



PacificSource OR Standard Bronze Plan NAV Individual Medical Policy

PacificSource Health Plans, herein called PacificSource, will pay the benefits of this Individual Medical Policy (policy herein) for covered losses in accordance with the policy provisions.

Policy Term. The term of this policy is from month to month. This policy is guaranteed renewable as long as none of the conditions for policy termination, as listed in the Guaranteed Renewability and Policy Termination section are met. We will renew this policy annually on January 1 of each year.

Policy Modification. PacificSource may change the premiums or other provisions of this policy as allowed by the state of issuance and federal law. For more information, see the Policy Selection, Renewal, and Modifications section.

Policy Disclosures. Additional information is available upon request prior to enrolling in this policy. This information, available from our Customer Service team or on our website, includes: information about premiums, cost sharing, Provider networks, utilization review, Appeals and Grievances, accreditation, benefits, pharmacy formulary, term definitions, and confidentiality policies.

Policy Return. If you are not satisfied with the policy for any reason, it may be returned to PacificSource within ten days after receipt and any premium paid will be refunded. Upon return of the policy within the ten day period, the policy will be considered void from the beginning and the parties shall be in the same position as if no policy had been issued. Any premiums paid will be refunded, unless benefits paid under this policy exceed the premiums paid.

This policy is issued in consideration of payment of the initial premium and the application.

IN WITNESS WHEREOF, PacificSource has caused this policy to be executed as of 12:00 a.m. local time on the policy effective date.

PacificSource Health Plans

By:

Kenneth P. Provencher
President and Chief Executive Officer

POLICY INFORMATION

Policyholder: Sarah K Carner
Additional Insured Persons: James R Carner and Oliver R Carner
Policy Number: 200868500
Policy Effective Date: January 01, 2023
Monthly Premium: \$1,266.00
Date of Issue: November 11, 2022

CONTACT INFORMATION

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Healthcare.gov

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Benefit Year: Calendar Year

Provider Network: Navigator

Deductible Per Benefit Year	In-network	Out-of-network
Individual/Family	\$8,800/\$17,600	\$10,000/\$20,000
Out-of-Pocket Limit Per Benefit Year	In-network	Out-of-network
Individual/Family	\$8,800/\$17,600	\$25,000/\$50,000

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 policy'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 policy.

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

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Preventive Care		
Well baby/Well child care	No deductible, 0%	After deductible, 50%
Preventive physicals	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%
Prostate cancer screening	No deductible, 0%	After deductible, 50%
Professional Services		
Office and home visits	No deductible, \$50	After deductible, 50%
Naturopath office visits	No deductible, \$50	After deductible, 50%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Specialist office and home visits	No deductible, \$100	After deductible, 50%
Telehealth visits	No deductible, \$50	After deductible, 50%
Newborn nurse home visits	No deductible, 0%	After deductible, 50%
Office procedures and supplies	After deductible, 0%	After deductible, 50%
Surgery	After deductible, 0%	After deductible, 50%
Outpatient rehabilitation services	No deductible, \$50 if provided in an office setting	After deductible, 50%
Acupuncture (12 visits per benefit year)	No deductible, \$50	After deductible, 50%
Chiropractic manipulation/Spinal manipulation (20 visits per benefit year)	No deductible, \$50	After deductible, 50%
Hospital Services		
Inpatient room and board	After deductible, 0%	After deductible, 50%
Inpatient rehabilitation services	After deductible, 0%	After deductible, 50%
Skilled nursing facility care	After deductible, 0%	After deductible, 50%
Outpatient Services		
Outpatient surgery/services	After deductible, 0%	After deductible, 50%
Diagnostic imaging – advanced	After deductible, 0%	After deductible, 50%
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	After deductible, 0%	After deductible, 50%
Urgent and Emergency Services		
Urgent care center visits	No deductible, \$100	After deductible, 50%
Emergency room visits – medical emergency	After deductible, 0%	After deductible, 0%
Emergency room visits – non-emergency	After deductible, 0%	After deductible, 50%
Ambulance, ground	After deductible, 0%	After deductible, 0%
Ambulance, air	After deductible, 0%	After deductible, 0%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Maternity Services**		
Physician/Provider services (global charge)	After deductible, 0%	After deductible, 50%
Hospital/Facility services	After deductible, 0%	After deductible, 50%
Mental Health and Substance Use Disorder Services		
Office visits	No deductible, \$50	After deductible, 50%
Inpatient care	After deductible, 0%	After deductible, 50%
Residential programs	After deductible, 0%	After deductible, 50%
Other Covered Services		
Allergy injections	After deductible, 0%	After deductible, 50%
Durable medical equipment	After deductible, 0%	After deductible, 50%
Home health services	After deductible, 0%	After deductible, 50%
Transplants	After deductible, 0%	After deductible, 50%

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

** 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 policy's deductible is the amount of money that you pay first, before your policy starts to pay. You'll see that many services, especially preventive care, are covered by the policy without you needing to meet the deductible. The individual deductible applies if you enroll without dependents. If you and one or more dependents enroll, the individual deductible applies for each member only until the family deductible has been met.

Note that there is a separate category for in-network and out-of-network when it comes to meeting your 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 policy will pay 100 percent of allowed amounts for covered services for the rest of that benefit year. The individual out-of-pocket limit applies only if you enroll without dependents. If you and one or more dependents enroll, the individual out-of-pocket limit applies for each member only until the family out-of-pocket limit has been met. Be sure to check your policy, 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.

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 policy, and if you meet the policy's eligibility requirements. Prior authorization does not change your out-of-pocket expense for in-network and out-of-network providers. 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: Calendar Year

Formulary: Oregon Drug List (ODL)

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

The amount you pay for covered prescriptions at in-network pharmacies applies toward your policy’s in-network out-of-pocket limit, the amount you pay for covered prescriptions at out-of-network pharmacies applies toward your policy’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 calendar year in which you have satisfied the medical out-of-pocket limit.

Medical Deductible

You must meet the medical deductible, which is shown on the Medical Benefit Summary, before your prescription drug benefits begin.

Affordable Care Act Standard Preventive No-cost Drug List

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

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	After deductible, 0%+	After deductible, 0%+	After deductible, 0%
31 - 60 day supply:	No deductible, \$40	After deductible, 0%+	After deductible, 0%+	After deductible, 0%
61 - 90 day supply:	No deductible, \$60	After deductible, 0%+	After deductible, 0%+	After deductible, 0%
In-network Mail Order Pharmacy				
Up to a 30 day supply:	No deductible, \$20	After deductible, 0%+	After deductible, 0%+	After deductible, 0%

Service/Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays	Tier 4 Member Pays
In-network Mail Order Pharmacy				
31 - 60 day supply:	No deductible, \$40	After deductible, 0%+	After deductible, 0%+	After deductible, 0%
61 - 90 day supply:	No deductible, \$40	After deductible, 0%+	After deductible, 0%+	After deductible, 0%
Compound Drugs**				
Up to a 30 day supply:		After deductible, 0%		
31 - 60 day supply:		After deductible, 0%		
61 - 90 day supply:		After deductible, 0%		
Out-of-network Pharmacy				
30 day maximum fill, no more than three fills allowed per year:			After deductible, 90%	

+Formulary prescription insulin is not subject to a deductible and may not exceed \$80 per 30 day supply.

**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 after the medical deductible is met. 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 after the medical deductible is met. The cost difference between the brand name and generic drug does not apply toward the medical deductible or out-of-pocket limit. Does not apply to formulary tobacco cessation and preventive bowel prep kits covered under USPSTF guidelines.

