants	After deductible, 40%
Orthodontia for medically necessary reasons for members age 18 and younger	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.

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 Benefit Summary for your deductible amount.

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 benefit 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 benefit year. Non-essential health benefits, penalties, and balance billed amounts over the allowable fee do not accumulate toward the out-of-pocket limit.

Prior authorization

Coverage of certain services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Discrimination is against the law

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

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, out-of-pocket limits, and benefit maximums. For more information, see the benefit summaries for plan details.

BENEFIT YEAR

Contract Year

Many benefits and provisions in this plan are calculated on a contract year basis. 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. Any benefit with a separate maximum benefit (for example, not on a contract year basis) is identified in the Covered Services section of this student guide. Each year these provisions renew and may change, and you must satisfy the new or revised amounts for that year.

If this plan renews or is modified mid-contract year, the previously satisfied Deductibles, out-of-pocket limits, and benefit maximums will be credited toward the renewed or modified plan.

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 Benefit Year. The amount that accrues to the Deductible is the Allowable Fee.

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

- Charges over the Allowable Fee;
- 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.

YOUR OUT-OF-POCKET LIMIT

This plan has an out-of-pocket limit provision. The benefit summaries show your plan's annual out-of-pocket limits. If you incur Covered Service expenses over those amounts, this plan will pay 100 percent of the Allowable Fee for the remainder of the Benefit 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 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 Drugs 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 AND DENTAL NECESSITY

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

Be careful – just because a treatment is prescribed or recommended by a Provider does not mean it is Medically/Dentally Necessary under the terms of this plan. This plan provides coverage only when such care is necessary to treat an Illness or Injury or the service qualifies as preventive care. All treatment is subject to review for Medical/Dental Necessity. Review of treatment may involve prior authorization, 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/Dental Necessity determination.

Some Medically/Dentally Necessary services are not Covered Services. Medically/Dentally 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 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. In addition, if you seek services from a Provider outside Idaho, Montana, Oregon, and Washington, we may delegate the development and use of evidence-based criteria to a third party for such services. 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 an eligible Provider, Hospital, Specialized Treatment Facility, Durable Medical Equipment Supplier, or other licensed 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.

COVERED SERVICES

This section of the student guide contains information about the benefits provided under the plan. You are responsible for all charges for services that are not a Covered Service.

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/Dentally Necessary, yet not be a Covered Service. For information about exclusions, see the Benefit Exclusions section.

Subject to all the terms of this plan, the following services and supplies are covered according to the benefit summaries.

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 benefit.

For a list of the services that fall within this benefit, please visit the USPSTF website, uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations or the HRSA website, hrsa.gov/womens-guidelines (note that these websites may change). For Members who do not have Internet access or have additional questions, please contact our Customer Service team 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. If this plan qualifies as a Health Savings Account (HSA) plan, only ACA required preventive services are covered before Deductible at In-network Providers.

Colorectal Cancer Screening

This plan covers colorectal cancer screening as required under ACA. Screening coverage includes a follow up colonoscopy performed after a positive non-invasive stool based screening or direct visualization. For colorectal cancer screenings not required to be covered as preventive under ACA, see the Diagnostic and Therapeutic Radiology/Laboratory and Dialysis – (non-advanced) section.

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 x-ray 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 Benefit 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.

Weight Reduction or Control Services

This plan covers medical nutritional therapy and obesity screening for children ages six and older and adults who qualify as obese, as required under the USPSTF recommendations.

Medical nutritional therapy will also be provided for women 40 to 60 years of age with normal or overweight body mass to maintain weight or limit weight gain to prevent obesity.

Well Baby/Well Child Care

This plan covers well baby/well child examinations. Only laboratory tests and other routine screening procedures related to the well baby/well child exam are covered by this benefit. Diagnostic x-ray 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 Benefit Year

Well Woman Care

This plan covers ACA recommended Women's Healthcare Services. Services include, but not limited to, preventive mammograms including 3D, preventive gynecological exams, pelvic exams, pap smears, and maternity related services to be covered as preventive under the ACA. For diagnostic mammograms, see the Diagnostic and Therapeutic Radiology/Laboratory and Dialysis – (non-advanced) section.

PROFESSIONAL SERVICES

Acupuncture

This plan covers services for acupuncture.

- Benefits are limited as follows: Up to 12 visits per Benefit Year.

Audiological Tests

This plan covers audiological (hearing) tests.

Biofeedback

This plan covers biofeedback services to treat migraine headaches or urinary incontinence.

- Benefits are limited as follows: Lifetime Maximum of ten 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 a Lifetime Maximum of 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 children's advocacy center. Children's advocacy 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

This plan covers services for chiropractic manipulation/spinal manipulation.

- Benefits are limited as follows: Up to 20 visits per Benefit 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;
- When necessary to correct a scar or defect on the head or neck that resulted from a covered surgery; or
- When necessary for gender affirmation.

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 review.

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.

Foot Care

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

Gender Affirmation

This plan covers Medically Necessary gender affirming services and related procedures.

Genetic Counseling

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

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.

Injectable Drugs and Biologicals

This plan covers injectable drugs and biologicals when administered by a Provider and Medically Necessary for diagnosis or treatment of an Illness or Injury. For information about drugs or biologicals that can be self-administered or are dispensed to a patient, see the Prescription Drugs section.

Injury of the Jaw or Natural Teeth

This plan covers the services of a Provider to treat Injury of the jaw or natural teeth.

Intravenous Immunoglobulin Therapy

This plan covers up to three monthly immunomodulatory courses of intravenous immunoglobulin therapy (IVIG) for the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS) when certain conditions are met. Certain medications to treat PANDAS/PANS may be available under your Prescription Drug benefit. For more information, contact our Customer Service team.

Medical Nutritional Therapy

This plan covers medical nutritional therapy for diabetes, inborn errors of metabolism, eating disorders, and obesity if provided by a qualified Provider.

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.

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.

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 Benefit Year.

Sleep Studies

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

Surgery

This plan covers surgery and other outpatient services performed in a Providers office or an Ambulatory Surgical Center.

Telehealth

This plan covers Medically Necessary Telehealth services when provided by a Provider.

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 wisdom teeth.

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 only covered when ground transportation is medically or physically inappropriate.

BLOOD TRANSFUSIONS

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

BREAST PROSTHESES

This plan covers removal, repair, and/or replacement of breast prostheses due to a contracture or rupture, but only when the original prosthesis was for a Medically Necessary Mastectomy. 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;
- Removal, repair, and/or replacement of the prosthesis is not covered when recommended due to an autoimmune disease, connective tissue disease, arthritis, allergic syndrome, psychiatric syndrome, fatigue, or other systemic signs or symptoms.

COCHLEAR IMPLANTS

This plan covers single or bilateral cochlear implants when Medically Necessary, including the fitting, programming and reprogramming, or other Assistive Listening Devices. The cost of repair and replacement parts are covered if the repair or replacement parts are not under warranty. Contact our Customer Service team for specific coverage requirements.

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:

- Diabetic supplies other than insulin and syringes (such as lancets, test strips, and glucostix).
- Insulin pumps.
- Diabetic insulin, syringes, and continuous glucose monitors are covered under your Prescription Drug benefit when criteria is met. 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 and prediabetes (via National Diabetes Prevention Programs). The training must be provided by a Provider with expertise in diabetes.
- Medically Necessary Telehealth, via two-way electronic communication, provided in connection with the treatment of diabetes.

