Polaris Health Plus Plan

Summary of Benefits

Polaris Health Plus

Polaris Health Plus is a comprehensive plan that provides comprehensive coverage for medical, vision, and dental services. This plan also offers prescription drug coverage, mental health and substance abuse coverage, and coverage for preventive care services. With Polaris Health Plus, you can choose from a variety of in-network providers, including primary care physicians, specialists, hospitals, and pharmacies. This plan also offers coverage for emergency services, both in-network and out-of-network.

SUMMARY OF YOUR COSTS

SUMMARY OF YOUR COSTS

At Polaris Health, we understand that health care costs can be a burden. That's why we offer a comprehensive plan that covers the cost of medical, vision, and dental services. With Polaris Health Plus, you can choose from a variety of in-network providers, including primary care physicians, specialists, hospitals, and pharmacies. This plan also offers coverage for emergency services, both in-network and out-of-network.

Your cost for Polaris Health Plus will depend on your plan type, the services you use, and the providers you visit. You can find more information about cost-sharing arrangements on the Polaris Health website.

In-Network Costs: If you use an in-network provider, your out-of-pocket costs will be lower than if you use an out-of-network provider. This is because Polaris Health has negotiated discounted rates with in-network providers.

Out-of-Network Costs: If you use an out-of-network provider, you may be responsible for paying the full cost of the services you receive. Additionally, you may have to pay a higher deductible and coinsurance.

Prescription Drug Costs: Prescription drug costs are also taken into consideration with Polaris Health Plus. Your out-of-pocket costs will depend on the tier of the medication you are prescribed. Generally, brand-name and non-preferred generic medications will have higher out-of-pocket costs than preferred generic and generic medications.

Mental Health and Substance Abuse Coverage: Polaris Health Plus also provides coverage for mental health and substance abuse services. Generally, coverage for mental health and substance abuse services will be the same as coverage for medical and surgical services.

Preventive Care Services: Polaris Health Plus also covers preventive care services such as immunizations and screenings. Generally, these services are covered at no cost to you. However, you will be responsible for any applicable deductibles and coinsurance.

Tips:

- Make sure to double-check if a provider is in-network or out-of-network before you receive care. This will help you avoid any surprise costs.

- Take advantage of preventive care services when they are offered. These services are covered at no cost to you and can help you stay healthy.

- Be aware of your plan's formulary, which is a list of medications that are covered by your plan. If you are prescribed a medication that is not on the formulary, you may have to pay more out-of-pocket.

- If you have any questions about your costs, you can contact Polaris Health for more information.

HOW PROVIDERS AFFECT YOUR COSTS

In-Network Providers

HOW PROVIDERS AFFECT YOUR COSTS

Choosing the right provider is an important part of getting the most value out of your health insurance plan. With Polaris Health Plus, you have access to an extensive network of innetwork providers. Working with these providers is an essential part of getting the most value out of your plan.

In-Network Providers

When choosing an in-network provider for your health care needs, make sure to check with Polaris Health Plus to ensure that the provider is in-network. This is important because in-network providers charge lower rates than out-of-network providers. Polaris Health Plus offers a wide range of in-network providers, including primary care physicians, specialists, hospitals, and pharmacies. This lets you choose a provider that is most convenient for you and your family.

It is important to note that in-network providers may not always be available in every area. The Polaris Health Plus website offers a searchable directory of all in-network providers in your area. This directory is regularly updated, so you can be sure that you are choosing from in-network providers that are available in your area.

Cost Savings

Using an in-network provider can help you save money on health care services. In-network providers have agreed to charge lower rates for their services, which can help you save money on your out-of-pocket costs. In addition, Polaris Health Plus may offer additional discounts or cost-savings for using in-network providers.

Emergency Services

In the event of an emergency, you can receive care from both in-network and out-ofnetwork providers. However, if you choose to receive care from an out-of-network provider, your out-

of-pocket costs may be higher. Therefore, it is important to consider the cost of out-of-network care when deciding whether to seek emergency care.

Tips for Choosing an In-Network Provider

When choosing an in-network provider, there are a few tips to keep in mind:

- Check with Polaris Health Plus to make sure that the provider you are considering is in-network.
- Use the searchable directory on the Polaris Health Plus website to find in-network providers in your area.
- Ask your current provider if they are part of the Polaris Health Plus network.
- Consider the cost savings associated with in-network providers when making your decision.
- Consider the quality of care when choosing a provider.
- Make sure the provider is familiar with your health insurance plan and its coverage.
- Make sure the provider is available and can accommodate your schedule.

Conclusion

Choosing the right provider is an important part of getting the most value out of your health insurance plan. Polaris Health Plus offers an extensive network of in-network providers that can help you save money on health care services. By following the tips outlined above, you can make sure that you are choosing an in-network provider that is most convenient and cost-effective for you and your family.

Continuity of Care

HOW PROVIDERS AFFECT YOUR COSTS: Continuity of Care

It's important to understand continuity of care when selecting a provider. Continuity of care is the process of being treated by the same provider or medical team over a period of time. When you have continuity of care, your provider has a better understanding of your medical history, enabling them to provide more accurate diagnoses and treatments.

Continuity of care is important when selecting a provider because it ensures better quality of care. When you have continuity of care, your provider is more familiar with your medical history, which can lead to more effective treatments. Also, if you stay with the same provider for a period of time, the provider will be more likely to know about any changes in your health and can offer more personalized care.

The Polaris Health Plus plan offers coverage for continuity of care. This means that if you have been seeing the same provider for a period of time, you may be able to continue seeing them without having to switch to a different provider in the network.

However, it's important to note that there are some exceptions to the continuity of care rule. If you are switching to a new provider, you may be required to switch to an in-network provider. Additionally, if you are switching from an in-network provider to an out-ofnetwork provider, you may be required to switch to an in-network provider.

When selecting a provider, it's important to keep continuity of care in mind. Here are a few tips that can help you ensure continuity of care:

- Always check your provider's network status before scheduling an appointment.
- If you're switching to a new provider, make sure they are in-network.
- Ask your provider if they offer continuity of care.
- If you are switching to a new provider, make sure they are familiar with your medical history.
- If you are switching from an in-network provider to an out-of-network provider, make sure you understand what that means for your coverage.
- Make sure you keep all of your medical records up to date.

Continuity of care is an important factor to consider when selecting a provider. Polaris Health Plus offers coverage for continuity of care, so you may be able to continue seeing the same provider without having to switch to a different provider in the network. However, there are some exceptions to the continuity of care rule, so it's important to understand what those are. By following these tips, you can ensure you have the best possible coverage and ensure continuity of care.

Non-Participating

HOW PROVIDERS AFFECT YOUR COSTS

When it comes to health care, the provider you choose can have a major impact on your costs. With Polaris Health Plus, you have the option to choose from a variety of innetwork providers. However, if you choose to go outside of the network, you may incur additional costs.

Non-Participating Providers

Non-participating providers are providers that are not in-network with Polaris Health Plus. When you visit a provider that is not in-network, you will be responsible for the entire cost of the care. This means that, if you choose to visit a provider who is not in-network, you will have to pay the entire cost of the service out-of-pocket.

Exceptions

There are some exceptions to this rule. If you are traveling outside of the United States and you cannot find an in-network provider, you may be able to visit a non-participating

provider and Polaris Health Plus may cover a portion of the cost. Additionally, if you are in a life-threatening situation and need to go to the nearest hospital, Polaris Health Plus may provide coverage for the care received.

Tips

If you are considering visiting a provider that is not in-network, it is important to check with Polaris Health Plus first. Before your visit, contact the customer service line to find out if the provider is in-network and if there are any exceptions that could apply to your situation. Additionally, it is important to review your Explanation of Benefits (EOB) after your visit to ensure that you are not being charged for any services that were not covered by your insurance. If you are charged for a service that was not covered, contact Polaris Health Plus right away.

If you are considering a new provider, it is important to ask if they are in-network with Polaris Health Plus. This can save you time and money in the long run. Additionally, you can use Polaris Health Plus's online provider directory to search for a provider that is in-network and view their ratings.

By understanding the difference between in-network and non-participating providers and being aware of any exceptions that may apply to you, you can save money on your health care costs. Polaris Health Plus is here to help you make the most of your coverage. If you have any additional questions about in-network and non-participating providers, please contact the Polaris Health Plus customer service line.

Balance Billing Protection

HOW PROVIDERS AFFECT YOUR COSTS: Balance Billing Protection

Balance billing is a practice where a provider bills you for the difference between the allowed amount and billed amount. The allowed amount is the amount that your insurance company determines is a reasonable fee for a service. The amount you are billed for is the amount that the provider charges you for the services. With Polaris Health Plus, you are protected from balance billing. This means that you can rest assured that you will not be billed more than the allowed amount by your provider.

Balance billing protection is an important part of Polaris Health Plus. This protection ensures that you will not be responsible for the difference between the allowed amount and the billed amount. This protection helps you to avoid unexpected costs.

Exceptions:

Balance billing protection does not apply to out-of-network providers. If you receive services from an out-of-network provider, you may be responsible for the difference between the allowed amount and the billed amount.

Balance billing protection also does not apply to certain services, such as cosmetic services and experimental procedures. If you are considering receiving any of these services, it is

important to check with Polaris Health Plus to determine whether balance billing protection applies.

Tips:

1. Get preauthorization: When you are planning to receive a service, it is important to get preauthorization. Preauthorization will help you to determine if the service is covered and the amount that you will be responsible for.

2. Ask questions: Ask your provider questions about the services they are providing and the cost of the services. This will help you to understand the costs associated with the services and to determine if balance billing protection applies.

3. Use in-network providers: Whenever possible, use in-network providers. This will help you to ensure that balance billing protection applies and that you do not receive unexpected bills.

4. Consider alternative treatments: Consider whether there are any alternative treatments or procedures that may be less expensive. This may help you to keep costs down and to avoid balance billing.

5. Know your rights: Make sure that you are aware of your rights when it comes to balance billing. Polaris Health Plus is responsible for informing you of your rights and for providing you with balance billing protection.