If your provider prescribes a brand name contraceptive due to medical necessity it may be subject to prior authorization for coverage at no charge.

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

Benefit Year: Calendar Year

The following shows the vision benefits (including vision exams, lenses, and frames when applicable) available under this policy 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 policy’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, up to \$40 then 100%
Vision hardware	No deductible, up to \$150 then subject to in-network deductible and 0%	

Benefit Limitations: members age 18 and younger

- One vision exam every calendar year.
- Vision hardware includes one pair of glasses (lenses and frames) or contacts (lenses and fitting) once per calendar 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 employment, required by a labor agreement or government body.
- Medical or surgical treatment of the eye.
- Nonprescription lenses.
- Plano contact lenses.
- Services or supplies not listed as covered expenses.
- Services or supplies received before this policy’s coverage begins or after it ends.
- Special procedures, such as orthoptics or vision training.
- Visual analysis that does not include refraction.

Important information about your vision benefits

Your policy 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 policy'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 policy's in-network benefits cannot be combined with any other discounts or coupons. You can use your policy's in-network benefits, or you can use your policy'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 policy's out-of-network benefits.

ADMINISTRATIVE PROVISIONS

This policy, including endorsements, addendums, and any other attached papers, if any, constitutes the entire contract of insurance. No change in this policy is valid unless approved by an executive officer of PacificSource, and unless such approval is endorsed hereon or attached hereto. No agent has the authority to change the policy or to waive any of its provisions.

This policy must comply with both state and federal law, including required changes occurring after the policy'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 policy, and the rights and obligations of the Members, will be governed by the state's laws where your policy is issued.

The provisions of this policy conform to the minimum requirements of state law and have control over any conflicting statutes of any state in which the Member resides, on or after the effective date of this policy.

The waiver by either party to this agreement of any breach of any of the provisions of this agreement will not constitute a continuing waiver or a waiver of any subsequent breach of the same or of a different provision of this agreement.

A person may be guilty of insurance fraud if they submit an application or claim containing a false or deceptive statement with either the intent to defraud PacificSource, or the knowledge that they are facilitating a fraud. Misrepresentations, omissions, concealments of facts, and incorrect statements shall not prevent a recovery under this policy unless the misrepresentations, omissions, concealments of facts, and incorrect statements are shown by PacificSource to be either material to the risk assumed by PacificSource or fraudulent.

In the absence of fraud, all statements made by the applicant, 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.

If the Member's age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid based on the correct age.

Many terms used in this policy are defined in the Definitions section of this policy. You can identify such terms by their being capitalized.

BECOMING COVERED

ELIGIBILITY

You must notify us within 30 days of the date on which you or an enrolled Dependent no longer meets the eligibility requirements listed below.

PacificSource does not limit, exclude, or deny coverage under this policy based on health status.

Requirements for Enrollment of Policyholder

In order to be eligible as an insured Policyholder, you must satisfy the following requirements:

- You must have completed a policy application that includes appropriate signatures and initials.
- Your application must be accepted by PacificSource, or if this is an exchange policy, by the Marketplace.
- You must not be entitled to benefits under Medicare Part A or B nor be enrolled in a Medicare Choice or Advantage plan.

- You must be a current resident of the policy's state of issuance.
- If this is a Catastrophic policy, you must also be under age 30 at the start of the policy year or have received a certificate of exemption for the reasons identified in the Affordable Care Act (ACA).

Requirements for Enrollment of Dependents

While you are insured under this policy, the following Dependents are also eligible for coverage:

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

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

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

If this is an Individual Catastrophic policy, Dependents must also be under age 30 at the start of the policy year or have received a certificate of exemption for the reasons identified in the ACA.

OPEN ENROLLMENT

PacificSource will accept applications for enrollment during the open enrollment period. Open enrollment is a designated period of time each Benefit Year during which anyone who qualifies for coverage may enroll. It is also the time when a Dependent who does not qualify for special enrollment may be added to an existing or newly issued policy. Please contact our Customer Service team for information about when the next open enrollment period will begin.

Effective Date for Open Enrollment

Coverage will begin on the first day of the month following the open enrollment period.

SPECIAL ENROLLMENT

Enrolling New Dependents

To enroll new Dependents that become eligible for coverage after your effective date, complete and submit an application to PacificSource or to the Marketplace, if your coverage is through the exchange. Requests for enrollment of a new Dependent due to a qualifying event must be received by PacificSource within 60 days of the qualifying event. PacificSource may ask for legal documentation to confirm the status of the Dependent.

A newborn child is eligible from the moment of birth for 60 days. A grandchild of a Member is not eligible unless court-ordered or legally adopted by the Policyholder. A claim for maternity care is not considered notification for the purpose of enrolling a newborn child.

Premium payment must be made within 31 days from the date of billing.

Qualifying Events

Coverage for newly eligible Dependents due to the following events will begin on the date of the event:

- Birth of a newborn Dependent Child; or
- Placement of an adopted or foster child.

Coverage for newly eligible Dependents due to the following events will begin on the first day of the month after the event:

- Marriage or domestic partnership;
- Guardianship; or
- Qualified medical child support order (QMCSO).

The Policyholder's Dependent, who is not eligible for coverage and experiences a loss of other coverage due to one of the following reasons, is eligible on the first day following the loss of coverage upon payment of premium:

- Legal separation;
- Divorce, annulment, or dissolution of domestic partnership;
- Cessation of Dependent status; or
- Death of primary Policyholder.
- Loss of minimum essential coverage, except if loss is due to failure to pay premiums or Rescission of coverage;
- Dependent is not enrolled in a qualified health plan due to an error by the state/federal marketplace;
- Dependent adequately demonstrates that the qualified health plan which they are enrolled in substantially violated a material provision of its contract; or
- Dependent who is an Indian defined by Section 4 of the Indian Health Care Improvement Act may enroll for coverage.

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

POLICY SELECTION, RENEWAL, AND MODIFICATIONS

Policy Selection

Unless you qualify for a special enrollment period, you may only change to a different policy option upon your policy's renewal date. You may select a different policy option, if available, by submitting an application. Policy selections made during open enrollment become effective on your policy's renewal date.

Policy Renewal

This policy continues in effect, provided that premiums are paid in full when due. This policy is automatically renewed from month to month thereafter unless modified or terminated.

PacificSource may modify any provision of the policy on the policy's renewal date by giving the Policyholder a 60 day prior written notice. Rejection of any modification terminates this policy at the end of the 60 day notification period. Payment of premium after receiving notice of modification constitutes the Policyholder's acceptance of the change.

PacificSource may modify premium rates after state approval on any renewal date by giving the Policyholder a 60 day prior written notice.

Policy Modifications Outside of Renewal Date

There may be times when it is necessary for PacificSource to modify or amend this policy on a date other than the renewal date. No changes will be made unless the change is made to all policies of the same form and class. Changes may, for example, be required due to legislative or regulatory changes.

Payment of premium after receiving notice of modification constitutes the Policyholder's acceptance of the change.

PREMIUM PAYMENT

Premium is due the first day of each month while the policy remains in effect. The Policyholder may deposit premium in advance, but doing so will not extend the policy term or limit the right of PacificSource to change the premium. Premium is not considered paid until PacificSource receives the full premium amount by check, money order, or an accepted electronic transaction.

The monthly premium amount is shown on this policy's cover page. Rates may change when the family composition changes.

Monthly Premiums

Rates are based on the age of each Member. Premiums will be charged for the Policyholder, Spouse, Domestic Partner, adult children age 21 and older, and up to three children under age 21.