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 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, non-preventive colonoscopies will be covered under the diagnostic benefit and is subject to cost sharing.

A mammogram, MRI, and ultrasound for a Diagnostic Breast Examination or Supplemental Breast Examination are paid at no cost share when provided by an In-network Provider.

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 an 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 the Medical Benefit Summary for Outpatient Services – Diagnostic and therapeutic radiology/lab and dialysis – (non-advanced).

Please see the Medical Benefit Summary for cost sharing information on benefits that fall under this category.

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.

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, performing physical activities, or essential job-related activities and are not for comfort or convenience, and that maximizes the Member's whole body health, including lower and upper limb functions. 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:
 - 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.
 - 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. 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 sleep disorders.

- Hearing Aids: Hearing Aids, Assistive Listening Devices, 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) 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 Benefit 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 the Medical Benefit Summary 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, or purchased from a retail outlet, and are limited to once per pregnancy. Hospital-grade breast pump rentals are covered.
- Wigs: Wigs following Chemotherapy or Radiation Therapy are covered up to one synthetic wig per Benefit Year.

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.

ELEMENTAL ENTERAL FORMULA

This plan covers Medically Necessary non-prescription elemental enteral formula ordered by a Provider for home use to treat severe intestinal malabsorption disorder when 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 HEALTHCARE SERVICES

This plan covers Home Healthcare services, including home infusion services that cannot be self-administered, when provided by a licensed home health agency.

- Benefits are limited as follows: 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 when determined Medically Necessary.
 - Respite care: Care is subject to a maximum of five consecutive days and to a Lifetime Maximum of 30 days. The Member must be enrolled in a hospice program to be eligible for respite care benefits.

INFERTILITY SERVICES

This plan covers Infertility services and procedures including evaluation and diagnostic services to determine the cause of Infertility. Covered Services are limited to office visits and related diagnostic procedures to establish the diagnosis of Infertility.

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. For more information, see Pediatric Dental Care Requiring General Anesthesia in the Professional Services section.

Inpatient Habilitation

This plan covers inpatient Physical/Occupational Therapy and speech therapy services. 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 concurrent review by PacificSource.

- Benefits are limited as follows: Up to 30 days per Benefit Year with extensions subject to Medical Necessity review. Benefit limit does not apply to Behavioral Health Condition. Additional treatment may be considered 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. Recreation therapy is only covered as part of an inpatient admission.

- Benefits are limited as follows: Up to 30 days per Benefit Year with extensions subject to Medical Necessity review. Benefit limit does not apply to Behavioral Health Condition. Additional treatment may be considered when criteria for individual benefits are met.

Mental Health and Substance Use Disorder Services – Inpatient

This plan complies with all federal laws and regulations related to the Mental Health Parity and Addiction Equity Act of 2008. Treatment of Substance Use Disorder and related disorders is subject to placement criteria established in the current edition of American Society of Addiction Medicine.

This plan covers crisis intervention, diagnosis, and treatment of Behavioral Health Conditions and Substance Use Disorders including withdrawal management by a Mental Health and/or Substance Use Disorder Healthcare Provider or Mental Health and/or Substance Use Disorder Healthcare Program or Mental Health and/or Substance Use Disorder Healthcare Facility, except as otherwise excluded in this plan. Services are also covered when provided by a qualified Provider for covered diagnoses when the Member is in a Skilled Nursing Facility.

Skilled Nursing Facilities and Convalescent Homes

This plan covers 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 Benefit Year. Confinement for Custodial Care is not covered.

MATERNITY SERVICES

This plan covers services of Providers practicing within the scope of their license, for prenatal and postnatal (provided within six weeks of delivery) maternity, 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.

This plan covers labor and delivery services at an out-of-network facility when a Member is unable to be treated by an in-network facility during a declared public health emergency. These services will be paid at the in-network cost sharing amount.

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.

OUTPATIENT SERVICES

Autism Spectrum Disorder Services and Applied Behavioral Analysis (ABA) Therapy

This plan covers treatment for autism spectrum disorders, including but not limited to, ABA according to PacificSource's guidelines for Medical Necessity. Treatment plans are required for certain services.

Mental Health and Substance Use Disorder Services – Outpatient

This plan complies with all federal laws and regulations related to the Mental Health Parity and Addiction Equity Act of 2008. Treatment of Substance Use Disorder and related disorders is subject to placement criteria established in the current edition of American Society of Addiction Medicine.

This plan covers crisis intervention, diagnosis, and treatment of Behavioral Health Conditions and Substance Use Disorders including withdrawal management by a Mental Health and/or Substance Use Disorder Healthcare Provider or Mental Health and/or Substance Use Disorder Healthcare Program, except as otherwise excluded in this plan.

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 Benefit Year with extensions subject to Medical Necessity review. Benefit limit does not apply to Behavioral Health Condition. Additional treatment may be considered 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: Up to a combined maximum of 30 visits per Benefit Year with extensions subject to Medical Necessity review. Benefit limit does not apply to Behavioral Health Condition. Additional treatment may be considered when criteria for individual benefits are met.

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

PEDIATRIC DENTAL SERVICES

Pediatric dental services are covered 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 Benefit Year. Separate charges for review of a proposed treatment plan or for diagnostic aids are not covered. Problem focused and emergency 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 Benefit Year. The limitation for dental cleaning applies to any combination of Prophylaxis and/or Periodontal Maintenance in the Benefit 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** are limited to a combined total of four applications per Benefit Year.
- **Caries arresting medicament** is limited to one application every six months per tooth.
- **Application of sealants** are limited to one application in a 36 month period to permanent molars and bicuspid, except for visible evidence of clinical failure.
- **Space maintainers** are covered.
- **Athletic mouth guards** are limited to a Lifetime Maximum of one.
- **Brush biopsies** used to aid in the diagnosis of oral cancer are covered.

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

- **Palliative (emergency) treatment of dental pain** is covered.
- **Composite Resin and Amalgam Restoration (fillings)** are limited to the same tooth 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 only covered 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 only covered for primary 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.
- **Initial cast partial denture, full denture, immediate denture, or overdenture** are limited to the cost of a standard full or cast partial denture. A separate charge for denture adjustments and relines performed within six months of the initial placement is not a Covered Service. 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 only covered 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 a Lifetime Maximum of one 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.
- **Occlusal guards (night guards)** are limited to a Lifetime Maximum of one.
- **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. A treatment plan is required by PacificSource.

PRESCRIPTION DRUGS

This plan covers certain prescription medications included on your Drug List. Please refer to [PacificSource.com/find-a-drug](https://www.pacificsource.com/find-a-drug) for an up-to-date list of drugs and other information about your prescription benefit including quantity limits. 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 a tier. Formularies are reviewed and updated monthly, and a drug may be added, removed, or moved to a higher or lower tier. 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 some Specialty Drugs.
- Tier 4 is comprised of medications that are mostly Specialty Drugs.