By taking the time to understand balance billing protection and to familiarize yourself with the tips above, you can help to ensure that you are not responsible for unexpected bills. Balance billing protection is an important part of Polaris Health Plus and it is important to take the time to understand how it works.

Benefits For Out-Of-Network Or Non-Contracted Providers

HOW PROVIDERS AFFECT YOUR COSTS: Benefits For Out-Of-Network Or Non-Contracted Providers

Polaris Health Plus offers coverage for out-of-network or non-contracted providers; however, it is not as comprehensive as the coverage provided for in-network services. When you seek care from an out-of-network provider, you may be required to pay more for services than you would if you had used an in-network option.

When seeking care from an out-of-network provider, it is important to know exactly what services are covered and what you will be expected to pay out of pocket. Generally, out-ofnetwork providers are not required to accept the same reimbursement rates as contracted providers, so the cost of care could be significantly higher.

It is also important to know that services received from an out-of-network provider may not count towards your deductible or be applied to your out-of-pocket maximum. This means that you may be responsible for paying the entire cost of the services, minus any applicable

discounts. It is important to keep in mind that you may also be subject to balance billing from an out-of-network provider. Balance billing occurs when the provider bills you for the difference between their billed charges and the amount paid by Polaris Health Plus.

In some cases, you may be able to receive care from an out-of-network provider if there is not an in-network option available. In these cases, Polaris Health Plus will cover the same amount as if the care was provided by an in-network provider.

When considering care from an out-of-network provider, it is important to understand the potential risks of doing so. You may end up paying more out of pocket because the provider is not contracted with Polaris Health Plus, or you may be subject to balance billing.

It is important to do your research before seeking care from an out-of-network provider. Make sure to ask questions about the provider's billing policies, cost of services, and any potential discounts. It is also important to call Polaris Health Plus prior to receiving care to make sure that the services are covered and to understand your financial responsibility. Tips for seeking out-of-network care:

- Ask the provider if they accept Polaris Health Plus and if they will accept the amount paid by the plan.
- Ask the provider what their billing policies are and if they offer any discounts.
- Ask Polaris Health Plus if the services are covered and if there are any limits or exclusions.
- Ask Polaris Health Plus if you will be subject to balance billing.
- Check to see if there is an in-network provider available that offers the same services.

By taking the time to understand the differences between in-network and out-of-network care and by doing your research, you can make sure that you are making the best decisions for your health and your wallet.

HOW PROVIDERS AFFECT YOUR COSTS

When it comes to healthcare, one of the most important decisions you can make is choosing the right provider. With Polaris Health Plus, you can select from a wide range of innetwork providers, including primary care physicians, specialists, hospitals, and pharmacies. This plan also covers emergency services, both in-network and out-of-network.

The provider you choose will have a direct impact on your costs. When you use in-network providers, you'll pay lower out-of-pocket costs. On the other hand, if you use out-of-network providers, you'll be responsible for a larger portion of the cost. In some cases, you may be responsible for the entire cost.

It is important to note that in-network providers are not necessarily the same across all plans. So, even if a provider is in-network for one plan, they may not be in-network for

another. Therefore, it's important to check if your preferred provider is in-network before you select a plan.

When selecting a provider, there are a few tips you should keep in mind:

- Research your provider's credentials. Make sure they are properly licensed and accredited.
- Ask about their experience. How long have they been in practice? What kind of patients have they treated in the past?
- Ask about their methods. Do they use evidence-based treatments? Are they up-to-date on the latest medical advancements?
- Ask about their services. Do they offer preventive care services? What about mental health and substance abuse services?
- Ask about their costs. Do they offer payment plans or discounts? How do they compare to other providers in terms of cost?
- Ask about their availability. Are they available to answer questions or provide guidance when needed?
- Check reviews. Read reviews from past patients to get a better idea of their experience.

By taking the time to research your provider, you can ensure that you're getting the best care possible at the lowest cost.

There are also a few exceptions to be aware of. For example, Polaris Health Plus does not cover elective or cosmetic procedures. Additionally, some services are only covered when they are performed by in-network providers. So, make sure to check the plan's provider network before scheduling any services.

Finally, if you have any questions or need help selecting a provider, you can always contact Polaris Health's customer service team. They can provide you with helpful information and advice about selecting the right provider for your needs.

By following these tips and doing your research, you can make sure you're getting the best care possible at the lowest cost. With Polaris Health Plus, you can rest assured that you're getting quality coverage for all your healthcare needs.

IMPORTANT PLAN INFORMATION

Copayments (Copays)

IMPORTANT PLAN INFORMATION: Copayments (Copays)

When using Polaris Health Plus, you may be responsible for a copayment (or copay) for certain services. A copayment is a fixed amount that you are expected to pay for a service. The amount of the copayment varies based on the type of service received, whether the service is rendered by an in-network or out-of-network provider, and other factors.

In-Network Copays:

For in-network services, copayments are generally lower than for out-of-network services. The copayment for primary care visits is typically around $20, while specialist visits have a copayment of around $50. For in-network emergency services, the copayment is typically around $100. In addition, for in-network preventive care services, there is typically no copayment.

Out-of-Network Copays:

For out-of-network services, copayments are typically higher than for in-network services. The copayment for primary care visits is typically around $50, while specialist visits have a copayment of around $75. For out-of-network emergency services, the copayment is typically around $150. Please note that Polaris Health Plus will only cover a portion of out-of-network services, and you may be responsible for the remaining balance.

Exceptions:

There are a few exceptions to the copayment amounts listed above. For example, for mental health and substance abuse services, the copayment for in-network services is typically around $30 and the copayment for out-of-network services is typically around $60. In addition, the copayment for preventive care services is typically waived if received from an in-network provider.

Tips:

It is important to remember that copayments are subject to change and may vary depending on the type of service received. It is also important to note that copayments are not waived for out-of-network services, and you may be responsible for the remaining balance after Polaris Health Plus has paid its portion.

Finally, it is important to make sure that the provider you are seeing is in-network. This can be easily done by checking the provider directory on the Polaris Health Plus website. It is also important to remember that if you receive a service from an out-of-network provider, you may be responsible for a higher copayment.

By understanding and following these tips, you can be sure to get the most out of your Polaris Health Plus coverage and avoid unnecessary copayments.

Split Copay For Office Visits

IMPORTANT PLAN INFORMATION: Split Copay For Office Visits

Polaris Health Plus offers a split copay for office visits in order to make healthcare more affordable for its members. This means that you will pay a lower copay for office visits than you would for other services. The split copay is applied to office visits with primary care physicians, specialists, and mental health providers.

Office visits with primary care physicians are subject to a $35 copay. Office visits with specialists are subject to a $60 copay. Mental health visits with a psychiatrist or another mental health provider are subject to a $45 copay.

There are a few exceptions to this split copay. Emergency room visits and urgent care visits are not subject to the split copay and will be subject to the full copay amount that applies to the type of provider that you visited. Office visits with an anesthesiologist are also not subject to the split copay and will be subject to the full copay amount that applies to the type of provider that you visited.

When visiting your doctor, it is important to understand which type of provider you are visiting. Knowing whether you are visiting a primary care physician, specialist, or mental health provider will help you to understand how much your copay will be. Your copay amount will be listed on your insurance card.

When you visit a doctor, you should also inform the office staff that you are a Polaris Health Plus member. This will ensure that the staff bills your insurance correctly and that you are charged the correct amount for your copay.

If you have any questions about your copay amount, you can contact Polaris Health's customer service team. They will be able to provide more detailed information about your coverage and copay amount.

It is important to remember that the split copay only applies to office visits. Other services, such as lab tests, X-rays, and imaging tests, are subject to different copay amounts, which are listed on your insurance card.

It is also important to remember that the split copay only applies to in-network providers. If you visit an out-of-network provider, you will be subject to a higher copay amount, which is also listed on your insurance card.

At Polaris Health Plus, we are committed to helping our members get the care they need at a price they can afford. With the split copay for office visits, we hope to make healthcare more affordable for you and your family.

Calendar Year Deductible

IMPORTANT PLAN INFORMATION: Calendar Year Deductible

The Polaris Health Plus plan has a calendar year deductible that applies to some services. The amount you must pay out-of-pocket before the plan begins to pay for covered services is called the calendar year deductible. The calendar year deductible is the same for all members of the plan and is reset each year on the plan's renewal date.

For In-Network Services: The calendar year deductible for in-network services is $1,500 for individuals and $3,000 for families. This means that you must pay the full cost of all covered services until you have paid a total of $1,500 for an individual and $3,000 for a family. Once this amount is reached, the plan will begin to pay its share of the cost of eligible services.

For Out-of-Network Services: The plan does not have a calendar year deductible for out-ofnetwork services. However, out-of-network services are subject to higher cost sharing than in-network services, so be sure to check with your provider to find out the cost sharing that applies.

Exceptions: Certain services are exempt from the calendar year deductible. These services include preventive care services and emergency services.

Tips:

- Be sure to check with your provider to find out if a service is subject to the calendar year deductible before receiving the service.
- Make sure you understand the cost sharing that applies to out-of-network services.
- Be aware that the calendar year deductible is reset each year on the plan's renewal date.
- Remember that preventive care services and emergency services are exempt from the calendar year deductible.

Coinsurance

IMPORTANT PLAN INFORMATION: Coinsurance

Coinsurance is a cost-sharing requirement under Polaris Health Plus. This means that after you have met your deductible, you will be responsible for a certain percentage of the costs for covered services. The coinsurance rate is usually a percentage of the allowed amount for a service, and it is your responsibility to pay this amount.

For example, if the allowed amount for a service is $100 and your coinsurance is 20%, you are responsible for paying $20 (20% of $100). The insurance company will pay the remaining amount of $80.

Coinsurance may apply to all services, including hospitalization, emergency room visits, preventive care, and some mental health and substance abuse services. However, coinsurance does not apply to some services, such as preventive care services.

It is important to understand the amount of coinsurance you are responsible for. Depending on the type of service, your coinsurance could be a percentage of the allowed amount or a fixed amount. This information should be provided to you in your plan documents.

When you receive care, you will receive a bill that outlines the cost of the service and the amount you are responsible for paying. If you have met all of your deductibles and coinsurance requirements, the plan will pay the remaining costs.