Grace Period

Policy purchased through the Marketplace

If enrolled in the Oregon Health Insurance Marketplace, the following grace periods apply:

- A grace period of 30 days from the premium due date for payment to be accepted by PacificSource if the Policyholder does not receive an Advanced Premium Tax Credit.
- A grace period of 90 days from the premium due date for payment to be accepted by PacificSource if the Policyholder is receiving an Advanced Premium Tax Credit.

The policy will expire at the end of the grace period or after PacificSource has notified the Policyholder in writing, at the last known address, that premium is past due. Coverage and all claim liability end on the last day of the last month through which premiums were accepted by PacificSource. If PacificSource deposits funds remitted by the Policyholder after the grace period, that action does not automatically constitute reinstatement of an expired policy. Policyholders who are receiving an Advanced Premium Tax Credit will have coverage for all allowable claims for the first month of the 90 day grace period. Subsequent claims in the second and third month of the 90 day grace period will be pended until all outstanding premium is accepted by PacificSource by the end of the grace period.

Policy purchased outside of the Marketplace

If enrolled direct through PacificSource, there is a grace period of 30 days from the premium due date for payment to be accepted by PacificSource. The policy will expire at the end of the grace period or, if later, ten days after PacificSource has notified the Policyholder in writing, at the last known address, that premium is past due. Coverage and all claim liability end on the last day of the last month through which premiums were accepted by PacificSource. If PacificSource deposits funds remitted by the Policyholder after the grace period, that action does not automatically constitute reinstatement of an expired policy.

Unpaid Premium

Any premium due and unpaid, or covered by a note or written order, may be deducted from a claim paid under the terms of this policy.

GUARANTEED RENEWABILITY AND POLICY TERMINATION

This policy is guaranteed renewable with respect to all Members at the option of the Policyholder, except in the following cases:

- For non-payment of the required premium. Notice of cancellation for non-payment of premiums will be mailed within 15 days after the due date of the missed premium for that period;
- For fraud or the intentional misrepresentation of a material fact by the Policyholder;
- When PacificSource discontinues offering or renewing all of its individual health policies within the state of issuance or in a specific area within the state. Discontinuation of all individual health benefit policies are subject to notification at least 180 days in advance of discontinuation of the policies;
- When PacificSource discontinues offering or renewing this policy within the state of issuance because of an inability to reach an agreement with the Providers or organization of Providers to provide services under this policy within the Service Area. Discontinuation of this policy is subject to notification at least 90 days in advance of discontinuation of this policy;
- If the Division of Financial Regulation finds that renewal would not be in the interest of the Member, or would impair PacificSource's ability to meet its contractual obligations;
- When the Member no longer lives or resides in the state of issuance or counties in which the product is offered; or
- When the Policyholder terminates the policy on any premium due date with 14 days prior written notice.

Cancellation

If for any reason, the Policyholder, Policyholder's estate, or entity cancels coverage under this policy, the Policyholder, Policyholder's estate, or entity shall notify PacificSource on a timely basis. PacificSource will refund to the Policyholder, Policyholder's estate, or entity any unused premium received for the period of ineligibility. Unused collected premium means that portion of any premium collected which is not used, on a pro-rata basis to the beginning of the next billing cycle at the time of cancellation, by PacificSource to insure against loss when there is no risk of loss, or that portion of any collected premium which would have not been collected had the Policyholder paid monthly.

Rescission

If the application for this policy contains any intentional misrepresentation of material facts by a Member, or a Member performs an act, practice, or omission that constitutes fraud, PacificSource may Rescind the policy. The Member will be given 30 days advance notice of PacificSource's decision to Rescind coverage, and offered an opportunity to Appeal that decision.

Time Limit on Certain Defenses

After two years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy 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 policy, 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 policy.

UNDERSTANDING HOW YOUR BENEFITS ARE PAID

This section of the policy contains information to help you understand the benefits of the policy and how certain aspects of your policy work, including Deductibles, Copayments, Coinsurance, out-of-pocket limits, and benefit maximums. For more information, see the benefit summaries for policy details.

BENEFIT YEAR

Calendar Year

Many benefits and provisions in this policy are calculated on a calendar year basis. Each January 1, these provisions renew and may change, and you must satisfy the new or revised amounts for that year. Any benefit with a separate maximum benefit (for example, not on a calendar year basis) is identified in the Covered Services section of this policy.

If this policy is modified mid-calendar year, the previously satisfied Deductibles, out-of-pocket limits, and benefit maximums will be credited toward the modified policy.

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 policy 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 policy 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 policy has an out-of-pocket limit provision. The benefit summaries show your policy's annual out-of-pocket limits. If you incur Covered Service expenses over those amounts, this policy 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 policy; and
- Charges for the difference in cost between brand name medication and generic equivalent as explained under Prescription Drugs section.

ESSENTIAL HEALTH BENEFITS

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

UNDERSTANDING MEDICAL NECESSITY

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

Be careful – just because a treatment is prescribed or recommended by a Provider does not mean it is Medically Necessary under the terms of this policy. This policy 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 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 Necessity determination.

Some Medically Necessary services are not Covered Services. Medically Necessary services and supplies that are specifically excluded from coverage under this policy 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 policy does not cover services or treatments that are Experimental, Investigational, or Unproven.

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

ELIGIBLE PROVIDERS

This policy provides benefits only for Covered Services and supplies rendered by an eligible Provider, Hospital, Specialized Treatment Facility, Durable Medical Equipment Supplier, or other licensed medical 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 policy. To be eligible, the Providers must be practicing within the scope of their licenses.

COVERED SERVICES

This section of the policy contains information about the benefits provided under the policy. The following list of benefits is exhaustive. 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 policy on the date the expense is incurred and eligible Providers practicing within the scope of their licenses must render the services. A treatment or service may be Medically Necessary, yet not be a Covered Service. For information about exclusions, see the Benefit Exclusions section.

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

PREVENTIVE CARE SERVICES

This policy 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 policy 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 policy qualifies as a Health Savings Account (HSA) policy, only ACA required preventive services are covered before Deductible at In-network Providers.

Colorectal Cancer Screening

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

Tobacco Cessation Program Services

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

Well Baby/Well Child Care

This policy 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 policy 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 policy covers services for acupuncture.

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

Audiological Tests

This policy covers audiological (hearing) tests.

Biofeedback

This policy covers biofeedback services to treat migraine headaches, urinary incontinence, or other conditions for which biofeedback is not deemed Experimental, Investigational, or Unproven.

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

Cardiac Rehabilitation

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

Chiropractic Manipulation/Spinal Manipulation

This policy covers services for chiropractic manipulation/spinal manipulation.

- Benefits are limited as follows: Up to 20 visits per Benefit Year.

Clinical Trials (Approved)

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

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

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

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

Craniofacial Anomalies

This policy covers dental and orthodontic services for the treatment of craniofacial anomalies when Medically Necessary to restore function. Coverage includes, but not limited to, physical disorders

identifiable at birth that affect the bony structure of the face or head, such as a cleft palate, cleft lip, craniosynostosis, craniofacial microsomia and Treacher Collins syndrome. Coverage is limited to the least costly clinically appropriate treatment. Cosmetic procedures and procedures to improve on the normal range of functions are not covered.

Dietary or Nutritional Counseling

This policy covers services for diabetic education and management of anorexia nervosa or bulimia nervosa if provided by a qualified Provider or as required under ACA for obesity. Coverage for other diagnoses will be determined by Medical Necessity review.