See the Prescription Drug Benefit Summary 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. In addition to payments made by a Member, a Member receives credit toward cost share for coupons or other payments made on their behalf for a covered Prescription Drug that is (a) without a generic or therapeutic equivalent on our formulary, or (b) for any drug on our formulary that the Member receives pursuant to prior authorization, Step Therapy, or through our Prescription Drug exception request process. If this is an HSA plan, the provisions of this section apply only to preventive services until the Member has satisfied the statutory minimum Deductible.

Mail Order Pharmacy

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

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 Specialty Pharmacies for these high-cost medications (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 and must be filled through our exclusive network Specialty Pharmacies. Specialty Drugs are not available through the in-network retail pharmacy network, mail order service, or non-exclusive Specialty Pharmacies without authorization.

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 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.

Continuous glucose monitors (receivers, transmitters, and sensors) are only covered under the pharmacy benefit with a Provider prescription when criteria is met.

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 exception review 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.

Perimenopause, Menopause, and Postmenopause

This policy covers treatment of perimenopause, menopause, and postmenopause, including:

- Hormone therapy including combination estrogen and hormone medicines, combination estrogen and progesterone medicines and estrogen-only medicines;
- Selective serotonin reuptake inhibitors (SSRIs) and selective serotonin and norepinephrine reuptake inhibitor (SNRIs);
- Vaginal estrogen;
- Medications to prevent or treat osteoporosis;
- Neurokinin B antagonists;
- Topical hormone therapy; and
- Bioidentical hormones.

Coverage of drugs is limited to those approved by the FDA. This benefit may be subject to utilization management or Medical Necessity review.

Pre-exposure and Post-exposure Prophylaxis

This plan covers pre-exposure prophylaxis (PrEP) medications for the prevention of HIV infection and post-exposure prophylaxis (PEP) medications after a potential exposure to HIV. These medications are paid at no cost share. If this is an HSA plan, these medications are subject to cost sharing until the Deductible is met. Select PrEP medications are covered at no cost under the Affordable Care Act (ACA) when used for preventive purposes.

Anticancer Medications

Orally administered and self-administered anticancer medications used to kill or slow the growth of cancerous cells are available when prescribed. All orally administered cancer medications will be covered on the same basis and at no greater cost sharing than imposed for IV or injected cancer medication. See the Prescription Drug Benefit Summary 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:
 - Drugs for any condition excluded under the medical plan.
 - FDA approved medications used for the purpose of weight reduction control or weight loss.
 - FDA approved medications for cosmetic purposes.
 - 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.
 - 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 formulary prenatal vitamins, fluoride products, and for drugs that have a rating of A or B from the USPSTF, some restrictions may apply.
 - Drugs provided to an international covered Member in their home country.
- 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. Determinations on standard exception requests will be made no later than 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 and Surgical Procedures, must be provided by Providers practicing within the scope of their licenses. Services are only covered 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, preparation, and facility fees for both donors and recipients: stem cell transplants and high-dose Chemotherapy; corneal transplants; heart; heart – lungs; intestine; kidney; kidney – pancreas; liver; lungs; and whole organ pancreas transplantation. Expenses for the acquisition of organs or tissues for transplantation are only covered 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:
 - 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 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 only covered 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 this plan's in-network transplant benefit. If our contract with the facility includes the services of the medical professionals performing the transplant, those charges are also subject to this plan's in-network transplant benefit. If the professional fees are not included in our contract with the facility, then those benefits are provided according to the Medical Benefit Summary.

Transplant services that are not received at an in-network Center of Excellence and/or services of out-of-network medical professionals are paid at the Out-of-network Provider percentages stated in the Medical Benefit Summary. 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 a Provider 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.

See the Vision Benefit Summary for cost share information and benefit details.

Adult

This plan covers vision examinations 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, or contact lenses for Members age 18 and younger.

WOMEN'S HEALTH AND CANCER RIGHTS

Breast Reconstruction

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 the patient for:

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

Benefits for breast reconstruction are subject to all terms and provisions of the plan, including Deductibles, 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.
- Adolescent wilderness treatment programs.
- Aesthetic (cosmetic) dental procedures – Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.
- Antimicrobial agents – Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.
- Athletic Injuries sustained while competing or practicing for a professional or semiprofessional athletic contest.
- Aversion therapy.
- Biofeedback, except as specified as a Covered Service in this plan.
- Charges for missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims unless otherwise contracted with the Provider.
- 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, including non-skilled care and helping with activities of daily living, except as specified above in conjunction with Home Healthcare or Hospice Care.
- Dental examinations and treatment, for Members age 19 and older, to prevent, diagnose, or treat diseases or conditions of the teeth and supporting tissues or structures, including treatment that restores the function of teeth.

- Denture replacement due to loss, theft, or breakage, unless otherwise noted in Covered Services.
- Diabetic shoes and shoe modifications.
- 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.
- Educational or correctional services or sheltered living provided by a school or halfway house, except outpatient services received while temporarily living in a shelter.
- Equine/animal therapy.
- Equipment commonly used for non-medical 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.
- Expense incurred by a Member; not a United States citizen; for services performed within the Student's home country; if the Student's home country has a socialized medicine program.
- 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: has not yet received recognized compendia support (for example, UpToDate, Lexicomp, FDA) for other than Experimental, Investigational, or Unproven, or clinical testing; is not of generally accepted medical practice in your plan's state of issuance or as determined by medical advisors, medical associations, and/or technology resources; is not approved for reimbursement by the Centers for Medicare and Medicaid Services; is furnished in connection with medical or other research; or is considered by any governmental agency or subdivision to be Experimental, Investigational, or Unproven, not reasonable and necessary, or any similar finding.

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.
- Eye glasses/Contact lenses for Members age 19 and older – The fitting, provision, or replacement of eye glasses, lenses, frames, contact lenses, or subnormal vision aids intended to correct refractive error.
- Eye 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.
- Gnathological recordings, occlusal equilibration procedures, or similar procedures.

- 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.
- Infertility – Surgery to reverse voluntary sterilization, sexual dysfunction, services and supplies for intrauterine insemination (IUI), in vitro fertilization, treatment of Infertility, and Prescription Drugs.
- Instructional or educational programs, except National Diabetes Prevention Programs, 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, medications, or supplies for developmental or degenerative abnormalities of the jaw, malocclusion, dental implants, improving placement of dentures, and artificial larynx.
- Maintenance supplies and equipment not unique to medical care.
- Massage or massage therapy, even as part of a physical therapy program.
- Mattresses and mattress pads unless Medically Necessary to heal pressure sores.
- Mental health treatment related to the following are excluded: court-mandated psychological evaluations for child custody determinations; voluntary mutual support groups; 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 Behavioral Health Condition; 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 services and bariatric surgery – All services, medications, supplies, food supplementation, or self-help programs provided for obesity, weight reduction control, weight loss, or cosmetic purposes, regardless of the medical conditions that may be caused or exacerbated by excess weight, except as specified under weight reduction or control services in the Preventive Care Services section. Bariatric surgery and other gastric restrictive procedures, or the revision or reversals of these procedures.
- Oral/facial motor therapy for strengthening and coordination of speech-producing musculature and structures, except as Medically Necessary in the restoration or improvement of speech following a traumatic brain Injury or for Members diagnosed with a pervasive developmental disorder.
- Orthodontic services – Repair or replacement of orthodontic appliances.