Tips for Using Your Coinsurance:

1. Review your plan documents to understand the coinsurance rates for all services you may need. This will help you budget for any services you may need in the future and be better prepared for the cost.

2. Consider using in-network providers when possible. Many plans offer lower coinsurance rates for in-network providers, meaning you will pay less for the same service.

3. Ask your provider for an estimate of the cost of a service before you receive it. This will help you determine how much of the cost you will be responsible for.

4. Keep track of the services you receive and the amount you pay. This will help you understand how much you have paid towards your coinsurance requirement for the year.

5. Contact your plan administrator if you have any questions about your coinsurance requirement or what services are subject to coinsurance.

Out-Of-Pocket Maximum

IMPORTANT PLAN INFORMATION: Out-Of-Pocket Maximum

Under the Polaris Health Plus plan, members are responsible for costs associated with their health care. These costs can include deductibles, copays, coinsurance, and other out of pocket expenses. To help members manage health care costs, the Polaris Health Plus plan offers a maximum out-of-pocket (OOP) limit. Once a member has reached the OOP limit, they pay no more out-of-pocket costs for the rest of the plan year.

Understanding the Out-of-Pocket Maximum

The Polaris Health Plus plan's out-of-pocket maximum includes deductibles, copays, coinsurance, and other out-of-pocket expenses. This amount does not include premiums, balance-billed charges, or charges for non-covered services. The OOP maximum resets at the start of each plan year, meaning members have to start from scratch when the new plan year begins.

The OOP maximum applies to all services, including in-network and out-of-network services, except for non-covered services, balance-billed charges, and premium payments. This means that all in-network services and out-of-network services count towards the OOP maximum. Exceptions

There are a few exceptions to the OOP maximum. For example, if a member seeks services from a provider that is not in-network, they may be balance-billed for the difference between what the provider charges and what Polaris Health Plus allows. Balance-billed charges do not count towards the OOP maximum.

Another exception is non-covered services. If a member receives a service that is not covered by the plan, they may be responsible for paying the full cost of the service. These services also do not count towards the OOP maximum.

Tips for Reaching the Out-of-Pocket Maximum

Reaching the OOP maximum can be a challenge, but there are a few tips that can help members get there.

First, it's important to understand what services are covered by the plan and which are not. Polaris Health Plus covers a wide range of services, including preventive care, primary care, and specialty care. It's important to know which services are covered and which are not so members can make the most of their coverage.

Second, it's important to stay in-network as much as possible. Staying in-network helps members get the most out of their coverage and saves them money. In-network providers typically charge lower rates and provide a higher level of care than out-of-network providers.

Third, it's important to understand the difference between deductibles, copays, and coinsurance. Deductibles are the amount a member has to pay before the plan starts paying, copays are a set fee for services, and coinsurance is the percentage of the cost a member has to pay. Understanding these three terms can help members make more informed decisions about their care.

Finally, it's important to take advantage of preventive care services. Preventive care services are covered at 100% by Polaris Health Plus and can help members stay healthy and avoid costly treatments and services down the road.

Reaching the out-of-pocket maximum can be a challenge, but with the right knowledge and tips, members can take advantage of their Polaris Health Plus plan and get the most out of their coverage.

Allowed Amount

IMPORTANT PLAN INFORMATION: Allowed Amount

When receiving services under Polaris Health Plus, you are responsible for paying a portion of the cost of care. The portion of the cost that you are required to pay is known as the Allowed Amount. The Allowed Amount is the amount that the plan will pay towards the cost of care. The Allowed Amount may vary depending on the type of care received.

For example, if you receive services from an in-network provider, the Allowed Amount may be lower than if you receive services from an out-of-network provider. The Allowed Amount also may vary depending on the type of service received. In general, preventive services such as physicals, immunizations, and screenings have lower Allowed Amounts than other types of care.

You should always check with the provider prior to receiving services to determine the Allowed Amount that Polaris Health Plus will pay for the services you are receiving.
This way, you will know what your financial responsibility will be and can plan accordingly.

When you receive services from an out-of-network provider, you may be required to pay the full Allowed Amount up front. You then can submit a claim to Polaris Health Plus for reimbursement of the Allowed Amount less any applicable copays, coinsurance, or deductibles.

In some cases, Polaris Health Plus may not cover services that are considered experimental or investigational. If a service is not covered, you may be responsible for the entire cost of the service. Therefore, it is important to check with Polaris Health Plus prior to receiving services to determine if a service is covered.

In addition, some services may be subject to pre-authorization or pre-certification. This means that you must obtain approval from Polaris Health Plus prior to receiving the service. If pre-authorization or pre-certification is not obtained, you may be responsible for the full cost of the services.

It is important to understand that the Allowed Amount does not include any applicable copays, coinsurance, or deductibles that may be due. It is also important to understand that the Allowed Amount may vary depending on the type of care received and the type of provider that is providing the care. Therefore, it is important to check with the provider prior to receiving services to determine the Allowed Amount that Polaris Health Plus will pay for the services you are receiving.

Finally, it is important to keep track of your out-of-pocket expenses. This includes any copays, coinsurance, or deductibles that you may be required to pay. It is important to understand what your financial responsibility is when receiving care under Polaris Health Plus, so that you can plan accordingly and make sure that you are meeting your financial obligations.

IMPORTANT PLAN INFORMATION

Polaris Health Plus is a comprehensive health plan that offers coverage for medical, vision, and dental services. It also provides coverage for prescription drugs, mental health and substance abuse services, and preventive care. You can choose from a variety of innetwork providers, including primary care physicians, specialists, hospitals, and pharmacies. Emergency services are also covered, both in-network and out-of-network.

Co-pays, deductibles, and out-of-pocket maximums may apply to your plan. Your plan may also include separate deductibles for different services, such as prescription drugs and hospitalization. It is important to know what your plan covers and what the cost-sharing requirements are. To get more information, please visit the Polaris Health website or contact them directly.

It is also important to remember that there may be certain exceptions or limitations in the plan. For instance, some plans may not cover certain types of services, such as cosmetic procedures, or they may have limits on the number of visits to a provider that are covered. It is important to read through your plan to understand what is and isn't covered.

When you are using your Polaris Health Plus plan, there are a few tips to keep in mind. First, remember to bring your Polaris Health Plus ID card with you when you go to the doctor or pharmacy. This will help the provider verify your coverage and process your claims. Second, if you are prescribed a medication, check to make sure it is covered by your plan. You may be able to save money by using a generic version of the drug or by using a mail-order pharmacy.

Finally, if you are seeing an out-of-network provider, remember that you may be responsible for paying more out-of-pocket costs than you would for an in-network provider. Make sure to check with the provider to get an estimate of what your costs will be.

By understanding the plan and its exceptions and limitations, and by following these tips, you can make sure you are getting the most out of your Polaris Health Plus plan.

COVERED SERVICES

Acupuncture

COVERED SERVICES: Acupuncture

Acupuncture is an ancient form of healing that has been practiced in China for thousands of years. It involves the use of very thin needles inserted into specific points in the body to stimulate energy flow and promote physical and emotional balance. Polaris Health Plus covers acupuncture services, including both in-network and out-of-network acupuncture providers.

When using an in-network acupuncture provider, coverage is provided for up to 12 visits per year. Each visit must be medically necessary and approved by your primary care physician. All acupuncture services must be performed by an appropriately licensed acupuncturist, and acupuncture services are limited to one hour per visit.

When using an out-of-network acupuncture provider, Polaris Health Plus covers up to $25 per visit, after the deductible has been met. Out-of-network acupuncture services must also be medically necessary and approved by your primary care physician. All acupuncture services must be performed by an appropriately licensed acupuncturist and services are limited to one hour per visit.

When you visit an acupuncture provider, be sure to bring your Polaris Health Plus insurance card and a form of payment for the office visit or copayment. You will also need to provide the acupuncture provider with the authorization from your primary care physician.

Before scheduling an acupuncture appointment, it's important to make sure the acupuncturist is licensed and in-network with Polaris Health Plus. It's also important to talk to your primary care physician to make sure that acupuncture is an appropriate treatment for your medical condition.

In addition to traditional acupuncture treatments, Polaris Health Plus also covers acupuncture-related services such as acupressure, cupping, moxibustion, and tui na. These

services may be covered when provided by an appropriate acupuncturist as part of a treatment plan approved by your primary care physician.

Polaris Health Plus does not cover services that are experimental, investigational, or for cosmetic purposes. Services for nutritional counseling, massage therapy, and physical therapy are also not covered. Polaris Health Plus also does not cover acupuncture services that are provided in a hospital or a skilled nursing facility.

If you have any questions about acupuncture services covered by Polaris Health Plus, contact the Member Services department at Polaris Health. They are available to answer any questions you may have about coverage and eligibility.

Allergy Testing and Treatment

COVERED SERVICES: Allergy Testing and Treatment

At Contoso, we understand that allergies can be a major source of discomfort and inconvenience for our employees. That's why we are proud to offer coverage for allergy testing and treatment through Polaris Health Plus. Allergy testing and treatment services are covered under the plan, with some exceptions.

Allergy Testing

If your physician determines that allergy testing is medically necessary, Polaris Health Plus will cover the cost of the testing. This includes skin tests, blood tests, patch tests, and other diagnostic tests that your doctor may order.

Allergy Treatment

Once your doctor has determined the cause of your allergies, Polaris Health Plus will cover the cost of treatment. This includes medications such as antihistamines, nasal sprays, and inhalers. In addition, Polaris Health Plus will cover the cost of immunotherapy, which is a long-term treatment that helps to reduce the severity of your allergies.

Exceptions

In some cases, Polaris Health Plus may not cover all of the costs associated with allergy testing and treatment. These exceptions include the following:

- Allergy medications that are available over-the-counter.
- Allergy shots that are not prescribed by a doctor.
- Allergy treatments or medications that are considered experimental or unproven.
- Alternative treatments, such as herbal remedies or homeopathic treatments.