Foot Care

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

Gender Affirmation

This policy covers Medically Necessary gender affirming surgery and related procedures, including hormone therapy, and requires prior authorization.

Genetic Counseling

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

Inborn Errors of Metabolism

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

Newborn Nurse Home Visiting Services

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

Office Visits and Urgent Care Visits

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

This policy 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 policy.

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 policy 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 policy covers facility charges of a Hospital or Ambulatory Surgical Center.

- Benefits are limited as follows: One visit per Benefit Year and is subject to prior authorization.

Sleep Studies

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

Surgery

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

Telehealth

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

Traumatic Brain Injury

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

AMBULANCE SERVICES

This policy 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. Non-emergency ground or air ambulance between facilities requires prior authorization.

BLOOD TRANSFUSIONS

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

BREAST PROSTHESES

This policy 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. Prior authorization by PacificSource is required, and eligibility for benefits is subject to the following criteria:

- The contracture or rupture must be clinically evident by a Provider's physical examination, imaging studies, or findings at surgery;

- Removal, repair, and/or replacement of the prosthesis is not covered when recommended due to an autoimmune disease, connective tissue disease, arthritis, allergenic syndrome, psychiatric syndrome, fatigue, or other systemic signs or symptoms.

COCHLEAR IMPLANTS

This policy covers single or bilateral cochlear implants when Medically Necessary, including programming and reprogramming. The cost of repair and replacement parts are covered if the repair or replacement parts are not under warranty. Some services may require prior authorization. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business). For more information, see the Durable Medical Equipment section.

CONTRACEPTIVES AND CONTRACEPTIVE DEVICES/FAMILY PLANNING

This policy 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 policy when prescribed.

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

This policy covers tubal ligation and vasectomy procedures.

DIABETIC EQUIPMENT, SUPPLIES, AND TRAINING

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

- Some supplies may require prior authorization. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).
- Diabetic supplies other than insulin and syringes (such as lancets, test strips, and glucoStix).
- Insulin pumps.
- Diabetic insulin and syringes are covered under your Prescription Drug benefit. Formulary lancets and test strips are also available under your Prescription Drug benefit in lieu of those covered supplies under the medical policy.
- Outpatient and self-management training and education for the treatment of diabetes. 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 policy 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. Non-preventive colonoscopies performed by an Out-of-network Provider will be covered under the diagnostic benefit and is subject to cost sharing.

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

See the Medical Benefit Summary for cost sharing information on benefits (other than colonoscopy which is at no cost share for In-network Provider) that fall under this category.

This policy 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).

DIAGNOSTIC IMAGING – ADVANCED

This policy 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. Some diagnostic imaging requires prior authorization. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

DURABLE MEDICAL EQUIPMENT

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

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

- Benefits are limited as follows:
 - The cost of Durable Medical Equipment that is not considered an Essential Health Benefit is covered up to \$5,000 per Benefit Year. Examples of Essential Health Benefits are Prosthetic Devices and Orthotic Devices, oxygen and oxygen supplies, diabetic supplies, wheelchairs, breast pumps, and medical foods for the treatment of inborn errors of metabolism.
 - Some Durable Medical Equipment requires a prior authorization. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).
 - 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 policy. If the cost of the purchase, rental, repair, or replacement is over \$2,500, prior authorization by PacificSource is required.
 - Only expenses for Durable Medical Equipment, or Prosthetic and Orthotic Devices that are provided by a PacificSource contracted Provider or a Provider that satisfies the criteria of the

Medicare fee schedule for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and Other Items and Services are eligible for reimbursement.

- Medically Necessary treatment for sleep apnea and other sleeping disorders is covered when prior authorization has been received by PacificSource. Coverage of oral devices includes charges for consultation, fitting, adjustment, follow-up care, and the appliance. The appliance must be prescribed by a Provider specializing in evaluation and treatment of obstructive sleep apnea, and the condition must meet criteria for obstructive sleep apnea.
- Hearing Aids: Hearing Aids, Hearing Assistive Technology Systems, and ear molds are provided in accordance with state and federal law. Contact our Customer Service team for specific coverage requirements. The Durable Medical Equipment benefit covers one Hearing Aid per hearing impaired ear every 36 months or more frequently if modification to an existing Hearing Aid will not meet the needs of the Member.
- Wheelchairs: Purchase, rental, repair, lease, or replacement of a power-assisted wheelchair (including batteries and other accessories) requires prior authorization and is payable only in lieu of benefits for a manual wheelchair.
- Lenses: Only lenses to correct a specific vision defect resulting from a severe medical or surgical problem are covered subject to the following limitations:
 - The medical or surgical problem must cause visual impairment or disability due to loss of binocular vision or visual field defects (not merely a refractive error or astigmatism) that requires lenses to restore some normalcy to vision.
 - The maximum allowance for glasses (lenses and frames), or contact lenses in lieu of glasses, is limited to one pair per Benefit Year when surgery or treatment is performed on either eye. Other policy 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 pumps are not covered.
- Wigs: Wigs following Chemotherapy or Radiation Therapy are covered up to one synthetic wig per Benefit Year.

Maxillofacial Prosthetic Services

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

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

INFERTILITY DIAGNOSTIC SERVICES

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

INPATIENT SERVICES

Hospital Services

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

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

Inpatient Habilitation

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

- Benefits are limited as follows: Up to 30 days per Benefit Year with extensions subject to Medical Necessity review. Additional treatment may be considered when criteria for individual benefits are met.

Inpatient Rehabilitation

This policy 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. Additional treatment may be considered when criteria for individual benefits are met.

Mental Health and Substance Use Disorder Services – Inpatient

This policy 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 by the American Society of Addiction Medicine, Third Edition.

This policy covers crisis intervention, diagnosis, and treatment of Mental Health Conditions and Substance Use Disorders including chemical dependency detoxification 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 policy. 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 policy 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 policy 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 policy 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 policy if the newborn is also eligible and enrolled in this policy.

This policy 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 policy's maternity benefits and help you enroll in our prenatal care program.

OUTPATIENT SERVICES

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

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

Mental Health and Substance Use Disorder Services – Outpatient

This policy 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 by the American Society of Addiction Medicine, Third Edition.

This policy covers crisis intervention, diagnosis, and treatment of Mental Health Conditions and Substance Use Disorders including chemical dependency detoxification 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 policy.

Outpatient Habilitation

This policy 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. Additional treatment may be considered when criteria for individual benefits are met.

Outpatient Rehabilitation

This policy 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 30 visits per Benefit Year with extensions subject to Medical Necessity review. Additional treatment may be considered when criteria for individual benefits are met.

Services for speech therapy are only covered to correct stuttering, hearing loss, peripheral speech mechanism problems, and deficits due to neurological disease or Injury. Speech and/or cognitive therapy for acute Illnesses and Injuries are covered up to one year post Injury when the services do not duplicate those provided by other eligible Providers.

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

PRESCRIPTION DRUGS

This policy 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 and prior authorization requirements. If you have any questions about your coverage, please contact our Customer Service team.

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

Prescription Drug List Tiers

PacificSource's Prescription Drug List (also known as formulary) includes drugs that are used to treat all medically recognized conditions that are not otherwise excluded by your benefits. All formulary drugs are placed on 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.

- 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. For any such medication where third party Copayment assistance is used, the Member shall not receive credit toward their Deductible or out-of-pocket limit for any Copayment or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

Mail Order Pharmacy

This policy 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. For more information, including prior authorization requirements, see our website, PacificSource.com/members/prescription-drug-information/resources.

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 policy.