- Orthodontic services – Treatment of misalignment of teeth and/or jaws, or any ancillary services performed because of orthodontic treatment, except as specified in the Covered Services section.
- 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 non-Prescription 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.
- Personal items such as telephones, televisions, and guest meals during a stay at a Hospital or other inpatient facility.
- Photographic images.
- Physical or eye examinations required 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.
- 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 in the Preventive Care 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 covered 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 not listed as a Covered Service, unless required under federal or state 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 professional that is an Immediate Family Member.
- 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 patient. This includes appliances like adjustable power beds sold as furniture, air conditioners, air purifiers, room humidifiers, heating and cooling pads, home blood pressure monitoring equipment, light boxes, conveyances other than conventional wheelchairs, whirlpool baths, spas, saunas, heat lamps, tanning lights, and pillows.
- Sexual disorders – Services or supplies for the treatment of erectile or sexual dysfunction, unless defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.
- Sinus lift grafts to prepare sinus site for implants.
- Skin and tissue removal related to cosmetic body contouring procedures.
- Snoring – Services or supplies for the diagnosis or treatment of snoring, except when attributed to the diagnosis of sleep apnea.
- 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.
- 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 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 the On-the-Job Illness or Injury and Workers' Compensation section.
- Treatment prior to enrollment.
- Unwilling to release information – Charges for services or supplies for which a Member is unwilling to release medical, dental, or eligibility information necessary to determine the benefits covered under this plan.
- War-related conditions – The treatment of any condition caused by or arising out of an act of war, armed invasion, or while in the service of the armed forces unless not covered by the Member's military or veterans coverage.

UTILIZATION REVIEW

PacificSource has a utilization review program to determine coverage. This program is administered by our Health Services team for prior authorization, concurrent reviews, and post-service reviews. PacificSource may delegate certain utilization review functions to third parties, including utilization review for services rendered by Providers outside of Idaho, Montana, Oregon, and Washington. Questions regarding Medical/Dental Necessity, possible Experimental, Investigational, or Unproven services, appropriate setting, and appropriate treatment are forwarded to the PacificSource Medical Director for review and Benefit Determination, where applicable.

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

PRIOR AUTHORIZATION

Coverage of certain services requires a Benefit Determination by PacificSource before the services are performed. This process is called prior authorization.

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

Your Provider can submit a prior authorization request on your behalf. If your Provider is unable to do so, you may contact us directly.

We may ask for more details or require a second opinion (provided at no cost to you if requested by PacificSource) before approving coverage. You and/or your Provider are responsible for ensuring PacificSource has all the information needed to make a Benefit Determination.

- When services are received from an In-network Provider, the Provider is responsible for contacting PacificSource to obtain prior authorization. If your service is denied as not Medically Necessary and your Provider did not obtain prior authorization, the Provider will be held responsible for the denied expense, and they cannot bill you for these charges.
- When services are received from an Out-of-network Provider, the Provider is not responsible for contacting PacificSource to obtain prior authorization. If you choose an Out-of-network Provider for services requiring prior authorization, you are responsible for obtaining the prior authorization before receiving services. If prior authorization is not obtained, you may be responsible for the expense if it is later determined not Medically Necessary. If the service is deemed Medically Necessary, out-of-network benefits (which may involve higher out-of-pocket costs) will apply.

Because of the changing nature of care, PacificSource continually reviews new technologies and standards. Therefore, procedures and services requiring prior authorization are subject to change. You can search for procedures and services that require prior authorization on our website,

Authgrid.PacificSource.com (select Commercial for the line of business). You can search for information about Prescription Drug prior authorization requirements on our website, PacificSource.com/find-a-drug. Our prior authorization search tool is not intended to suggest that all items listed are covered by the benefits in this plan.

If your treatment does not receive prior authorization, you can still seek treatment, but your Post-service Claim will be subjected to retrospective authorization. If a treatment requires prior authorization but was not received, the Post-service Claim must be submitted within 60 days of the date of service. If the claim is not submitted within 60 days or if the review determines the expenses were either not covered by this plan or were not Medically/Dentally Necessary, you will be held responsible for the expense. Remember, any time you are unsure if an expense will be covered, contact our Customer Service team before receiving services.

If more information or a second opinion is needed (at no cost to you if requested by PacificSource), you or your Provider may be asked to supply additional documentation before coverage is approved. You will receive confirmation (via letter, fax, or electronic transmission) once PacificSource has made its Benefit Determination. If time is critical, you may be notified by phone, with written follow-up to follow. For more information regarding the timelines for review of Pre-service Review and Post-service Claims, see Benefit and Claim Determinations in the Benefit Determinations and Claims Payment section.

In a medical emergency, services and supplies necessary to determine the nature and extent of an Emergency Medical Condition and to Stabilize the Member are covered without prior authorization requirements. A Hospital or other healthcare facility must notify PacificSource of an emergency admission within two business days of admission.

PacificSource reserves the right to contract with a third party to perform prior authorization procedures on its behalf and such third parties may impose independently developed, evidence-based criteria for making prior authorization determinations. If you have questions about any third party criteria, please contact our Customer Service team.

If your Provider's prior authorization request is denied for reasons such as not Medically/Dentally Necessary or as Experimental, Investigational, or Unproven, your Provider may Appeal on your behalf. You also maintain the right to Appeal PacificSource's decision independently of 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, spinal cord Injury, trauma or traumatic 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 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 result in both improved health of Member and overall reduction of costs). 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 Linfield Student Health Center, 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.

All Providers are independent contractors. PacificSource cannot be held liable for any claim for damages or Injuries you experience while receiving care. Members have the right to choose their Providers.

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 prior authorization 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.

LINFIELD STUDENT HEALTH CENTER

The Policyholder has a Student health clinic that provides certain services to Students at no cost or for a nominal fee. Any charges not covered by insurance will be the financial responsibility of the Student. Contact the Linfield Student Health, Wellness and Counseling Center for additional information.

IN-NETWORK PROVIDERS

In-network Providers contract with PacificSource to provide services and supplies for an 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 Deductibles, Copayments, and/or Coinsurance amounts. 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 Idaho, Montana, Oregon, and Washington are also considered PacificSource In-network Providers under your plan.

It is not safe to assume that when you are treated at an in-network facility that all services are performed by In-network Providers. Whenever possible, you should arrange for professional services,

such as surgery, anesthesiology, and laboratory services, 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 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.

YOUR PRIMARY CARE PROVIDER

Some In-network Providers for your plan are designated as primary care Providers (PCPs). PCPs are family practitioners, physician associates, pediatricians, internists, nurse practitioners, naturopaths credentialed as a PCP, and Women's Healthcare Providers. PCPs are noted in your plan's Provider directory.

When enrolling in this plan, Members have the right to select a PCP from the Provider directory. You have the right to designate any PCP who participates in the network and who is available to accept Members. If a PCP is not designated in 90 days, PacificSource will designate one for you. For Dependent Children, you may designate a pediatrician as the primary care Provider. You do not need prior authorization from your PCP in order to obtain access to obstetrical or gynecological care from a Provider in the network who specializes in obstetrics or gynecology. The Provider may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. The PCP assumes primary responsibility for medical care and maintains your medical records. Your PCP will assist in coordinating your medical care, including specialist services, Hospital services, and urgent medical needs.