Tips

- Talk to your doctor about all of your allergy symptoms, so they can determine the best course of testing and treatment.
- Ask your doctor about the cost of any allergy medications that they prescribe.
- Be sure to fill any prescriptions at a pharmacy that is in-network, so you can receive the lowest cost for your medications.
- If you are considering an alternative treatment for your allergies, be sure to discuss it with your doctor first.
- Keep your receipts for any out-of-pocket expenses related to your allergy testing and treatment, so you can be reimbursed for your expenses.

At Contoso, we are committed to providing our employees with the best coverage for their healthcare needs. With Polaris Health Plus, you can be sure that you are getting the best coverage for your allergy testing and treatment.

Ambulance

COVERED SERVICES: Ambulance

Ambulance services are covered under Polaris Health Plus. This includes any transportation to and from medical facilities, as long as it is medically necessary. In most cases, ambulance services are covered when no other form of transportation is available.

If you need to use an ambulance, it must be one that is in your network and has been approved by Polaris Health. You will be responsible for paying any applicable coinsurance and copays for this service. If you use an out-of-network ambulance, you may be responsible for the entire cost of the service.

When deciding whether you need an ambulance, you should consider your medical condition and the available transportation options. If you are able to use a car or another form of transportation, this will usually be the most cost-effective option. However, if you require medical assistance during transportation, an ambulance may be necessary.

It is important to remember that ambulance services are only covered if they are medically necessary. If you are unsure of whether a service is medically necessary, you should speak to your primary care physician or a Polaris Health representative.

If you have an emergency medical condition and require ambulance services, you should call 911. In this case, you will not be responsible for any out-of-pocket expenses, as emergency services are covered under Polaris Health Plus.

In addition to emergency services, Polaris Health Plus also covers non-emergency ambulance services. These services are typically used when non-emergency transportation is needed to and from a medical facility. If you require non-emergency transportation, you should speak to your primary care physician who can determine if the service is medically necessary.

If your primary care physician determines that ambulance services are medically necessary, you should contact your local ambulance provider. You should provide them with your Polaris Health Plus plan information and Polaris Health will cover the cost of the service, minus any applicable coinsurance and copays.

In conclusion, Polaris Health Plus covers ambulance services when they are medically necessary. This includes emergency services and non-emergency services. If you need to use an ambulance, it must be one that is in your network and has been approved by Polaris Health. You should always contact your primary care physician to determine if a service is medically necessary before using an ambulance, as this will help you to avoid any out-of-pocket costs.

Blood Products And Services

COVERED SERVICES: Blood Products and Services

Polaris Health Plus covers a variety of blood products and services that are necessary for a healthy life. This plan provides coverage for blood tests, transfusions, and other related services required for diagnosis, treatment, and management of a medical condition.

In-Network Coverage:

Polaris Health Plus provides in-network coverage for a variety of blood products and services. Services covered by this plan include:

• Blood tests and transfusions

• Blood typing

• Platelet donation and collection

• Hemoglobin testing

• Hemophilia treatment

• Anemia treatment

Out-of-Network Coverage:

Polaris Health Plus also covers blood products and services received from out-ofnetwork providers. However, coverage for out-of-network services may be limited and you may be required to pay more for out-of-network services than for in-network services.

Exceptions:

Polaris Health Plus does not cover any blood products or services not specifically listed in the plan document. This includes any experimental treatments or other services that are not medically necessary.

Tips for Employees:

- Always check with Polaris Health Plus to determine if the blood test or transfusion you need is covered under the plan.
- Look for in-network providers to receive the highest level of coverage.
- Ask your provider if there are any generic alternatives for the blood products or services you need.
- Keep detailed records of all your blood tests and transfusions, including the date, type, and results.
- Check your Explanation of Benefits regularly to make sure you are being charged correctly for any blood products or services.

Cellular Immunotherapy And Gene Therapy

Cellular Immunotherapy and Gene Therapy

Cellular Immunotherapy and gene therapy are two of the newest treatments available in the medical world, and are covered under Polaris Health Plus.

Cellular Immunotherapy is a type of treatment that boosts a patient's own immune system to fight off diseases and illnesses. This type of treatment is done through the use of a patient's white blood cells, which are extracted and modified to be able to recognize and attack cancer cells. These modified white blood cells are then reintroduced into the patient's body, allowing their immune system to fight the cancer. This type of therapy is typically used to treat cancers like leukemia and lymphoma, as well as some other types of cancer.

Gene therapy is a therapeutic modality that involves the introduction of exogenous genetic material into an individual's cells for the purpose of modifying or correcting pathological gene expression patterns. This process can be accomplished through various vectors, including viral and non-viral delivery systems, with the aim of inducing therapeutic effects through the modulation of cellular processes.

Both of these treatments are covered under the Polaris Health Plus plan, but there are some exceptions. For example, treatments that are experimental in nature are not covered. Additionally, treatments that are deemed to be not medically necessary or not recommended by a physician are also not covered.

When considering cellular immunotherapy or gene therapy, it is important to discuss the risks and benefits with your doctor. It is also important to make sure that the treatment is covered by your insurance, and to review any pre-authorization requirements that may be necessary for the treatment. Additionally, it is important to be aware of any potential side effects that may occur from these treatments, and to make sure that you are comfortable with the potential risks and benefits of the treatment.

Chemotherapy And Radiation Therapy

Chemotherapy and Radiation Therapy: Covered Services

At Contoso, we are proud to offer our employees the Polaris Health Plus plan, which provides comprehensive coverage for medical, vision, and dental services. This plan also includes coverage for chemotherapy and radiation therapy.

What Is Covered Under Chemotherapy and Radiation Therapy?

Polaris Health Plus provides coverage for chemotherapy and radiation therapy services for the treatment of cancer. This includes drugs and supplies for chemotherapy and radiation therapy, as well as related services and procedures, such as imaging tests and laboratory tests. This coverage also includes hospitalization for chemotherapy and radiation therapy.

It is important to note that coverage for chemotherapy and radiation therapy is subject to the terms and conditions of the Polaris Health Plus plan. Any services that are not specifically listed in the plan document are not covered.

Tips for Employees Regarding Chemotherapy and Radiation Therapy

At Contoso, we want our employees to make the most of their coverage for chemotherapy and radiation therapy services. Here are a few tips to help employees make sure they are getting the most out of their benefits:

- Become familiar with the Polaris Health Plus plan document. Understand what services are covered and what services are not.
- Make sure that any treatments or services related to chemotherapy and radiation therapy are pre-authorized. This will help ensure that the treatments and services are covered under the plan.
- Talk to your doctor about the treatments and services that are covered under the plan. Make sure that your doctor is aware of any exclusions or limitations that may be in the plan document.
- Ask your doctor about any discounts or other cost-savings measures that may be available through the Polaris Health Plus plan.
- Take advantage of the resources available through Polaris Health Plus, such as their 24-hour nurse advice line and their online cost estimator tool.
- Ask your doctor or pharmacist if there are generic or over-the-counter alternatives to any medications that are prescribed for chemotherapy and radiation therapy.

By following these tips, employees can make sure they are getting the most out of their coverage for chemotherapy and radiation therapy services. Employees should keep in mind that any services that are not specifically listed in the plan document are not covered.

Clinical Trials

COVERED SERVICES: CLINICAL TRIALS

At Polaris Health Plus, we understand that life-saving treatments can come from clinical trials. That is why we cover certain clinical trials as part of your plan.

What Are Clinical Trials?

Clinical trials are research studies conducted in an effort to identify new treatments, drugs, or procedures that can help improve patient outcomes. A clinical trial typically involves a group of participants who are given a certain type of treatment for a certain period of time. The results of the trial are then evaluated to measure the effectiveness of the treatment.

What Does Polaris Health Plus Cover?

Polaris Health Plus covers certain clinical trials that are approved by the Food and Drug Administration (FDA) and that are considered medically necessary. These clinical trials must also be recommended by your doctor or health care provider. The plan covers FDAapproved drugs, medical treatments, and medical devices that are used in the clinical trial.

What Are Some Exceptions?

Polaris Health Plus does not cover any experimental treatments that are not approved by the FDA or that are not considered medically necessary. Additionally, the plan does not cover any treatments that are used in the clinical trial that are not considered medically necessary. Clinical trials must be recommended by your doctor or health care provider and must be approved by the FDA in order for the plan to cover them.

Tips for Employees

If you are considering participating in a clinical trial, there are a few things to keep in mind:

- Make sure the clinical trial has been approved by the FDA.
- Talk to your doctor or health care provider about the trial and ask any questions you may have.
- Ask about the potential risks and benefits of participating in the trial.
- Ask about any potential side effects.
- Ask if there are any costs associated with the trial that are not covered by Polaris Health Plus.
- Make sure you understand what is expected of you as a participant in the trial.
- Ask if the trial results will be published or available to you in any way.

Clinical trials can be a great opportunity to explore potential treatments that could improve your health. Polaris Health Plus covers certain clinical trials that are approved by the FDA and that are considered medically necessary. It is important to talk to your doctor or health

care provider to make sure that you understand the details of the clinical trial before you decide to participate.

Dental Injury and Facility Anesthesia

COVERED SERVICES: Dental Injury and Facility Anesthesia

Polaris Health Plus offers coverage for dental injury and facility anesthesia services. This coverage includes medically necessary services for the relief of pain resulting from dental injury, as well as services for the administration of anesthesia in a facility. This coverage is subject to any limitations, copayments, and/or deductibles that are set forth in the plan.

In order for services to be eligible for coverage, they must be performed by a dental professional who is licensed to practice dentistry in the state in which the services are provided. All services must be for the relief of pain resulting from dental injury, or for the administration of anesthesia in a facility.

Dental Injury

Polaris Health Plus covers medically necessary services for the relief of pain resulting from dental injury. This includes services such as extractions, fillings, root canals, and other services that are necessary to relieve pain caused by dental injury.

Facility Anesthesia

Polaris Health Plus covers services related to the administration of anesthesia in a facility. This includes, but is not limited to, services such as spinals, epidurals, and general anesthetics.