Diabetic Supplies

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

Contraceptives

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

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 policy only covers drugs prescribed by eligible Providers prescribing within the scope of their professional licenses. This policy does not cover the following:
 - Drugs for any condition excluded under the medical policy.
 - Some Specialty Drugs that are not self-administered are not covered by this prescription benefit, but may be covered under the medical policy's office supply benefit. For a list of drugs that are covered under your medical benefit and which may require prior authorization, please refer to the medical authorization grid on our website, Authgrid.PacificSource.com (select Commercial for the line of business).
 - Some immunizations may be covered under either your medical or pharmacy benefit. Vaccines covered under the pharmacy benefit include, but not limited to: influenza, hepatitis B, herpes zoster (shingles), and pneumococcal. Most other immunizations must be provided by your Provider under your medical benefit.

- Some drugs and all devices to treat erectile or sexual dysfunction unless defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.
- Drugs used as a preventive measure against hazards of travel.
- Vitamins, minerals, and dietary supplements except for prescription prenatal vitamins, fluoride products, and for drugs that have a rating of A or B from the USPSTF, some restrictions may apply.
- Certain drugs require prior authorization (PA). An up-to-date list of drugs requiring prior authorization along with all of our requirements is available on our website.
- Certain drugs are subject to Step Therapy (ST) protocols, which means we may require you to try a pre-requisite drug before we will pay for the requested drug. An up-to-date list of drugs requiring Step Therapy along with all of our requirements is available on our website.
- Certain drugs have quantity limits (QL), which means we will generally not pay for quantities above posted limits. An up-to-date list of drugs requiring quantity limit exceptions along with all of our requirements is available on our website.
- For most prescriptions, you may refill your prescription only after 75 percent of the previous supply has been taken. This is calculated by the number of days that have elapsed since the previous fill and the days' supply entered by the pharmacy. PacificSource will not approve early refills, except under the following circumstances:
 - The request is for ophthalmic solutions or gels, refillable after 70 percent of the previous supply has been taken.
 - The Member will be on vacation in a location that does not allow for reasonable access to a network pharmacy for subsequent refills.

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

Formulary Exception and Coverage Determination Process

Requests for formulary exceptions can be made by the Member or Provider by contacting our Pharmacy Services team. 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.

TRANSPLANT SERVICES

This policy covers the following Medically Necessary organ and tissue transplants including supplies, treatment and facility fees for both donors and recipients: bone marrow, peripheral blood stem cell

and high-dose Chemotherapy; corneal transplants; heart; heart – lungs; intestine; kidney; kidney – pancreas; liver; lungs; and pancreas whole organ transplantation. Expenses for the acquisition of organs or tissues for transplantation are only covered when the transplantation itself is covered under this policy, and is limited to selection, removal of the organ, storage, and transportation of the organ or tissue.

- Benefits are limited as follows:
 - Except for corneal transplants which do not require prior authorization, transplant supplies, treatments, services and evaluations, including pre-transplant evaluations, require prior authorization.
 - 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 policy 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 policy does not cover any vision services 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 policy 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 policy covers breast reconstruction in connection with a Medically Necessary Mastectomy, as required by the Women's Health and Cancer Rights Act of 1998. Coverage is provided in a manner determined in consultation with the attending Provider and for:

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

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

Post-Mastectomy Care

This policy 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 policy does not cover the following:

- Abdominoplasty for any indication.
- Academic skills training. This exclusion does not apply if the program, training, or therapy is part of a treatment plan for a pervasive developmental disorder.
- Athletic injuries sustained while competing or practicing for a professional or semiprofessional athletic contest.
- Aversion therapy.
- Biofeedback (other than as specifically noted under the Covered Services section).
- Charges for 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.
- 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 to prevent, diagnose, or treat diseases or conditions of the teeth and supporting tissues or structures, including treatment that restores the function of teeth.
- 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 policy requirements.
- Drugs or medications not prescribed for inborn errors of metabolism, diabetic insulin, or autism spectrum disorder that can be self-administered (including Prescription Drugs, injectable drugs, and biologicals), unless given during a visit for outpatient Chemotherapy or dialysis or during a Medically Necessary Hospital, emergency room, or other institutional stay.
- Educational or correctional services or sheltered living provided by a school or halfway house, except outpatient services received while temporarily living in a shelter.
- Electronic Beam Tomography (EBT).
- Equine/animal therapy.
- Equipment commonly used for non-medical purposes and/or marketed to the general public.
- Equipment used primarily in athletic or recreational activities. This includes exercise equipment for stretching, conditioning, strengthening, or relief of musculoskeletal problems.
- Experimental, Investigational, or Unproven – This policy 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 policy's state of issuance or as determined by medical advisors, medical associations, and/or technology resources; is not approved for reimbursement by the Centers for Medicare and Medicaid Services; is furnished in connection with medical or other research; or is considered by any governmental agency or subdivision to be Experimental, Investigational, or Unproven, not reasonable and necessary, or any similar finding.

If you or your Provider have any concerns about whether a course of treatment will be covered, we encourage you to contact our Customer Service team. We will arrange for medical review of

your case against our criteria, and notify you of whether or not the proposed treatment will be covered.

- Eye examinations (preventive) for Members age 19 and older.
- 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.
- Growth hormone injections or treatments, except to treat documented growth hormone deficiencies.
- Homeopathic medicines or homeopathic supplies.
- Hypnotherapy.
- Immunizations when recommended for, or in anticipation of, exposure through travel or work.
- Infertility – Services and supplies for artificial insemination, in vitro fertilization, treatment of Infertility, or surgery to reverse voluntary sterilization. Services and supplies, surgery, treatment, or prescriptions determined to be Experimental, Investigational, or Unproven in nature are not covered, except for medication to preserve fertility during treatment with cytotoxic Chemotherapy.
- Instructional or educational programs, except diabetes self-management programs when Medically Necessary.
- Jaw – Services or supplies for developmental or degenerative abnormalities of the jaw, malocclusion, dental implants, improving placement of dentures, Prosthetic Devices for treatment of TMJ conditions, 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 such as Alcoholics Anonymous; adolescent wilderness treatment programs; mental examinations for the purpose of adjudication of legal rights; psychological testing and evaluations not provided as an adjunct to treatment or diagnosis of a Mental Health 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 policy.
- Naturopathic supplies.

