

PacificSource Group Plan Limitations – Oregon Preferred, Prime, and Choice

GENERAL BENEFIT LIMITATIONS (see handbook for a more complete list and details)

- Ambulance for emergency transport to nearest facility able to treat condition (air only if ground is medically or physically inappropriate).
- Biofeedback to treat migraine headaches or urinary incontinence is limited to a lifetime max of 10 sessions.
- Cardiac rehabilitation for Phase I covered under inpatient hospital, Phase II covered as outpatient hospital benefits up to a lifetime max benefit of 36 sessions if preauthorized by PacificSource, and Phase III is not covered.
- Colorectal Cancer Screening: fecal, occult blood test, flexible sigmoidoscopy, routine colonoscopy for ages 50 to 75 years, and double contrast barium enema. [*Colonoscopies for under age 50, for medical diagnosis, or out-of-network are Outpatient Surgery/Services.*]
- Contraceptive devices (IUD, Norplant, diaphragm, cervical cap) and insertion/removal are covered. (Over-the-counter not covered.)
- Diabetic self-management education covered when diagnosed up to three hours of education per year if significant change.
- Durable medical equipment: Annual \$5,000 max (limit does not apply to essential services). Preauthorization if over \$800. Lenses to correct vision defect from severe medical problem or eye surgery other than refraction has a \$200 max. Breast pump rental/purchase has \$200 lifetime max. Power-assisted wheelchair in lieu of manual wheelchair (one per lifetime for age 19 years or older).
- Hearing aids covered for members under 18, and dependent children 18 years or older who are enrolled in an accredited educational institution, up to a max of \$4,000 every 48 months. Adjusted annually to reflect US CPI.
- Inpatient rehabilitative care for disease or injury limited to 30 days per calendar year if preauthorized. Limited to 30 days per calendar year except for head or spinal cord injury. Covered services after a head or spinal cord injury is limited to 60 days per calendar year.
- Mental health and chemical dependency treatment and/or services are subject to the same standards for medical necessity and experimental/investigational criteria as other medical conditions covered under this policy.
- Organ transplants covered after 24 consecutive months of group coverage or since birth. Travel/living expenses not covered for recipient's family/donor. Travel/housing expenses for recipient and a caregiver limited to \$5,000. If transplant performed at participating transplant facility, covered charges of facility are subject to plan deductibles; coinsurance and copays after deductible are waived. If transplant services available through contracted transplant facility but performed at noncontracted facility, plan pays 50% to 60% of billed amount or \$100,000, whichever is less and otherwise subject to deductibles, copays, coinsurance, and out-of-pocket max.
- Pediatric dental care requiring general anesthesia has a \$2,000 lifetime max for facility if preauthorized.
- Physical, occupational, and speech therapy limited to 30 visits per calendar year if prescribed. Benefit consideration for additional visits only given to cases involving the treatment of severe neurologic conditions. No extension beyond additional 30 visits.
- Prostate Cancer Screening includes: digital rectal examination and a prostate specific antigen test.
- Pulmonary rehabilitation (outpatient) covered for severe chronic lung disease is subject to medical review.
- Routine costs of care associated with qualifying clinical trials covered. Excludes services/supplies that are not routine costs.
- Routine gynecological exam annually. Includes Pap smear, pelvic/breast exam, blood pressure, and weight check. Annual mammogram (*non-routine or subsequent mammogram is diagnostic radiology*). Lab limited to occult blood, urinalysis, and complete blood count.
- Routine physicals: Ages to 36 months is 13 visits (12 plus one in-hospital exam); Ages 3-21 is one exam per year; Ages 22-34 is one exam every four years; Ages 35-59 is one exam every two years; and Ages 60 and older is one exam per year.
- Skilled nursing facility covered for up to 60 days per calendar year when preauthorized by PacificSource.
- Sleep apnea and other sleeping disorders and related oral devices requires preauthorization.
- Telemedical health services covered when medically necessary if it does not duplicate or supplant a service available patient in person.
- Tobacco cessation covered if by a PacificSource approved program up to a max lifetime benefit of two quit attempts. Program will send an 8-week supply of nicotine patches or gum, or can get a 12-week supply of Bupropion or Chantix at participating pharmacy
- USPSTF Preventive Care Grade A and B Recommendations are covered for specific criteria at participating providers; and up to a 90-day supply for certain prescribed drugs when meet age, dose, and other specific criteria at participating pharmacies.

GENERAL EXCLUDED SERVICES NOT NOTED ABOVE (see handbook for a more complete list and details)

- Acupuncture, naturopathic treatment, and chiropractic care (unless employer has Alternative Care / Chiropractic endorsement)
- Contraceptive drugs for any diagnosis (except as covered under prescription drug card)
- Cosmetic or reconstructive services, except post-mastectomy reconstruction
- Custodial care or daycare, including help with activities such as walking, bed, bathing, dressing, eating, and meals; Private duty nursing
- Dental examinations and treatment to prevent, diagnose, or treat diseases of the teeth, tissues, or structures
- Eyeglasses, contact lenses, vision aids; Eye refraction procedures, orthoptics, vision therapy, or other services to correct refractive error
- Education/training for career, personal growth, assertiveness, sensitivity, image therapy, relaxation, stress management, parenting, family, self-help, to use medical equipment, or self-administer drugs or nutrition (except for diabetic education)
- Experimental or investigational treatment
- Foot care (routine), unless you are being treated for diabetes mellitus
- Immunizations for the purpose of travel, occupation, or foreign residence
- Infertility, sterility, impotency, frigidity, sexual dysfunction, or sexual transformation diagnose or treatment
- Obesity or weight control treatment or surgery, even if there are other medical reasons for you to control your weight
- Orthognathic procedures and over the counter medications
- Prescription drugs (except as covered under prescription drug card) and over the counter medications
- TMJ services or treatment for associated myofascial pain, including physical or oromyofascial therapy
- Treatment of any condition caused by a war, armed invasion, or act of aggression, or while serving in the armed forces
- The following are excluded for the first six months on Preferred plans and paid at 50% for Prime/Choice: pre-existing conditions for most services for members age 19 and over; and surgical procedures for inner/middle ear infections, elective surgeries and procedures, removal of tonsils/adenoids, vasectomies, and tubal ligations (except at time of a covered newborn delivery). If covered by a group health plan before enrolling, you may be credited for prior coverage to reduce pre-existing exclusion periods.
- Except for corneal transplants, organ/tissue transplants not covered until you have been enrolled in this plan for 24 months.