Exceptions

Polaris Health Plus does not cover the following services when related to dental injury or facility anesthesia:

• Cosmetic procedures, such as teeth whitening or veneers

• Services that are not medically necessary to relieve pain resulting from dental injury

• Services provided outside of a facility

Tips for Employees

• Make sure that your dentist is licensed to practice in your state

• Check your plan to make sure that the full cost of services is covered

• Ask your dentist about any additional costs that may not be covered by your plan

• Have a list of any medications or allergies that may affect the anesthesia

- Make sure that the dentist is aware of any medical conditions that might increase the risk of complications
- Ask your dentist about any special instructions that you may need to follow before or after the procedure
- Make sure that you understand the risks and benefits of the procedure
- Ask your dentist about any follow-up care that may be needed after the procedure
- Make sure that you have a plan for transportation in case you need to get to the facility for the procedure.

Diagnostic X-Ray, Lab And Imaging

COVERED SERVICES: Diagnostic X-Ray, Lab and Imaging

Polaris Health Plus covers diagnostic X-ray, lab, and imaging services. This includes services like X-rays, CAT scans, MRIs, ultrasounds, and mammograms. Lab services are covered for tests such as blood tests, urine tests, and other diagnostic tests ordered by a doctor. Coverage for imaging services includes Magnetic Resonance Imaging (MRI), Computed Tomography (CT) scans, and Positron Emission Tomography (PET) scans.

Exceptions

While most diagnostic X-ray, lab, and imaging services are covered by Polaris Health Plus, there are some exceptions. The plan does not cover services that are not medically necessary, such as cosmetic surgery. It also does not cover services that are experimental or investigational.

Tips

If you are considering one of the services that is not covered by Polaris Health Plus, such as cosmetic surgery, it is important to understand that you will be responsible for the full cost of the service. Additionally, it is important to check with your doctor to make sure that the service is medically necessary before you receive it.

In order to make sure that you get the most out of your coverage, it is important to be aware of which services are covered by Polaris Health Plus. Additionally, it is important to understand that while most diagnostic X-ray, lab, and imaging services are covered by the plan, there are some exceptions. Be sure to talk to your doctor or healthcare provider to make sure that the service is covered before you receive it.

When you receive services that are covered by Polaris Health Plus, be sure to bring your insurance card with you so that your provider can bill your insurance company directly. This will help ensure that you receive the full benefit of your coverage.

It is also important to understand that there may be certain limits on the amount of coverage that Polaris Health Plus provides for diagnostic X-ray, lab, and imaging services.

For example, the plan may have a limit on the number of services that it will cover in a given year. Be sure to check with your plan administrator for more information about the limits of your coverage.

Finally, it is important to keep in mind that Polaris Health Plus is a comprehensive plan, and it provides coverage for a wide range of services. Be sure to take full advantage of the coverage that is available to you and to make sure that you are taking advantage of all the benefits that are offered. This will help ensure that you get the most out of your plan.

Dialysis

COVERED SERVICES - Dialysis

At Contoso, we are proud to offer employees Polaris Health Plus, which provides comprehensive coverage for medical, vision, and dental services. This plan also includes coverage for dialysis services for eligible employees.

Dialysis is a medical treatment process used to replace the normal functions of the kidney. When the kidneys are no longer able to perform their normal functions, dialysis is typically required to filter waste and excess fluids from the blood. It can also help balance electrolytes in the body.

Dialysis services covered by Polaris Health Plus include in-center hemodialysis, home hemodialysis, and peritoneal dialysis. This plan also provides coverage for dialysis-related services and supplies, such as home dialysis machines, dialyzers, and other necessary supplies.

In-network dialysis services are covered at 80% of the allowed amount. Out-of-network dialysis services may also be covered, but the amount of coverage may vary. It is important to note that Polaris Health Plus does not cover services or supplies related to kidney transplants, including the cost of the donor organ.

It is also important to note that Polaris Health Plus does not cover experimental or investigational treatments, such as stem cell therapy or xenotransplantation. If you are considering a treatment that is not covered by your plan, please contact your provider to discuss your options.

For those receiving dialysis services, it is important to note that Polaris Health Plus requires that you receive your dialysis treatments from a certified dialysis center. It is also important to keep track of your dialysis treatments and any supplies that you may need. Your provider may also be able to provide you with information about support groups or other organizations that can provide additional resources or assistance.

If you have questions about the dialysis coverage offered by Polaris Health Plus, please contact your provider or Polaris Health directly. We are committed to providing our employees with comprehensive coverage and support.

Emergency Room

COVERED SERVICES - EMERGENCY SERVICES

At Contoso, we understand that unplanned medical emergencies can arise, and so our insurance partner, Polaris Health, provides coverage for emergency services. This coverage applies to both in-network and out-of-network providers.

In-Network Providers

If you seek emergency care from an in-network provider, your plan will cover the cost of treatment, including any necessary hospitalization and follow-up care. Depending on the type of plan you have, you may also be responsible for paying a copayment and/or coinsurance.

Out-of-Network Providers

Emergency services received from out-of-network providers will also be covered, but you may be responsible for higher out-of-pocket costs such as copayments and coinsurance. If you receive services from an out-of-network provider, you may also be responsible for paying the difference between the amount billed by the provider and the amount the plan will pay.

Exceptions

Polaris Health Plus does not cover certain types of emergency services. These include services for certain social and cosmetic procedures, elective surgery, experimental treatments, and services for injuries or illnesses that are not medically necessary.

Tips for Employees

It is important to keep in mind that if you have an emergency, you should seek care from the nearest hospital or medical facility. Regardless of whether it is in-network or out-ofnetwork, you will be covered. It is also important to remember that if you receive care from an out-of-network provider, you may be responsible for higher out-of-pocket costs.

It is also important to be aware of the exceptions to Polaris Health Plus' coverage of emergency services. Certain services, such as those for elective surgery and experimental treatments, are not covered.

Lastly, it is important to keep your Polaris Health Plus ID card with you at all times. This card will provide proof of coverage and will help ensure you get the care you need.

Foot Care

COVERED SERVICES: Foot Care

At Polaris Health Plus, we understand that foot care is an important part of your overall health and well-being. That's why our plan covers foot care services, including diagnosis and treatment of conditions affecting the feet.

Our plan covers the following foot care services:

- Diagnostic and laboratory tests
- X-rays
- Treatment of infections, such as ingrown toenails and athlete's foot
- Treatment of foot injuries, such as fractures, sprains, and strains
- Orthopedic devices, such as casts and braces
- Surgery, if medically necessary
- Custom orthotics, when prescribed by a physician
- Prescription drugs, when prescribed by a physician

Exceptions

Our plan does not cover:

- Routine foot care, such as trimming toenails, callus removal, and shoe inserts
- Foot care products, such as arch supports, shoe inserts, and foot orthotics
- Services that are not medically necessary

Tips for Employees

- Take preventive steps to minimize foot problems, such as wearing comfortable shoes that fit properly and provide adequate support.
- If you have diabetes, check your feet daily for sores or other problems.
- If you have any foot problems, don't delay seeking medical care. Early diagnosis and treatment can often prevent more serious problems from developing.
- If you need custom orthotics, be sure to get them from a qualified provider who is knowledgeable in their use.
- If you're prescribed orthotics, be sure to follow the instructions for use and wear them as directed.
- If you're prescribed medication, be sure to take it as directed.
- If you have any questions about your foot care coverage, please contact Polaris Health Plus.

Gender Affirming Care

COVERED SERVICES: Gender Affirming Care

Contoso is proud to offer employees comprehensive coverage for gender affirming care through Polaris Health Plus. This coverage includes hormone therapy, gender affirming surgery, and mental health services related to gender transition.

Hormone Therapy:

Polaris Health Plus covers hormone therapy for individuals undergoing gender transition. This includes gender-affirming hormone replacement therapy such as testosterone or estrogen. The coverage also includes many medications and treatments related to hormone therapy, such as monitoring blood work, doctor visits, and lab tests.

Gender Affirming Surgery:

Polaris Health Plus covers gender affirming surgery for individuals undergoing gender transition. Polaris Health Plus also covers pre- and post-operative care related to gender affirming surgery.

Mental Health Services:

Polaris Health Plus covers mental health services related to gender transition. This includes counseling and therapy visits, as well as medications related to mental health treatment.

Exceptions:

Polaris Health Plus does not cover any experimental treatments related to gender transition, such as facial hair removal, hair transplants, and voice therapy.

Tips for Employees:

- Make sure to inform your provider that you are using Polaris Health Plus to cover gender affirming care.
- Be sure to bring your Polaris Health Plus card with you to all medical and mental health appointments related to gender affirming care.
- Ask your provider for an itemized bill after each visit to ensure that all charges related to gender affirming care are included.
- Keep all receipts and documentation of your gender affirming care expenses.
- Polaris Health Plus may require pre-authorization for certain gender affirming care services. Be sure to check with your provider and Polaris Health Plus about any preauthorization requirements.
- If you have any questions about your coverage, call Polaris Health Plus customer service.

Hearing Care

COVERED SERVICES: Hearing Care

At Contoso, we understand how important it is for our employees to stay on top of their overall health. That is why we are proud to offer comprehensive hearing care coverage through Polaris Health Plus. This coverage can be used for a variety of hearing care services, including but not limited to hearing tests and evaluations, hearing aids and other associated services, as well as hearing aid fittings and adjustments.

In order to take advantage of this coverage, employees must receive care from an innetwork provider. Polaris Health Plus has a wide selection of providers in its network, making it easy to find a provider who is right for you. Additionally, the plan covers hearing aid fittings, adjustments, repairs, and replacements, as well as batteries, when necessary.

When it comes to hearing aid coverage, Polaris Health Plus covers up to $1,500 every 3 years for all hearing aid services, including the hearing aid itself. This amount is based on the plan's usual and customary charges, and any additional costs over this amount are the responsibility of the employee.

It is important to note that Polaris Health Plus does not cover the cost of custom ear molds for hearing aids, nor does the plan cover any over-the-counter hearing aids or other devices. Additionally, hearing care coverage is limited to individuals 18 years of age or older.

At Contoso, we also want to make sure that our employees have the best hearing care possible. Here are a few tips to help our employees make the most of their coverage:

- Schedule regular hearing tests and evaluations. This can help you stay on top of your hearing health and detect any issues early.
- Try to get all of your hearing care needs met by the same provider. This can help you establish a relationship with the provider and make it easier to get the care you need.
- Make sure to keep all of your receipts, and submit them to Polaris Health Plus for reimbursement.
- Ask your provider about any discounts or promotions they may have available.
- Talk to your provider about any financing options they may have.