- Nicotine related disorder treatment, other than those covered through Tobacco Cessation Program services.
- Obesity or weight reduction control – Surgery or other related services or supplies provided for weight reduction control or obesity (including all categories of obesity), whether or not there are other medical conditions related to or caused by obesity. This also includes services or supplies used for weight loss, such as food supplementation programs and behavior modification programs, regardless of the medical conditions that may be caused or exacerbated by excess weight, and self-help or training programs for weight reduction control. Obesity screening and counseling are covered for children and adults. For more information, see dietary or nutritional counseling in the Professional Services section.
- Oral/facial motor therapy for strengthening and coordination of speech-producing musculature and structures, except as Medically Necessary in the restoration or improvement of speech following a traumatic brain Injury or for Members diagnosed with a pervasive developmental disorder.
- Orthognathic surgery – Services and supplies to augment or reduce the upper or lower jaw, except to repair an Accidental Injury or for removal of a malignancy, including reconstruction of the jaw.
- Orthopedic shoes, diabetic 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 policy. Does not apply to tobacco cessation medications covered under USPSTF guidelines.
- Panniculectomy (removal of panniculus, or excess skin, from lower abdomen) for any indication.
- Personal items such as telephones, televisions, and guest meals during a stay at a Hospital or other inpatient facility.
- Physical or eye examinations required for administrative purposes such as participation in athletics, admission to school, or by an employer.
- Private nursing service.
- Programs that teach a person to use medical equipment, care for family members, or self-administer drugs or nutrition, except for diabetic education benefit.
- Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present.
- Recreation therapy – outpatient.
- Rehabilitation – Functional capacity evaluations, work hardening programs, vocational rehabilitation, community reintegration services, and driving evaluations and driving training programs, except as Medically Necessary in the restoration or improvement of speech following a traumatic brain Injury or for Members diagnosed with a pervasive development disorder.
- Replacement costs for worn or damaged Durable Medical Equipment that would otherwise be replaceable without charges under warranty or other agreement.
- Scheduled and/or non-emergent care outside of the United States.
- Screening tests – Services and supplies, including imaging and screening exams performed for the sole purpose of screening and not associated with specific diagnoses and/or signs and symptoms of disease or of abnormalities on prior testing (including, but not limited to, total body CT imaging, CT colonography, and bone density testing). This does not include preventive care screenings listed 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 or supplies covered under any policy 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 directly related to the Member by blood or marriage.
- Services required by state law as a condition of maintaining a valid driver license or commercial driver license.
- Services, supplies, and equipment not involved in diagnosis or treatment but provided primarily for the comfort, convenience, 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.
- 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.
- Support groups.
- Temporomandibular joint (TMJ) – Related services, or treatment for associated myofascial pain including physical or orofacial therapy. Advice or treatment, including physical therapy and/or orofacial therapy, either directly or indirectly for temporomandibular joint dysfunction, myofascial pain, or any related appliances. For related provisions, see jaw and orthognathic surgery in this section and in the Professional Services section.
- Transplants – Any services, treatments, or supplies for the transplantation of bone marrow or peripheral blood stem cells or any human body organ or tissue, except as expressly provided under the provisions of this policy for covered transplantation expenses.
- Treatment after insurance ends – Services or supplies a Member receives after the Member's coverage under this policy ends.
- Treatment not Medically Necessary – Services or supplies that are not Medically Necessary for the diagnosis or treatment of an Illness or Injury.
- Treatment of any Illness or Injury resulting from an illegal occupation or attempted felony, or treatment received while in the custody of any law enforcement other than with the local supervisory authority while pending disposition of charges.
- Treatment of any work-related Illness or Injury except as described in On-the-Job Illness or Injury and Workers' Compensation.
- Treatment prior to enrollment.

- Unwilling to release information – Charges for services or supplies for which a Member is unwilling to release medical or eligibility information necessary to determine the benefits covered under this policy.
- 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. Questions regarding Medical Necessity, possible Experimental, Investigational, or Unproven services, appropriate setting, and appropriate treatment are forwarded to the PacificSource Medical Director for review and Benefit Determination.

If you would like information on how we reached a particular utilization review Benefit Determination, please contact our Health Services team by phone at 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 and supplies are covered under this policy, and if you meet the policy's eligibility requirements.

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

Because of the changing nature of care, PacificSource continually reviews new technologies and standards. Therefore, procedures and services requiring prior authorization is 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). Our prior authorization search tool is not intended to suggest that all items listed are covered by the benefits in this policy.

When services are received from an In-network Provider, the Provider is responsible for contacting PacificSource to obtain prior authorization.

If your treatment does not receive prior authorization, you can still seek treatment, but your claim will be subjected to retrospective authorization. If a treatment requires prior authorization but was not received, the claim must be submitted within 60 days. If the claim is not submitted within 60 days or if the review determines the expenses were either not covered by this policy or were not Medically 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.

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

In a medical emergency, services and supplies necessary to determine the nature and extent of 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.

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

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

CASE MANAGEMENT

Case management is a program designed to provide early detection and intervention in serious cases of Illness or Injury that have the potential for ongoing major or complex resource use. Case management services may be initiated by PacificSource when there is a high utilization of health services or multiple Providers, or for health problems such as, but not limited to, transplantation, high risk obstetric or neonatal care, 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 policy (for example, continuation of home health physical therapy beyond the benefit limit, if Medical Necessity determines that continuation would prevent a Hospital stay). PacificSource may cover these supplemental benefits through case management if PacificSource determines that supplemental benefits are Medically Necessary and will result in an overall reduction in covered costs and improved quality of care. The decision to allow supplemental benefits will be made by PacificSource on a case-by-case basis. PacificSource and the Member's attending Provider must concur in the request for supplemental benefits in lieu of specified Covered Services before supplemental benefits will be covered. PacificSource's determination to cover and pay for supplemental benefits for a Member does not set a precedent for coverage of continued or additional supplemental benefits for a Member. No substitution will be made without the consent of the insured.

USING THE PROVIDER NETWORK

This section explains how your policy benefits differ when you use 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 policy, 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 policy is designed to restrict Members from contracting to obtain any healthcare services outside the policy on any terms Members choose.

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 our Service Area are also considered PacificSource In-network Providers under your policy.

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 and anesthesiology, to be provided by an In-network Provider. Doing so may help you maximize your benefits and limit your out-of-pocket expenses.

Risk-sharing Arrangements

By agreement, an In-network Provider may not bill a Member for any amount in excess of the 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 policy are designated as primary care Providers (PCPs). PCPs are family practitioners, physician assistants, pediatricians, internists, nurse practitioners, and Women's Healthcare Providers. PCPs are noted in your policy's Provider directory.

When enrolling in this policy, Members are highly encouraged 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. You do not need prior authorization from your PCP in order to obtain access to obstetrical or preventive 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 or following a pre-approved treatment plan. 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 policy, you are free to seek care from Providers other than your PCP without a referral.

In addition to the In-network Providers for your policy, 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 policy'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](https://www.pacificsource.com), 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 the Provider or facility may 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, contact Oregon Division of Financial Regulations at dfp.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 **1-800-985-3059**.

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 Protections Against Surprise Medical Bills and Balance Billing).

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 policy'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 policy'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, providerdirectory.PacificSource.com 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.

Out-of-network Provider for Non-Emergency Services

If you use an Out-of-network Provider for non-emergency Covered Services, your policy's Out-of-network Provider benefits will apply. For more information, see the Out-of-network Providers section.

Non-emergency care outside of the United States is not covered.

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.

DEPENDENT CHILDREN RESIDING OUTSIDE THE SERVICE AREA

If a Dependent Child under age 26 does not live with the Policyholder and lives outside of the Service Area, they are not required to use the services of a PCP to receive benefits from this policy. These Dependent Children may access the highest level of benefits by using the services of a PacificSource In-network Provider or a nationwide Provider. For more information, see the Finding an In-network Provider section.

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 may be entitled to continue care with an individual Provider, whose contract was terminated without cause, for a limited period of time at the in-network cost share. Continuation of care will not be available if you are no longer covered under this policy, the Provider will not accept the Allowable Fee, the Provider no longer holds an active license, or the Provider is otherwise unavailable to continue the care. Contact our Customer Service team for additional information.

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

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. We will never pay a claim that was submitted more than a year after the date of service.

Proofs of Loss

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

Claim Handling Procedures

Claim Determination – PacificSource will make a claim determination within the time period noted in the chart below for the specific type of claim, unless additional information is necessary to process the claim. 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. No extension is permitted for Urgent Care Claims.

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

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 policy’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 policy nor a claim for payment of benefits under the policy are assignable in whole or in part to any person or entity.