Once you have chosen a PCP, if you are not an existing patient, you may want to phone the Provider's office and introduce yourself as a new PacificSource Member. When you call, you may arrange for your medical records to be transferred and find out how to contact your PCP after hours.

Changing PCPs

You may change your PCP by contacting our Customer Service team.

The PCP change will be effective on the first of the month after we receive your request.

SHARED DECISION MAKING

Shared decision making (SDM) is a collaborative process that allows Members and their Providers to make healthcare decisions together, taking into account the best scientific evidence available, as well as the Member's values and preferences. SDM honors both the Provider's expert knowledge and the Member's right to be fully informed of all care options and the potential harms and benefits. This process provides Members with the support they need to make the best decisions about their care, while allowing Providers to feel confident in the care they prescribe. For certain procedures, Members may be required to complete SDM tools for review with their Providers in order to receive the highest level of benefits.

Under this plan, you are free to seek care from Providers other than your PCP without a referral.

In addition to the In-network Providers for your plan, PacificSource has agreements with a number of medical centers and specialized treatment programs. If you need services for which PacificSource

has Provider contracts, you will be required to use the contracted Providers for your treatment to be covered at the plan's highest benefit level.

FINDING AN IN-NETWORK PROVIDER

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

- On the PacificSource website, pacificsource.com/students, 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

PacificSource's payment to Out-of-network Providers 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.

Your Rights and Protections Against Surprise Medical Bills and Balance Billing

When you get emergency care or get treated by an Out-of-network Provider at an in-network Hospital or Ambulatory Surgical Center, you are protected from Balance Billing. In these cases, you shouldn't be charged more than your plan's Copayments, Coinsurance, and/or Deductible.

What is Balance Billing (sometimes called 'surprise billing')?

When you see a doctor or other healthcare Provider, you may owe certain out-of-pocket costs, like a Copayment, Coinsurance, or Deductible. You may have additional costs or have to pay the entire bill if you see a Provider or visit a healthcare facility that isn't in your health plan's network.

Out-of-network means Providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network Providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called 'Balance Billing'. This amount is likely more than in-network costs for the same service and might not count toward your plan's Deductible or annual out-of-pocket limit.

'Surprise billing' is an unexpected Balance Bill. This can happen when you can't control who is involved in your care - like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an Out-of-network Provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are Protected from Balance Billing for:

- **Emergency Services:**

If you have an Emergency Medical Condition and get Emergency Services from an Out-of-network Provider or facility, the most they can bill you is your plan's in-network cost sharing amount (such as Copayments, Coinsurance, and Deductibles). You can't be Balance Billed for these Emergency Services. This includes services you may get after you're in stable condition, unless you give

written consent and give up your protections not to be Balance Billed for these post-stabilization services.

- **Certain Services at an in-network Hospital or Ambulatory Surgical Center:**

When you get services from an in-network Hospital or Ambulatory Surgical Center, certain Providers there may be out-of-network. In these cases, the most those Providers can bill you is your plan's in-network cost sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeons, hospitalists, or intensivist services. These Providers can't Balance Bill you and may not ask you to give up your protections not to be Balance Billed.

If you get other types of services at these in-network facilities, Out-of-network Providers can't Balance Bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from Balance Billing. You also aren't required to get out-of-network care. You can choose a Provider or facility in your plan's network.

When Balance Billing Isn't Allowed, You also have the Following Protections:

You are only responsible for paying your share of the cost (like the Copayments, Coinsurance, and Deductibles) that you would pay if the Provider or facility was in-network. Your health plan will pay any additional costs to Out-of-network Providers and facilities directly.

Generally, your health plan must:

- Cover Emergency Services without requiring you to get approval for services in advance (also known as 'prior authorization');
- Cover Emergency Services by Out-of-network Providers;
- Base what you owe the Provider or facility (cost sharing) on what it would pay an In-network Provider or facility and show that amount in your explanation of benefits; and
- Count any amount you pay for Emergency Services or out-of-network services toward your in-network Deductible and out-of-pocket limit.

If you think you've been wrongly billed, you may file a Complaint with the Oregon Division of Financial Regulation at dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx or by calling **503-947-7984** or **888-877-4894**; and/or file a Complaint with the federal government at cms.gov/nosurprises/consumers or by calling **800-985-3059**.

Visit cms.gov/nosurprises/consumers for more information about your rights under federal law.

Example of Provider Payment

The following provides an example of how a payment could be made for In-network or Out-of-network Providers.

PacificSource will pay 80 percent of the Allowable Fee for In-network Providers and 60 percent of the Allowable Fee for Out-of-network Providers. The benefits would appear as follows:

In-network Provider	Out-of-network Provider
Payment: After Deductible, Member pays 20% of the Allowable Fee.	Payment: After Deductible, Member pays 40% of the Allowable Fee and the balance of billed charges unless the service qualifies for Balance Billing protection (see Your Rights and

In this example, the Provider's charge for a service is \$5,000 and the Allowable Fee for an In-network Provider is \$4,000. This example assumes that the Member has met the plan's Deductible during the Benefit Year, but has not yet met the out-of-pocket limit for the Benefit Year:

In-network Provider:

PacificSource would pay 80 percent of the Allowable Fee and the Member would pay 20 percent of the Allowable Fee, as follows:

Amount the In-Network Provider must discount (Allowable Fee):	\$1,000
Amount PacificSource pays (80% of the \$4,000 Allowable Fee):	\$3,200
Amount the Member pays (20% of the \$4,000 Allowable Fee):	\$800
Total:	\$5,000

Out-of-network Provider:

PacificSource would pay 60 percent of the Allowable Fee. (For this example, \$4,000 is also the charge upon which the Out-of-Network Provider's Allowable Fee is established.) Because the Out-of-Network Provider does not accept the Allowable Fee and may charge more, the Member would pay 40 percent of the Allowable Fee, plus the \$1,000 difference between the Out-of-Network Provider's billed charges and the Allowable Fee, as follows:

Amount PacificSource pays (60% of the \$4,000 Allowable Fee):	\$2,400
Amount the Member pays (40% of the \$4,000 Allowable Fee and the \$1,000 difference between the billed charges and the Allowable Fee):	\$2,600
Total:	\$5,000

Your plan's actual benefits may vary, so please review the benefit summaries and Covered Services section to determine how your benefits are paid. Please remember that the Allowable Fee may vary for a Covered Service depending upon the selected Provider.

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, pacificsource.com/students 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

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 attempt 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 are entitled to continue care with an individual Provider or facility, 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 Allowable Fee under the terms of their terminated agreement, 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 the benefit summaries. 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 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;

- 90 days after you were notified that the contract ended; or
- In the case of pregnancy, the 45th day after the birth or no later than the 120th day after you were notified that the contract ended.

BENEFIT DETERMINATIONS AND 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 (NPI), procedure codes, and diagnosis codes. It must also include your name, PacificSource Member ID number, group number, and the patient's name. If you were treated for an Accidental Injury, please include the date, time, place, and circumstances of the Accident.