By taking advantage of this coverage, Contoso employees can ensure they have access to the hearing care they need. With Polaris Health Plus, our employees can rest assured that their hearing health is taken care of.

Home Health Care

COVERED SERVICES: Home Health Care

Polaris Health Plus provides coverage for medically necessary home health care services. This includes services such as skilled nursing, physical therapy, and occupational therapy. Home health care services must be ordered by a licensed physician and provided by a home health agency or other qualified provider.

Exceptions:

Polaris Health Plus does not cover home health care services that are not medically necessary or that are requested solely for the convenience of the patient or those providing care. Home health care services are not covered when they are provided in the patient's place of residence or in a family member's home.

Tips:

- If you are planning to receive home health care services, it is important to speak with your primary care provider to ensure that the services are medically necessary and meet the requirements of Polaris Health Plus.

- Before you receive home health care services, be sure to ask the provider if they are innetwork with Polaris Health Plus. This will help ensure that you receive the most comprehensive coverage for your services.

- If you have any questions about the types of services covered by Polaris Health Plus or the specific benefits associated with your plan, be sure to contact Polaris Health customer service for more information.

- Make sure to keep all documentation related to your home health care services, including orders from your primary care provider, receipts, and other paperwork. This will help ensure that your claims are processed quickly and accurately.

- If you are not satisfied with the services provided by your home health care provider, be sure to contact Polaris Health Plus customer service to file a complaint.

Home Medical Equipment (HME), Orthotics, Prosthetics And Supplies

COVERED SERVICES – Home Medical Equipment (HME), Orthotics, Prosthetics And Supplies

The Polaris Health Plus plan covers Home Medical Equipment (HME), Orthotics, Prosthetics And Supplies (OP&S), when medically necessary. This means that any equipment, prosthetics, and orthotics that are prescribed by your doctor and are medically necessary for treatment can be covered under this plan.

Home Medical Equipment (HME)

HME is any equipment that is used in the home to help you recover from an injury or illness, or to help with a disability. Examples of HME include power wheelchairs, hospital beds, walkers, canes, and crutches. In order to have these items covered under the Polaris Health Plus plan, you must have a valid prescription from a qualified medical provider, and the item must be medically necessary.

Orthotics and Prosthetics

Orthotics and Prosthetics are items that assist with movement or provide support. Examples of items that may be covered under the Polaris Health Plus plan include braces, splints,

orthopedic shoes, and prosthetic devices. In order to have these items covered, you must have a valid prescription from a qualified medical provider, and the item must be medically necessary.

Supplies

Supplies are items that are used in conjunction with HME, prosthetics, and orthotics. Examples of supplies that may be covered under the Polaris Health Plus plan include wound care supplies, catheters, and oxygen therapy supplies. In order to have these items covered, you must have a valid prescription from a qualified medical provider, and the item must be medically necessary.

Exceptions

There are a few exceptions to the coverage of HME, orthotics, prosthetics, and supplies under the Polaris Health Plus plan. These include items that are not medically necessary, items that are experimental or investigational, and items that are not prescribed by a qualified medical provider.

Tips

When considering whether or not a particular item is covered under the Polaris Health Plus plan, it is important to keep the following tips in mind:

- Always make sure that the item you are considering has been prescribed by a qualified medical provider, and is medically necessary.

- Be aware that some items may not be covered, even if they are prescribed by a qualified provider. These items can include items that are not medically necessary, items that are experimental or investigational, and items that are not prescribed by a qualified medical provider.

- Make sure to keep all receipts and documentation related to the item you are considering, as this will be important if you need to file a claim for coverage.

- If you have any questions about the coverage of a particular item, make sure to contact the Polaris Health Plus customer service team for more information.

By following these tips, you can be sure that the items you are considering are covered under the Polaris Health Plus plan. With this coverage, you can get the medical equipment, prosthetics, orthotics, and supplies you need to maintain your health and wellbeing.

Hospice Care

COVERED SERVICES - HOSPICE CARE

Polaris Health Plus provides coverage for hospice care services to members who are terminally ill and are expected to have a life expectancy of six months or less if their illness

runs its normal course. Hospice care services are designed to provide comfort and support to terminally ill members and their families.

Under Polaris Health Plus, coverage for hospice care services includes:

- Care provided by a hospice care team that includes a doctor, nurse, social worker, chaplain, hospice aide, and volunteer
- Medications, medical supplies, and equipment used in the treatment of the terminal illness
- Counseling services for the member and their family members
- Inpatient and respite care
- Grief counseling and bereavement services

In addition, Polaris Health Plus covers the costs of services that are related to the member's terminal illness, such as medical equipment and supplies, home health care, homemaker services, physical therapy, and speech-language pathology.

Exceptions:

Polaris Health Plus does not cover services related to treatment that is intended to cure the member's terminal illness. This includes treatments such as chemotherapy, radiation therapy, and surgery.

Tips:

If you are considering hospice care for a terminally ill family member, it is important to know that Polaris Health Plus covers some of the costs associated with hospice care. It is important to talk to your doctor about your options and what services are covered under Polaris Health Plus.

It is also important to be aware of the types of services that are not covered under Polaris Health Plus. Be sure to ask your doctor about any treatments that are not covered and make sure that you understand the implications of not receiving these treatments.

It is also important to talk to your doctor about any medications and medical supplies that you may need that are not covered under Polaris Health Plus. You may be able to get these medications and supplies from another provider or through a private insurance plan.

In addition, it is important to talk to your doctor about the types of services that are available through hospice care providers. Different hospice care providers offer different services, so it is important to understand what services are offered and what is covered by Polaris Health Plus.

Finally, it is important to talk to your doctor about any other services that may be available to you and your family through hospice care. These services may include palliative care,

bereavement services, and support groups. These services can provide emotional and spiritual support to members and their families during this difficult time.

Hospital

COVERED SERVICES: Hospitals

Polaris Health Plus provides coverage for hospital services, both in-network and out-ofnetwork. In-network hospital services are covered at 100%, meaning you won't be responsible for any additional costs. Out-of-network services are covered at a lower rate, meaning you may be responsible for a portion of the costs.

When visiting an in-network hospital, you may be required to pay a copayment or coinsurance depending on the type of service you're receiving. Copayments are a fixed dollar amount that you're responsible for paying, while coinsurance is a percentage of the total cost of the services.

It's important to note that some services, such as cosmetic procedures, are not covered by Polaris Health Plus. Be sure to check with your plan to see what is and isn't covered.

Tips for Using Your Hospital Coverage

When visiting a hospital, it's important to be as informed as possible about your coverage. Here are a few tips to help you make the most of your Polaris Health Plus hospital coverage:

- Make sure you know if the hospital you're visiting is in-network or out-of-network. If it's out-of-network, you'll be responsible for a portion of the costs.

- Ask your doctor or hospital staff about any potential copayments or coinsurance costs you'll be responsible for before receiving any services. This will help you budget accordingly.

- If you're admitted to the hospital, make sure you understand the services you'll be receiving and verify that they're covered by your plan.

- Ask the hospital staff if they've taken all the necessary steps to ensure that all the services you're receiving are covered by your plan.

- Keep track of all your hospital bills and make sure that you're only paying for services that are covered by your plan.

- If you have any questions about your hospital coverage, contact Polaris Health Plus directly.

By following these tips and understanding your hospital coverage, you can make sure that you're getting the most out of your Polaris Health Plus plan.

Infusion Therapy Infusion Therapy:

Infusion therapy is a type of medical treatment where medications are administered directly into the bloodstream. At Polaris Health Plus, infusion therapy is covered as part of the plan's medical benefits. It is covered when it is medically necessary and prescribed by a doctor. This includes medications and supplies that are used during the infusion.

Exceptions:

There are a few exceptions to coverage of infusion therapy under Polaris Health Plus. All infusion medications must be approved by the insurance company's medical review team. In addition, certain types of treatments, such as those related to infertility, are not covered under the plan. If you have any questions about coverage for a specific type of infusion therapy, it is best to call the insurance company to find out if it is covered.

Tips for Employees:

It is important to be aware of the coverage for infusion therapy under the Polaris Health Plus plan. Here are a few tips to help you get the most out of this coverage:

- Make sure to get a written prescription from your doctor for the infusion therapy you need.
- Ask your doctor or pharmacist about drugs that are covered under the plan.
- Ask your doctor or pharmacist about the cost of the infusion medications and supplies so you can plan ahead and budget accordingly.
- Talk to your doctor or pharmacist about any potential side effects or interactions that could occur with the medications you are taking.
- Ask your doctor or pharmacist about any special instructions you need to follow while receiving the infusion.
- Make sure to keep track of your infusion treatments and the medications you take. This will help you stay on top of your healthcare needs.
- If you have any questions or concerns about your infusion therapy, talk to your doctor or pharmacist. They can help you understand your coverage and ensure you are getting the best care possible.

Massage Therapy

COVERED SERVICES: Massage Therapy

At Contoso, we want to provide our employees with the best healthcare possible, which is why we have partnered with Polaris Health to offer Polaris Health Plus. Under this plan, massage therapy is covered for our employees and their eligible dependents.

Massage therapy is a type of therapy that involves pressing, rubbing, and manipulating muscles and other soft tissues to improve overall health and well-being. It can be used to

reduce pain, relax muscles, reduce stress, and improve overall health. Massage therapy is a great way to reduce stress and relax the body, and with Polaris Health Plus, you can have massage therapy covered.

However, there are some restrictions and exceptions to this coverage. Massage therapy must be prescribed and provided by a licensed massage therapist. It must also be medically necessary, meaning that it must be a service that is used to treat a condition or illness that is diagnosed by a doctor or other healthcare provider. Massage therapy must also be performed in a professional setting, such as a doctor's office, hospital, or massage therapy clinic.

In addition, there are certain services that are not covered under this plan. This includes services that are not medically necessary, services that are not provided by a licensed massage therapist, and services that are not performed in a professional setting.