Questions about Claims

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

Benefits Paid in Error

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

In the same manner, if PacificSource applies expenses to the Deductible that would not otherwise be reimbursable under the terms of this policy, we may deduct a like amount from the accumulated

Deductible amounts and/or recover payment of medical 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 policy until 60 days after your claim is submitted to us. Also, you must exhaust this policy'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.

COORDINATION OF BENEFITS

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

Double Coverage

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

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

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

Primary or Secondary?

If you are covered by more than one health plan, and you do not know which is your primary plan, you or your Provider should contact any one of the health plans to verify which plan is primary. You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the primary or secondary benefit payer. The primary plan always pays first when you have a claim.

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

When This Plan is Primary

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

Your Own Expenses

- The claim is for your own healthcare expenses.

Your Spouse's or Domestic Partner's Expenses

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

Your Child's Expenses

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

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

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

Other Situations

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

How We Pay Claims When We Are Primary

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

How We Pay Claims When We Are Secondary

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

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

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

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

THIRD PARTY LIABILITY

If you use this policy'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 policy's coverage is secondary. By enrolling in this policy, 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 policy 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 medical expenses are not covered by this policy if they are covered by any other type of insurance policy.

PacificSource may pay your medical 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 policy 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 must reimburse PacificSource for Covered Services related to conception, pregnancy, delivery, or postpartum care that are received in connection with the surrogacy agreement. PacificSource is entitled to reimbursement for any paid claims out of the compensation a Member receives or is entitled to receive under a surrogacy agreement. A Member who enters into a surrogacy agreement must inform PacificSource of that agreement within 30 days of entering that agreement and provide a copy of the agreement to PacificSource.

COMPLAINTS, GRIEVANCES, AND APPEALS

QUESTIONS, CONCERNS, OR COMPLAINTS

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

If you do not speak English, have literacy difficulties, or have physical or mental disabilities that impede your ability to file an 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 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 policy;
- Rescission or cancellation of your policy, 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 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 must receive 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://www.pacificsource.com/resources/documents-and-forms). For more information, see the How to Submit Grievances or Appeals section.

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

PacificSource may, at its discretion and with your consent, waive the requirements of compliance with the Internal 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.

The above time frames do not apply if the period is too long to accommodate the clinical urgency of a situation, or if you do not reasonably cooperate, or if circumstances beyond your or our control

prevent either party from complying with the time frame. In the case of a delay, the party unable to comply must give notice of delay, including the specific circumstances, to the other party.

Information Available with Regard to an Adverse Benefit Determination

The final Adverse Benefit Determination will include:

- A reference to the specific internal rule or guideline PacificSource used in the Adverse Benefit Determination; and
- An explanation of the scientific or clinical judgment for the Adverse Benefit Determination, if the Adverse Benefit Determination is based on Medical Necessity, Experimental, 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 in writing by you or your Authorized Representative. Before submitting a Grievance or Appeal, we suggest you contact our Customer Service team with your concerns. 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 cs@pacificsource.com, with Grievance or Appeal as the subject

Fax 541-225-3628

Assistance Outside PacificSource

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

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

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

Email dfr.insurancehelp@dcbs.oregon.gov

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

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 policy;
- 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 and utilization review procedures; and
- Information about any policy offered by PacificSource.

Information Available from the Division of Financial Regulation about PacificSource

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

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

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

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 policy, 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 policy benefits and exclusions.
- You have a right to be treated with respect and dignity.
- You have a right to impartial access to healthcare without regard to race, religion, gender, national origin, or disability.
- You have a right to honest discussion of appropriate or Medically Necessary treatment options. You are entitled to discuss those options regardless of how much the treatment costs or if it is covered by this policy.
- 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 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 policy and all other communications from PacificSource, and for understanding your policy'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 policy.
- 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 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 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 form provided at [PacificSource.com/resources/documents-and-forms](https://pacificsource.com/resources/documents-and-forms).

DEFINITIONS

Wherever used in this policy, 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.

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 policy;
- Rescission or cancellation of your policy;
- 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 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.

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

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

- Access to healthcare benefits, including an Adverse Benefit Determination made pursuant to utilization management;
- Claims payment, handling, or reimbursement for healthcare services;
- Matters pertaining to the contractual relationship between a Member and PacificSource;
- Rescission or cancellation of your policy; 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.

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, 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 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 policy 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 Necessity (including underlying criteria), coverage under the policy, 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 policy maximums and is on a calendar year basis, beginning January 1 through December 31 of the same year.

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

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.

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

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

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 policy subject to applicable Deductibles, Copayments, Coinsurance, out-of-pocket limit, or other specific limitations.

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 policy are applied. A policy may include more than one Deductible.

Dependent means the Policyholder's legal Spouse, Domestic Partner, and Dependent Children who qualify for coverage under the Member's policy. For more information, see the Eligibility section.

Dependent Children means the following:

- Biological children;
- Step children;
- Adopted children; a child will be considered a Dependent upon assumption of a legal obligation for total or partial support in anticipation of adoption; and
- Foster children or children for whom you or your Spouse/Domestic Partner are under a current court order to act as legal custodian or guardian.

Domestic Partner means an individual that meets the following definition:

- **Registered Domestic Partner** means an individual, age 18 or older, who is joined in a domestic partnership, and whose domestic partnership is legally registered in any state.
- **Unregistered Domestic Partner** means an individual of same or opposite gender who is joined in a domestic partnership with the Policyholder and meets the following criteria:
 - Is age 18 or older;
 - Not related to the Policyholder by blood closer than would bar marriage in the state where they have permanent residence and are domiciled;
 - Shares jointly the same permanent residence with the Policyholder for at least six months immediately preceding the date of application to enroll and intent to continue to do so indefinitely;
 - Has an exclusive domestic partnership with the Policyholder and has no other Domestic Partner;
 - Does not have a legally binding marriage nor has had another Domestic Partner within the previous six months; and
 - Was mentally competent to consent to contract when the domestic partnership began and remains mentally competent.

Drug List (also known as a formulary) is a list of covered medications used to treat various medical conditions. Please refer to [PacificSource.com/find-a-drug](https://www.pacificsource.com/find-a-drug) 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 Medical Condition means a medical, mental health, or Substance Use Disorder condition:

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

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

Emergency Services means:

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

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

- Ambulatory patient services;
- Emergency Services;
- Hospitalization;
- Laboratory services;

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

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

- Experimental, Investigational, or Unproven services and supplies include, but not limited to, services, supplies, procedures, devices, Chemotherapy, drugs or medicines, or the use thereof, which at the time they are rendered and for the purpose and in the manner they are being used:
 - Have not yet received full U.S. government agency required approval (for example, FDA) for other than Experimental, Investigational, or Unproven, or clinical testing;
 - Are not of generally accepted medical practice in your policy’s state of issue or as determined by medical advisors, medical associations, and/or technology resources;
 - Are not approved for reimbursement by the Centers for Medicare and Medicaid Services;
 - Are furnished in connection with medical or other research; or
 - Are considered by any governmental agency or subdivision to be Experimental, Investigational, or Unproven, not considered reasonable and necessary, or any similar finding.
- When making decisions about whether treatments are Experimental, Investigational, or Unproven, PacificSource relies on the above resources as well as:
 - Expert opinions of specialists and other medical authorities;
 - Published articles in peer-reviewed medical literature;
 - External agencies whose role is the evaluation of new technologies and drugs; and
 - External Review by an independent review organization.
- The following will be considered in making the determination whether the service is in an Experimental, Investigational, or Unproven status:
 - Whether there is sufficient evidence to permit conclusions concerning the effect of the services on health outcomes;
 - Whether the scientific evidence demonstrates that the services improve health outcomes as much or more than established alternatives;
 - Whether the scientific evidence demonstrates that the services’ beneficial effects outweigh any harmful effects; and
 - Whether any improved health outcomes from the services are attainable outside an investigational setting.