All claims for benefits should be turned in to PacificSource within 90 days of the date of service. Failure to submit a claim within 90 days may result in a denial of coverage. If you are unable to submit a claim within 90 days, present the claim with an explanation for consideration for coverage. Claims submitted more than a year following the date of service may be denied as untimely.

Proofs of Loss

PacificSource, upon receipt of a notice of claim, will furnish to the claimant 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 claimant 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 claimant 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.

Claims Payment Practices

Unless additional information is needed to process your claim, we will make every effort to pay or deny your claim within 30 days of receipt. If a claim cannot be paid within 30 days of receipt because additional information is needed, we will acknowledge receipt of the claim and explain why payment is delayed.

Benefit and Claim Determinations

Benefit Determination – PacificSource will make a Benefit Determination for healthcare services, including those subject to prior authorizations, within the time period noted in the chart below for the specific type of review. This does not apply to Emergency Services or Urgent Care services. No extension is permitted for Urgent Care Reviews.

Benefit Determination	Pre-service Review	Concurrent Care Review	Urgent Care Review
Initial determination by PacificSource	2 business days	24 hours	72 hours

Benefit Determination	Pre-service Review	Concurrent Care Review	Urgent Care Review
If PacificSource requires additional information, PacificSource will make request within	2 business days	24 hours	24 hours
Provider or Member must provide requested additional information within	15 business days	24 hours	48 hours
Once PacificSource receives the information, decision will be made and written notice sent within	2 business days	24 hours	48 hours

Claim Determination – PacificSource will make a claim determination within the time period noted in the chart below, unless additional information is necessary to process the claim. In that event, we will send you notice that the claim was received and explain what 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.

Claim Determination	Post-service Claim
Initial determination by PacificSource	30 calendar days
If PacificSource requires additional information, PacificSource will make request within	30 calendar days
Provider or Member must provide requested additional information within	15 calendar days
Once PacificSource receives the information, decision will be made and written notice sent within	30 calendar days

Adverse Benefit Determinations – PacificSource will notify you in writing of a decision to deny, modify, reduce, or terminate payment, coverage authorization or provision of services or benefits.

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.

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.

Questions about Benefit Determinations and Claims

If you have questions about the status of a Benefit Determination or claim, you are welcome to contact our Customer Service team or go online to view the information via our website.

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.

In the same manner, if PacificSource applies expenses to the Deductible 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.

Legal Procedures

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

You must exhaust this plan's Appeal procedures, including but not limited to, seeking an External Review before filing benefits litigation under this plan.

COORDINATION OF BENEFITS

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

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

Definitions

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

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

- Plan includes: group and non-group health insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
- Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; Accident only coverage; specified disease or specified Accident coverage; school Accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

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

Order of Benefit Determination Rules. The rules that determine whether this plan is a primary plan or secondary plan when the person has healthcare coverage under more than one plan.

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

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

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

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

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

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

Order of Benefit Determination Rules

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

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

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

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

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

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

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

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

- For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:
 - The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
 - If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
- For a Dependent Child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
 - If a court decree states that one of the parents is responsible for the Dependent Child's healthcare expenses or healthcare coverage, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;
 - If a court decree states that both parents are responsible for the Dependent Child's healthcare expenses or healthcare coverage, the provisions above shall determine the order of benefits;
 - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the Dependent Child, the provisions above shall determine the order of benefits; or
 - If there is no court decree allocating responsibility for the Dependent Child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
 - The plan covering the custodial parent;
 - The plan covering the Spouse of the custodial parent;

- The plan covering the non-custodial parent; and then
- The plan covering the Spouse of the non-custodial parent.
- For a Dependent Child covered under more than one plan of individuals who are not the parents of the child, the provisions above shall determine the order of benefits as if those individuals were the parents of the child.

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

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

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

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

Effect on the Benefits of this Plan

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

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

Right to Receive and Release Needed Information

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

benefits under this plan must give PacificSource any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

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

Right of Recovery

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

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 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 expenses incurred both before and after the settlement. If you have ongoing 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.

Right of Recovery – Time Limit for Reimbursements

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 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 would be 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 program;
- The appropriate state or federal workers' compensation insurance program has determined that coverage is not available for your Injury; or
- You are employed by an Oregon based group, and have timely filed an application for coverage with the State Accident Insurance Fund or other Workers' Compensation carrier, and are waiting for determination of coverage from that entity.

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

A Member who enters into a Surrogacy Agreement and receives compensation under such Surrogacy Agreement, must reimburse PacificSource for claims paid for Covered Services related to conception, fertility treatments, 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 or becoming a PacificSource Member, 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.

If you do not speak English, have literacy difficulties, or have physical or mental disabilities that impede your ability to file a Grievance and/or Appeal, you may contact our Customer Service team for assistance. We can usually arrange for a multilingual staff member or interpreter to speak with you in your 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 orally or 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 plan;
- Rescission or cancellation of your plan, whether or not the Rescission has an adverse effect on any particular benefit at the time;
- Imposition of a third party liability, network exclusion, annual benefit limit, or other limitation on otherwise Covered Services or items;
- Determination that a healthcare item or service is Experimental, Investigational, or Unproven, not Medically/Dentally 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 a Medical Necessity; 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 may require a signed Authorization To Use/Disclose Protected Health Information form within five business days of your external independent review request. This form must be signed to grant the review organization access to health records relevant to the decision.

This form is located on our website, [PacificSource.com/resources/documents-and-forms](https://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 receipt 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 are provided five days to submit additional written information to the independent review organization for consideration during the review.

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

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.

In addition, if your Appeal qualifies for an expedited response, a decision in response to the Appeal will be completed as soon as possible, but no later than 72 hours of receipt of the request.

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/Dental Necessity, Experimental, Investigational, or 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 by you or your Authorized Representative. Grievances can be submitted orally or in writing. Appeals can be submitted in writing. Before submitting a Grievance

or Appeal, we suggest you contact our Customer Service team with your concerns. 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 newappeal@pacificsource.com, with Grievance or Appeal as the subject

Call 888-977-9299

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@dcbs.oregon.gov

Website dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx

BECOMING COVERED

ELIGIBILITY

Requirements for Enrollment of Student

See the Policyholder for eligibility requirements to determine if you are eligible to enroll in 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 eligible to enroll on this plan.

All Students are required to carry medical insurance coverage comparable to that offered through the school's Student Health Insurance Plan. Unless specifically waived with proof of coverage with another plan, Students will automatically be covered under the Student Health Insurance Plan, and the premiums charged to their account with the school.

If a Student incurs a creditable loss of coverage and requests to be covered under the Student plan mid semester, they can as long as they request coverage within 60 days of losing their coverage. The premium will be pro-rated to the end of the current semester from the date their other coverage ends. If they are a hard waiver Student, the Student would need to contact the school's administration office to rescind their waiver and pay the school the pro-rated premium.

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

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 to enroll in this plan.

Coverage for Fall semester will run from August 15, 2026 through January 31, 2027.

Coverage for Winter semester will run from January 1, 2027 through August 14, 2027.

Coverage for Spring/Summer semester will run from February 1, 2027 through August 14, 2027.