Here are some helpful tips for getting the most out of your massage therapy coverage with Polaris Health Plus:

1. Make sure to get pre-authorization from your doctor or healthcare provider before scheduling an appointment.

2. Make sure to find a licensed massage therapist who is in-network with Polaris Health Plus.

3. Do your research and find a massage therapist who is experienced in treating your specific condition or illness.

4. Make sure to keep all receipts and documentation of your massage therapy sessions for reimbursement.

5. Take advantage of the preventive care coverage offered by Polaris Health Plus, which can help to reduce your out-of-pocket costs.

At Contoso, we want to make sure that our employees are getting the best care possible. With our partnership with Polaris Health Plus, our employees can take advantage of the massage therapy coverage that it offers. We hope that you find this coverage useful and that it helps you to improve your overall health and well-being.

Mastectomy and Breast Reconstruction

Mastectomy and Breast Reconstruction

At Polaris Health, we understand that it is important to support our members through all stages of life and medical needs. We offer coverage for mastectomy and breast reconstruction services through our Polaris Health Plus plan to ensure that our members have access to the care they need.

Covered Services

Polaris Health Plus offers coverage for both the mastectomy procedure itself, as well as the breast reconstruction procedure following the mastectomy. This includes coverage for implants, prostheses, and other reconstructive surgery. We also offer coverage for outpatient services related to the mastectomy, such as skin grafts, lymph node dissection, and other associated procedures.

In addition, we provide coverage for breast reconstructive surgery following a mastectomy, including breast reconstruction with implants or flap surgery. We cover the cost of surgery, anesthesia, hospital stays, and any prostheses or implants that may be necessary.

Exceptions

Polaris Health Plus does not cover cosmetic breast surgery, such as breast augmentation, breast reduction, or breast lifts. We also do not cover services for male breast reduction.

Tips for Employees

If you are considering mastectomy or breast reconstruction surgery, it is important to be aware of the coverage that is available to you through Polaris Health Plus. Talk to your doctor about the options available to you and make sure to ask questions about the cost and coverage of any procedure that you are considering.

In addition, if you have questions about your coverage or need help understanding our policy, please call our Member Services team at 1-800-123-4567. Our team is available 24/7 to answer any questions that you may have about your Polaris Health Plus coverage.

Maternity Care

COVERED SERVICES: Maternity Care

At Contoso, we understand that having a baby is an exciting and important time for new parents and their families. That's why we want to make sure you and your growing family have the support and coverage you need. Polaris Health Plus provides comprehensive coverage for maternity care, including prenatal and post-natal care and labor and delivery services.

Prenatal Care

Prenatal care is essential for both the mother and baby, as it helps to ensure the health and safety of both during pregnancy. Polaris Health Plus covers all services related to prenatal care, including office visits, tests, and ultrasounds. Additionally, Polaris Health Plus covers any necessary vaccines or medications that may be prescribed by your doctor during prenatal care.

Delivery and Post-natal Care

Polaris Health Plus covers all services related to the delivery of your baby, including labor and delivery, as well as post-natal care for both mother and baby. This includes any necessary treatments, tests, or medications prescribed by your doctor. Polaris Health Plus

also covers any necessary follow-up care for both mother and baby for up to six weeks post-delivery. Exceptions

Polaris Health Plus does not cover infertility treatments or elective or cosmetic procedures. Additionally, Polaris Health Plus does not cover any services related to the termination of a pregnancy.

Tips

To ensure you are getting the best care possible, it is important to choose a doctor who is innetwork and who is experienced in providing prenatal and post-natal care. Additionally, it is important to familiarize yourself with the coverage provided by Polaris Health Plus and be aware of any out-of-pocket expenses you may be responsible for. Finally, it is important to get regular check-ups throughout your pregnancy to make sure you and your baby are healthy and safe.

Medical Foods

COVERED SERVICES: Medical Foods

At Contoso, we are proud to provide our employees with access to Polaris Health Plus, a comprehensive insurance plan that covers a variety of medical services. Included in this plan is coverage for medical foods. Medical foods are specially formulated products used to manage medical conditions and promote overall health.

What is a medical food?

Medical foods are specially formulated products intended for the dietary management of a medical condition. Medical foods are intended for the dietary management of a disease or condition that has distinctive nutritional requirements, and which cannot be managed by normal diet alone. They are designed to be used as a supplement to a normal diet and are typically available only with a prescription. Examples of medical foods include enteral formulas, low-protein foods, and specialty formulas.

What is covered?

Polaris Health Plus covers the cost of medical foods prescribed by a physician for the treatment of a medical condition. These medical foods must be used as part of an overall dietary management plan. Medical foods used for general nutrition or preventive care are not covered by this plan.

Tips for Employees

When selecting a medical food, it is important to consider the nutritional needs of the individual. For example, a low-protein medical food may be necessary for individuals with kidney disease. It is also important to consider the cost of the medical food, as well as the cost of shipping and storage.

When using medical foods, it is important to follow the instructions provided by the physician and the manufacturer. Medical foods must be stored and used properly to ensure safety and effectiveness. It is also important to keep accurate records of the medical foods used, as these records may be necessary for insurance reimbursement.

At Contoso, we are committed to providing our employees with access to the best medical care available. Polaris Health Plus offers coverage for medical foods, helping to ensure that our employees have access to the treatments they need.

Medical Transportation

COVERED SERVICES: Medical Transportation

At Polaris Health Plus, we understand how challenging it can be to get to and from medical appointments, especially if you don't have access to a personal vehicle or any other means of transportation. For this reason, we are proud to offer Medical Transportation coverage for our members.

Medical Transportation coverage provides access to transportation for medical-related purposes, including doctor's appointments, physical therapy, and other medical-related activities. This includes coverage for transportation to and from the doctor's office, as well as travel to and from any in-network hospital or urgent care facility. Our Medical Transportation coverage is provided in partnership with a third-party provider to ensure that our members have access to reliable transportation when they need it most.

In addition to providing coverage for routine medical appointments, Polaris Health Plus also covers transportation for emergency care. If you require emergency care and don't have access to a personal vehicle, you can use our Medical Transportation coverage to get to the nearest hospital or urgent care facility.

For members who require transportation to and from a medical appointment, Polaris Health Plus offers a variety of options. Our coverage includes non-emergency medical transportation through ground transportation services, such as taxi, Uber, or Lyft. In addition, we also offer coverage for medical transportation via air or train.

It's important to note that our Medical Transportation coverage does not apply to transportation for non-medical purposes, such as travel to work or leisure activities. Additionally, our coverage does not include transportation for medical appointments outside of your network, as these are not covered by Polaris Health Plus.

Here are a few tips to help you make the most of your Medical Transportation coverage:

- Make sure to call your Polaris Health Plus Member Services team before scheduling any medical appointments to ensure that you have access to the coverage you need.

- Keep your Medical Transportation coverage card with you at all times, so you can easily access it when needed.

- If you need to access Medical Transportation coverage for an emergency situation, make sure to call the Member Services team as soon as possible.

- Before scheduling any medical transportation services, check to make sure that the provider is an in-network provider.

At Polaris Health Plus, we are committed to providing our members with access to quality healthcare services, including Medical Transportation coverage. If you have any questions about your coverage, our Member Services team is always available to help.

Medical Transportation – State Restricted Care

COVERED SERVICES - Medical Transportation – State Restricted Care

Medical transportation, also known as non-emergency medical transportation (NEMT), is an important benefit provided by Polaris Health Plus. This service provides transportation for medically necessary services and is available to members living in select states.

The states that currently offer this service are Colorado, Delaware, Georgia, Indiana, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Jersey, Ohio, Pennsylvania, and Wisconsin. If you are a member in any of these states, you are eligible to receive NEMT services.

NEMT services are available to members who need to travel to medical appointments as long as they meet certain criteria. These criteria include:

- The member is unable to arrange for transportation on their own.

- The member is unable to travel to their appointment safely by themselves.

- The member is unable to travel to their appointment by public transportation.

- The appointment is medically necessary and is covered by Polaris Health Plus.

If you meet these criteria, you may be eligible to receive NEMT services. You will need to contact your provider to arrange for transportation. You will also need to inform your provider of the date, time, and location of your appointment, as well as the type of service you require.

It's important to note that NEMT services are not available for all types of medical appointments. This service is only available for medically necessary services that are covered by Polaris Health Plus. Additionally, NEMT services are only available for appointments within the state you live in. For example, if you live in Delaware, you can only receive NEMT services for appointments in Delaware.

When you need to arrange for transportation, make sure to contact your provider at least 72 hours in advance. This will help ensure that your transportation request is processed in time for your appointment. Additionally, be sure to have your Polaris Health Plus member ID card with you when you receive transportation services.

Finally, it's important to note that NEMT services are provided by a third-party provider. Polaris Health Plus is not responsible for any fees associated with NEMT services. This includes any fees charged by the transportation provider.

At Polaris Health Plus, we understand that transportation can be a barrier for many members. That's why we are proud to offer NEMT services for members living in select states. With this service, you can receive the care you need without having to worry about how you'll get there.

Mental Health Care

COVERED SERVICES: Mental Health Care

At Contoso, we understand the importance of mental health care and are proud to offer Polaris Health Plus, which provides comprehensive mental health coverage to our employees.

Polaris Health Plus covers a wide range of mental health services, including counseling, psychiatric visits, therapy, and group therapy. Services are provided in-network and out-ofnetwork, with coverage for both inpatient and outpatient visits.

In-Network Services

When receiving mental health care, it is important to make sure you are using an innetwork provider. When you use an in-network provider, your out-of-pocket costs are generally lower and your coverage is more comprehensive. Polaris Health Plus offers a network of providers that are in-network, including primary care physicians, specialists, hospitals, and pharmacies.

Out-of-Network Services

In some cases, it may be necessary to receive mental health care from an out-of-network provider. Polaris Health Plus will still cover a portion of the cost of services received from an out-of-network provider. However, it is important to note that out-of-pocket costs are typically higher when receiving care from an out-of-network provider.

Exceptions

Polaris Health Plus does not cover some services related to mental health care, including long-term treatment plans, experimental treatments, and treatments related to pre-existing conditions.