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

Generic Drugs are drugs that, under federal law, require a prescription by a Provider, and are not a brand name medication. By law, Generic Drugs must have the same active ingredients as the brand name medication and are subject to the same standards of their brand name counterpart. Generic

Drugs must be approved by the FDA through an Abbreviated New Drug Application and generally cannot be limited to a single manufacturer.

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

Grievance means a written Complaint submitted by 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.

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

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

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

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

Illness means a sickness, disease, ailment, bodily disorder, and pregnancy.

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

Infertility means:

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

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

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

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 policy. If any Covered Service is deemed to be an Essential Health Benefit as determined by the Secretary of the U.S. Department of Health and Human Services, Lifetime Maximum dollar limits will not apply to that Covered Service in accordance with the standards established by the Secretary.

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

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

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

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

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

Member means a person covered by this policy.

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

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

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

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

Mental Health Condition means all disorders defined in the current edition of Diagnostic and Statistical Manual of Mental Disorders.

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

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

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 means the Member who is issued the policy.

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

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

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

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.

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 an individual health insurance policy for reasons other than failure to timely pay required premiums toward the cost of coverage.

Routine Costs of Care mean costs for Medically Necessary services or supplies covered by the policy 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 your policy 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 your policy 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.

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

Stabilize means to provide medical treatment as necessary to ensure that, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during or to

result from the transfer of the patient from a facility; and with respect to a pregnant woman who is in active labor, to perform the delivery, including the delivery of the placenta.

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

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

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

Surgical Procedure means any of the following listed operative procedures:

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

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

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

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

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

Discrimination is Against the Law

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

PacificSource:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

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

If you believe that PacificSource has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 7068, Springfield, OR 97475-0068, 888-977-9299, TTY 711, Fax 541-684-5264, or email CRC@PacificSource.com. Please indicate you wish to file a civil rights grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Customer Service Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
 200 Independence Avenue, SW
 Room 509F, HHH Building
 Washington, D.C. 20201
 1-800-368-1019, 800-537-7697 (TDD)

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

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

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

Korean	<p>본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 PacificSource Health Plans 을 통한 커버리지 에 관한 정보를 포함하고 있습니다.</p> <p>본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 리가 있습니다. (888) 977-9299 로 전화하십시오.</p>
Laotian	<p>ການແຈ້ງການນີ້ ມີຂໍ້ ມູ ນໍ້ສາຄໍ ນ. ການແຈ້ງການນີ້ ມີຂໍ້ ມູ ນໍ້ສາຄໍ ນກໍ່ ງອກ ບໍ່ຄາຍ້ ອງສະໜັ ກຫ ັ້ ການຄໍ ມ ອອງຂອງທ່ ານໂດຍຜ່ ານ PacificSource Health Plans. ຕື່ ບ່ງສາວ້ ບກໍ່ ານ ດວ້ ນທ ັ້ ສາຄໍ ນໃນແຈ້ ງການນີ້ . ທ່ ານອາດຈາເປ້ ນຕໍ່ ອງໃຊ້ ເວລາອໍ ດາເນນການໂດຍກໍ່ ານ ດເວລາອໍ ດາເນນ ນອນ ຈະ ຮໍ ກສາການຄໍ ມອອງສຂະພາບຂອງທ່ ານຫ ັ້ ການຊໍ ວຍເຫ ັ້ ອໍ ທມຄໍ າໃຊ້ ຈໍ າຍ. ທ່ ານມີສດທຈະໂດ້ ຮໍ ບໍ່ຂໍ້ ມູ ນ ຂໍ າວສານນີ້ ແລະການຊໍ ວຍເຫ ັ້ ອໃນພາສາຂອງທ່ ານທໍ່ ບມຄໍ າໃຊ້ ຈໍ າຍ. ໂທ (888) 977-9299.</p>
Nepali	<p>यो स चनामाा महत्त्वप र्ु जानकारी छ । यो स चनामाा तपाईंको आवेिन वा PacificSource Health Plans का माध्यमबाट प्राप्त हुने सद्दु विबारे महत्त्वपर्ु जानकारी छ । यो सचू नामा भएका महत्त्वपर्ु दमदतहरू ख्याल िनुहु ोस् । तपाईंले पाइरहके ो स्वास्थ्य दबमा पाइरहन वा तपाईंको खचुको भक्तानीमासहायता पाउन के ही समयकारवाही िन -सीमामा काम-ुपनु हनसक्छु । तपाईंले यो जानकारी र सहायता आफ्नो मातभू ाषामा दन शल्ु क पाउनु तपाईंको अधिकारः हो (888) 977-9299 मा फोन िनुहु ोस् ।</p>
Norwegian	<p>Denne kunngjøringen har viktig informasjon. Kunngjøringen inneholder viktig informasjon om programmet eller dekning gjennom PacificSource Health Plans. Se etter viktige datoer i denne kunngjøringen. Du må kanskje ta affære ved visse frister for å beholde helse-dekning eller økonomisk bistand. Du har rett til å få denne informasjonen og hjelp i ditt spark uten kostnad. Ring (888) 977-9299.</p>
Pennsylvania Dutch	<p>Die Bekanntmachung gebt wichdichi Auskunft. Die Bekanntmachung gebt wichdichi Auskunft baut dei Application oder Coverage mit PacificSource Health Plans. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimnde Deadlines, so ass du dei Health Coverage bhalde kansch, odder bezaahle helfe kansch. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix. Kansch du (888) 977-9299 uffrufe</p>
Persian	<p>این اعلامیه حامی اطلاعات مهم میباشد. این اعلامیه حامی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما مربوط به PacificSource Health Plans به تاریخ های مهم در این اعلامیه توجه نمایید. شما ممکن است تا به تاریخ های مشخصی برای حفظ پوشش مزایای یا برای کمک به مخارج مزایای ملزوم به انجام کارهایی شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید (888) 977-9299</p>
Punjabi	<p>ਇਸ ਨੇ ਜਿਸ ਜਵਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੇ ਜਿਸ ਜਵਚ PacificSource Health Plans ਵਲੋਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਿਾਰੇ ਮਹਿੰ ਤਵਪ ਰਨ ਜਾਣਕਾਰੀ ਹੈ . ਇਸ ਨੇ ਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਲਈ ਵੇਖੋ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱ ਚ ਮਦਦ ਦੇ ਇਛਿੱ ਕ ਹੋ ਤਾਂ ਤੁਹਾਨ ੂੰ ਆ ਤਮ ਤਾਜਰਖ ਤੋ ਪਜਹਲਾਂ ਕੁਿੱ ਝ ਖਾਸ ਕਦਮ ਚੁਿੱ ਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ. ਤੁਹਾਨ ੂੰ ਮੁਫਤ ਜਵਚ 'ਤੇ ਆਪਣੀ ਭਾਸਾ ਜਵਿੱ ਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪਰਾਪਤ ਕਰਨ ਦਾ ਅਜਿਕਾਰ ਹੈ. ਕਾਲ (888) 977-9299</p>
Romanian	<p>Prezenta notificare conține informații importante. Această notificare conține informații importante privind cererea sau acoperirea asigurării dumneavoastră de sănătate prin PacificSource Health Plans. Căutați datele cheie din această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la (888) 977-9299.</p>

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