ENROLLING AFTER THE INITIAL ENROLLMENT PERIOD

Special Enrollment Periods

You may decline coverage during your initial enrollment period. To do so, you must submit a waiver of coverage provided by your school before your school's required deadline. You may enroll in this plan later if you qualify under the special enrollment rules below. To do so, you must submit an enrollment change within 31 days of the qualifying event.

- **Special Enrollment Rule #1**

If you declined enrollment for yourself because of other insurance coverage, you 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 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 at that time. Coverage will begin on the first day of the month after becoming eligible for such assistance.

Medical Leave of Absence

Students on an approved medical leave of absence may remain on student insurance for an additional semester if the semester falls in the same policy year – e.g., approved medical LOA in the fall, may remain on coverage for the spring semester.

GENERAL PLAN PROVISIONS

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.

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;
 - Mid semester termination due to a qualifying event (for example, access to other group coverage) is not allowed and no refund will be given;
 - The Student does not attend during the first 31 days of school. They will be retroactively termed and receive full premium refund;
 - 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 semester for which they are enrolled and for which premium has been paid.

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

RESOURCES FOR INFORMATION AND ASSISTANCE

Assistance

PacificSource Members who do not speak English, have literacy difficulties, or have physical or mental disabilities 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, PacificSource.com. Available disclosure information includes, but not limited to, the following:

- A directory of Providers under your plan;

- Information about our Drug List (also known as a formulary);
- A copy of our annual report on Complaints and Appeals;
- A summary of Adverse Benefit Determinations and Grievance processes;
- Information about our policy for protecting the confidentiality of your 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 health 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 prior authorization, Predetermination, and utilization review procedures;
- Information about any plan offered by PacificSource; and
- Information about PacificSource's price transparency for all Covered Services, items, and Prescription Drugs is available on our website. This allows Members to understand their cost share information such as Deductible and Coinsurance amounts. A paper form of the estimate is available upon request.

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 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@dcbs.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/students. 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/Dentally 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 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 Out-of-network Provider obtains prior authorization 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 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 contacting 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 and dental 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 medical and dental records. Detailed information is available at [PacificSource.com/privacy-policy](https://pacificsource.com/privacy-policy).

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 Oregon Request for Confidential Communication form provided at [PacificSource.com/resources/documents-and-forms](https://pacificsource.com/resources/documents-and-forms).

PLAN ADMINISTRATION

Insurance Contract

This plan is fully insured. Benefits are provided under a blanket group policy between the Policyholder and PacificSource Health Plans. Under the blanket group policy, 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:

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, or PacificSource's failure to provide or make a payment in whole or in part, for a benefit that is based on PacificSource's:

- Denial of eligibility for or termination of enrollment in a plan;
- Rescission or cancellation of your coverage;
- Imposition of a third party liability, network exclusion, annual benefit limit, or other limitation on otherwise Covered Services or items;
- Determination that a healthcare item or service is Experimental, Investigational, or Unproven, not Medically/Dentally 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 Service 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.

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 request from a Member or 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;
- Rescission 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. Life threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. 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.

Assistive Listening Devices 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.

Authorized Representative is an individual who by law or by the consent of a Member may act on behalf of the Member. 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/students, 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 the service qualifies for protection rights under federal law. For more information, see the Your Rights and Protections Against Surprise Medical Bills and Balance Billing section.

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

Behavioral Health Condition means any mental or Substance Use Disorder covered by diagnostic categories listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases.

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 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 claims;
- Review of healthcare services with respect to Medical/Dental Necessity (including underlying criteria), coverage under the plan, appropriateness of care, Experimental, Investigational, or Unproven treatment, justification of charges; and
- Utilization review activities, including precertification and prior authorization of services and concurrent and post-service review of services.

Benefit Year refers to the period of time during which benefits accumulate toward plan maximums and is on a contract year basis, beginning on the plan's date of issuance or date of renewal through the last day of that contract year.

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

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.

Chemotherapy means the use of drugs approved for use in humans by the FDA and ordered by the Provider for the treatment of disease.

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 Review 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.

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 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, 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 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.

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

Diagnostic Breast Examination means a Medically Necessary and clinically appropriate examination of the breast that is used to evaluate an abnormality seen or suspected from a screening examination for breast cancer or detected by another means of examination. This term includes examinations using diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound.

Drug List (also known as a formulary) is a list of covered medications used to treat various medical conditions. Please refer to pacificsource.com/students 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, and TENS units.

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.

Emergency Dental Condition means a dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain or infection such that a prudent layperson, who possesses an average knowledge of health and dentistry, could reasonably expect the absence of immediate

dental attention to result in:

- 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.

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 services transport;
- 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.

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, 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, drugs or medicines, or the use thereof, which at the time they are rendered and for the purpose and in the manner they are being used:
 - Have not yet received full U.S. government agency required approval (for example, FDA) for other than Experimental, Investigational, or 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, or Unproven, not considered reasonable and necessary, or any similar finding.
- Chemotherapy is considered Experimental, Investigational, or Unproven when its use is not recommended by National Comprehensive Cancer Network with at least a 2A level of evidence.
- 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.

PacificSource may delegate the determination whether a service is Experimental, Investigational, or Unproven to a third party for services received outside Idaho, Montana, Oregon, and Washington. Such determinations shall be based upon evidence-based criteria and may vary from PacificSource's determinations within Idaho, Montana, Oregon, and Washington.

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 or oral Complaint submitted by or on behalf of a Member regarding service delivery issues other than denial of payment for services or non-provision of services, including dissatisfaction with care, waiting time for services, Provider or staff attitude or demeanor, or dissatisfaction with service provided by the carrier.

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.

Home Healthcare 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. Services provided by Home Healthcare include:

- Home health aide services;
- Hospice services;
- 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 means a sickness, disease, ailment, bodily disorder, and pregnancy.

Immediate Family Member means:

- Your Dependents, your parents, your parent's Spouse or Domestic Partner, your siblings, and your half-siblings;

- Your Spouse's or Domestic Partner's parents, siblings, and half-siblings;
- Your Dependent Child's Spouse or Domestic Partner; and
- Any other of your relatives by blood or marriage who shares a residence with you.

In-network Provider means a Provider that directly or indirectly holds a Provider contract or agreement with PacificSource.

Infertility means disease of the male or female reproductive system defined by the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse.

Injury means bodily trauma or damage that is independent of disease or infirmity. The damage must be caused through external and Accidental means.

Inquiry means a written request for information or clarification about any subject matter related to the Member's 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 Member while the Member is covered by a PacificSource insurance plan. 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.

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;
- The least costly of the alternative services or supplies that can be safely provided;
- When referring specifically to infused medications, it further means that they may require administration at a designated location or preferred site of care as outlined in the infusion therapy site of care policy and Drug List;
- 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; and

- When applied to Hospital outpatient services (imaging, infusion, surgery), it further means that the services or supplies can be safely provided in other than a Hospital outpatient setting without adversely affecting the patient's condition or the quality of medical care rendered.

PacificSource may delegate determinations of Medical Necessity to third parties for services outside Idaho, Montana, Oregon, and Washington, and such third parties may utilize evidence-based criteria for determining Medical Necessity consistent with the above. 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 Behavioral 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.

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.

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.

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

Pre-service Review means a request for benefits that requires approval by PacificSource in advance (prior authorization) 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 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.

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.

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.

Radiation Therapy is the treatment of disease using x-rays or similar forms of radiation.

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 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 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 a Member participating in the clinical trial; or
- Items or services that are not covered by this plan if provided outside of the clinical trial.

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.

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 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, alcohol, or addictive substance 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 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.

Supplemental Breast Examination means a Medically Necessary and appropriate examination of the breast that is used to screen for breast cancer when there is no abnormality seen or suspected and is based on personal or family medical history or other factors that may increase a person's risk of breast cancer.

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.

Surrogacy Agreement means an agreement between one or more intended parents and a woman who is not an intended parent in which the woman agrees to become pregnant through assisted reproduction and which provides that each intended parent is a parent of a child conceived under the agreement.

Telehealth means the use of audio, video, or other telecommunications technology or media, including audio-only communication, that is used by a Provider or facility to deliver services, and delivered over a secure connection that complies with state and federal privacy laws.

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 Review 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 associate, 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 Provider's 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.

X-ray (radiographic image) is a computerized image that provides information for detecting, diagnosing, and treating conditions that can threaten oral and general health. It includes cone beam X-rays, bitewing X-rays, single film X-rays, intraoral X-rays, extraoral X-rays, panoramic X-rays, periapical X-rays, and cephalometric X-rays.



Contact us.

Phone: 888-977-9299
TTY: 711
En Español: 541-684-5456
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 and PacificSource Community Health Plans ("PacificSource") complies with applicable Federal civil rights laws, including Section 1557 of the Affordable Care Act. PacificSource does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), sex (consistent with the scope of sex discrimination described at 45 CFR 92.101(a)(2)), age or disability. PacificSource does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

In compliance with Section 1557 and other federal civil rights laws, we provide individuals the following in a timely manner and free of charge:

Language assistance services

PacificSource will provide language assistance services for individuals with limited English proficiency (including individuals' companions with limited English proficiency) to ensure meaningful access to our programs, activities, services, and other benefits. Language assistance services may include:

- Electronic and written translated documents
- Qualified interpreters
- Appropriate auxiliary aids and services for individuals with disabilities (including individuals' companions with disabilities) to ensure effective communication

Appropriate auxiliary aids and services may include:

- Qualified interpreters, including American Sign Language interpreters
- Video remote interpreting
- Information in alternate formats (including but not limited to large print, recorded audio, and accessible electronic formats)

Reasonable modifications

PacificSource will provide reasonable modifications for qualified individuals with disabilities, when necessary to ensure accessibility and equal opportunity to participate in our programs, activities, services, or other benefits.

To access our language assistance services, auxiliary aids and services, and for assistance in getting a reasonable modification, please contact Customer Service at **888-977-9299**, TTY: 711. We accept all relay calls.

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 PacificSource's Section 1557 Coordinator.

Phone: **888-977-9299**, TTY: 711. We accept all relay calls. | Email: 1557Coordinator@PacificSource.com

Mail: PacificSource
PO Box 7068
Springfield, OR 97475

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

Electronically: [OCRPortal.hhs.gov](https://ocrportal.hhs.gov)

Mail: U.S. Department of Health & Human Services
200 Independence Avenue, S.W., Room 509F
Washington, D.C. 2020

Contact our commercial Customer Service team:

Phone Toll-free: 888-977-9299, TTY: 711

We accept all relay calls.

Email CS@PacificSource.com

PacificSource.com

Contact our Medicare Customer Service team:

Oct. 1 – Mar. 31: 8:00 a.m. – 8:00 p.m., seven days a week

Apr. 1 – Sept. 30: 8:00 a.m. – 5:00 p.m., Monday – Friday

Phone Toll-free: 888-863-3637, TTY: 711

We accept all relay calls.

En Español: 866-281-1464

Email MedicareCS@PacificSource.com

Medicare.PacificSource.com

Notice of availability of language assistance services and auxiliary aids and services

English	ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 800-431-4135 (TTY: 800-735-2900) or speak to your provider.
አማርኛ Amharic	ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 800-431-4135 (TTY: 800-735-2900) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على وسائل أو تحدث إلى مقدم الخدمة الرقم 4135-431-800 (800-735-2900)
Bantu-Kirundi	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 800-431-4135 (TTY: 800-735-2900).
ភាសាខ្មែរ Cambodian Non-Khmer	សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ សេវាកម្មជំនួយភាសាភគគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។ ហៅទូរសព្ទទៅ 800-431-4135 (TTY: 800-735-2900) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។
中文 Simplified Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 800-431-4135（文本电话：800-735-2900）或咨询您的服务提供者。
中文 Traditional Chinese	注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 800-431-4135（TTY：800-735-2900）或與您的提供者討論。
Cushite-Oromo	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-431-4135 (TTY: 800-735-2900).
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 800-431-4135 (TTY: 800-735-2900) an oder sprechen Sie mit Ihrem Provider.

فارسی Farsi	توجه: اگر فارسی صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود تماس بگیرید یا با ارائه‌دهنده خود می‌باشند. با شماره 800-431-4135 (تله‌تایپ: 800-735-2900) صحبت کنید.
Français French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-431-4135 (ATS : 800-735-2900).
Italiano Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-431-4135 (TTY: 800-735-2900).
日本語 Japanese	注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。800-431-4135（TTY：800-735-2900）までお電話ください。または、ご利用の事業者にご相談ください。
한국어 Korean	주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 800-431-4135 (TTY: 800-735-2900) 번으로 전화하거나 서비스 제공업체에 문의하십시오.
ລາວ Laotian	ເລື່ອງລາວ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 800-431-4135 (TTY: 800-735-2900) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.
Nepali	ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 800-431-4135 (टिटिवाइ: 800-735-2900) ।
Norwegian	MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 800-431-4135 (TTY: 800-735-2900).
Pennsylvania Dutch	Wann du Deitsch (Pennsylvania German/Dutch) schwetztscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 800-431-4135 (TTY: 800-735-2900).
ਪੰਜਾਬੀ Punjabi	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੂਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। 800-431-4135 (TTY: 800-735-2900) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।
Romanian	ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 800-431-4135 (TTY: 800-735-2900).
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 800-431-4135 (TTY: 800-735-2900) или обратитесь к своему поставщику услуг.
Srpsko-hrvatski Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 800-431-4135 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 800-735-2900).

Soomaali Somali	FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 800-431-4135 (TTY: 800-735-2900) ama la hadal bixiyahaaga.
Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 800-431-4135 (TTY: 800-735-2900) o hable con su proveedor.
Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 800-431-4135 (TTY: 800-735-2900) o makipag-usap sa iyong provider.
Thai	เรียน: หากคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-431-4135 (TTY: 800-735-2900).
українська мова Ukrainian	УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 800-431-4135 (TTY: 800-735-2900) або зверніться до свого постачальника.
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 800-431-4135 (Người khuyết tật: 800-735-2900) hoặc trao đổi với người cung cấp dịch vụ của bạn.

PacificSource Health Plans (commercial) | PacificSource Community Health Plans (Medicare)

PacificSource Community Health Plans is an HMO, HMO D-SNP, and PPO plan with a Medicare contract and a contract with Oregon Health Plan (Medicaid). Enrollment in PacificSource Medicare depends on contract renewal.