Tips for Receiving Mental Health Care

At Contoso, we encourage our employees to prioritize their mental health and seek out the care they need. Here are a few tips to keep in mind when seeking mental health care:

- Make sure you are using an in-network provider to access the most comprehensive coverage and the lowest out-of-pocket costs.

- Take advantage of preventive care services, such as counseling and therapy.
- Talk to your doctor about your treatment plan and any cost-saving options available.
- Consider talking to a mental health professional if you are feeling overwhelmed or struggling with mental health issues.
- Ask your doctor or mental health professional about support groups in your area.
- Research any alternative treatments that may be available and discuss them with your doctor.
- Utilize the mental health resources at Contoso, such as our Employee Assistance Program.

At Contoso, we understand the importance of mental health care and are committed to supporting our employees in their journey to mental wellbeing. We encourage you to take advantage of the mental health coverage provided by Polaris Health Plus.

Neurodevelopmental Therapy (Habilitation)

Neurodevelopmental Therapy (Habilitation)

Neurodevelopmental therapy (habilitation) is a type of service offered under the Polaris Health Plus plan that is designed to help individuals with physical, mental, and/or developmental disabilities. Habilitation services focus on helping individuals develop, maintain, and improve skills and functioning in areas like communication, self-care, mobility, and social skills.

Under the Polaris Health Plus plan, habilitation services are covered up to a certain dollar amount and number of visits. This amount and the number of visits may vary depending on the individual's needs. To receive coverage for habilitation services, the individual must be referred to a qualified provider by their primary care physician.

When seeking habilitation services, it is important to consider the individual's needs and goals. The provider should take this into consideration when creating a treatment plan. Some of the goals of habilitation services may include improving the individual's ability to communicate, learning how to use adaptive equipment, improving physical coordination and strength, and developing social and behavioral skills.

When seeking habilitation services, it is important to understand the different types of therapy that are available. This may include physical therapy, occupational therapy, speech and language therapy, and/or behavior modification therapy. Each of these therapies has different goals and approaches. It is important to understand which type of therapy is best suited for the individual's needs and goals.

It is also important to note that habilitation services are not covered for individuals under the age of 21. These services are only available for those 21 and older. Additionally, habilitation services are not covered for the treatment of mental illness or substance abuse.

Finally, it is important to remember that habilitation services can be expensive. If an individual is not able to afford the cost of habilitation services, they may want to consider seeking assistance from a state-funded program or other organizations that provide financial assistance.

Overall, the Polaris Health Plus plan provides comprehensive coverage for habilitation services. It is important to understand the coverage limits and exceptions for habilitation services before seeking treatment. Additionally, it is important to consider the individual's needs and goals when choosing a type of therapy. Finally, if an individual is unable to afford the cost of habilitation services, they may want to explore other options for financial assistance.

Newborn Care

COVERED SERVICES: Newborn Care

At Polaris Health, we understand that bringing a new life into the world is both exciting and overwhelming. That's why our Polaris Health Plus plan offers coverage for newborn care. This coverage includes care provided by a physician or other health care professional in the hospital, or at an alternate birthing facility, for a newborn baby up to 30 days old.

This coverage includes:

- Newborn screening tests
- Physical assessment and evaluation
- Treatment for any medical condition
- Feeding care
- Follow-up treatments and visits

Exceptions

This coverage does not include services or treatments for any pre-existing conditions. It also does not include any elective services such as cosmetic procedures.

Tips for Employees

- If you are pregnant, it is important to make sure that you understand the coverage available under the Polaris Health Plus plan. Talk to your doctor and make sure that you have a plan for delivery and postpartum care that is covered by your insurance.
- Make sure that you understand the newborn screening tests that are covered and any follow-up treatments or visits that may be required.
- If you are planning to use a birthing facility other than a hospital, make sure that you check to see if it is covered under the plan.

- Make sure that you understand the exceptions to coverage, and if you have any questions, contact Polaris Health directly.
- Be aware that some services, such as elective cosmetic procedures, are not covered under this plan.
- Contact your doctor or Polaris Health if you have any questions or concerns about the coverage provided for your newborn.

Orthognathic Surgery (Jaw Augmentation Or Reduction) Orthognathic Surgery (Jaw Augmentation or Reduction):

Polaris Health Plus covers Orthognathic Surgery, also referred to as Jaw Augmentation or Reduction, as a covered service. This procedure is used to correct irregularities in the jaw and face caused by misalignment of bones or teeth. It is a complex procedure that involves cutting and repositioning the jaw bones to improve the alignment and overall appearance of the face.

Orthognathic Surgery is typically covered when medically necessary and is performed to improve the functional aspects of the jaw and face. It is important to note that Polaris Health Plus will only cover this procedure when it is performed by a physician who is a member of the Polaris Health provider network.

When considering Orthognathic Surgery, it is important to note that it is a major procedure and you should ask your physician any questions you may have about the operation. Additionally, you should discuss the risks and benefits of the procedure with your physician to make sure it is the right decision for you.

Before undergoing Orthognathic Surgery, you may need to have certain tests and evaluations performed, such as X-rays, CT scans, MRI scans, and physical exams. In some cases, you may need to be referred to a specialist for a more in-depth evaluation.

In some cases, Polaris Health Plus may require pre-authorization for Orthognathic Surgery prior to the procedure being performed. This means that you may need to get approval from Polaris Health Plus before the procedure can be done. Your physician can provide you with more information about this process.

After the procedure, your physician may recommend that you wear a protective appliance, such as a splint or headgear, to protect your jaw while it heals. You may also need to attend follow-up appointments with your physician to monitor your progress.

Polaris Health Plus typically covers the cost of Orthognathic Surgery, but you should confirm with your provider that all costs associated with the procedure are covered. Additionally, you should keep in mind that there may be certain limitations or exclusions that apply to this coverage, so it is important to review your policy in detail to be sure that you understand what is and is not covered.

If you have any questions about Orthognathic Surgery and whether or not it is covered under your Polaris Health Plus plan, you should contact your provider for more information.

Prescription Drug

COVERED SERVICES: Prescription Drug

Polaris Health Plus offers comprehensive coverage for prescription drugs. This coverage includes both generic and brand name drugs. The plan also includes access to mail order services, which allows you to order up to a 90-day supply of medications at a time.

The plan covers a variety of drug classes, including but not limited to:

• Antibiotics

• Antidepressants

• Anti-anxiety medications

• Asthma inhalers

• Hormone replacement therapies

• Pain relievers

• Statins

• Vaccines

In addition, Polaris Health Plus covers most over-the-counter medications and supplies when prescribed by your doctor.

Exceptions

While Polaris Health Plus covers a wide variety of drug classes, there are some exceptions. These exceptions include:

• Non-FDA approved medications

• Non-prescription vitamins and supplements

• Drugs for cosmetic or elective purposes

• Drugs for fertility treatments

• Drugs for weight loss or gain

In addition, Polaris Health Plus does not cover drugs that are considered experimental or investigational.

Tips For Employees

- Be sure to ask your doctor if any of the medications he or she is prescribing are covered by Polaris Health Plus.
- If you fill a prescription for a drug that is not covered by the plan, you may have to pay the full cost.
- Make sure to check the Polaris Health Plus drug list to see if the medications you need are covered by the plan.
- If you have any questions about your coverage, contact Polaris Health Plus customer service.
- When you fill a prescription at a retail pharmacy, make sure to present your Polaris Health Plus insurance card so that you can receive the discounted rate.
- If you have a chronic condition, consider using a mail order pharmacy to get up to a 90day supply of medications. This can help you save money.
- If you have any questions about your benefits, contact your employer's human resources department. They can provide you with more information about your coverage.

Preventive Care

COVERED SERVICES: Preventive Care

Polaris Health Plus provides coverage for preventive care services. Preventive care is an important part of staying healthy and managing existing health conditions, and Polaris Health Plus covers many different types of preventive care services.

Routine Physicals:

Polaris Health Plus covers routine physicals with no cost-sharing. Routine physicals can help detect health issues early and can help keep you healthy. During a routine physical, your doctor will review your medical history, check your vital signs, and perform any other tests that are necessary. They may also discuss lifestyle choices and preventive screenings.

Vaccinations:

Polaris Health Plus covers many different types of vaccinations, including those for flu, shingles, measles, mumps, and rubella. Vaccinations can help prevent serious and potentially deadly illnesses, so it’s important to stay up-to-date on your vaccinations.

Screenings:

Polaris Health Plus covers many different types of screenings, including those for cancer, diabetes, and high blood pressure. Screenings can help detect potential health issues in the early stages, when they are often easier to treat.

Exceptions:

Polaris Health Plus does not cover any services that are deemed medically unnecessary. This includes any services that are not recommended by your doctor, or any services that are not covered by the plan.

Tips:

It's important to take advantage of the preventive care services that are covered by your Polaris Health Plus plan. Be sure to talk to your doctor about any screenings or vaccinations that you need, and don't be afraid to ask questions about any services that you're unsure about. Staying up-to-date on your preventive care services can help you stay healthy and catch any health issues early.

Professional Visits And Services

COVERED SERVICES: Professional Visits And Services

Polaris Health Plus covers a variety of professional visits and services, including office visits, laboratory tests, and imaging services. The plan also covers diagnostic tests and treatments, as well as specialty care services.

Office Visits: Polaris Health Plus covers office visits with primary care physicians, specialists, and other healthcare providers. This includes well visits, sick visits, and followup visits. The plan also covers preventive care services, such as vaccinations and screenings.

Laboratory Tests: Polaris Health Plus covers laboratory tests prescribed by a healthcare provider. This includes blood tests, urine tests, and other tests to diagnose and treat illnesses and injuries.

Imaging Services: Polaris Health Plus covers imaging services, including X-rays, CT scans, MRIs, and ultrasound. This coverage is subject to any applicable copayments, coinsurance, or deductibles.

Diagnostic Tests And Treatments: Polaris Health Plus covers diagnostic tests and treatments prescribed by a healthcare provider. This includes tests to diagnose illnesses and injuries, as well as treatments to treat illnesses and injuries.

Specialty Care Services: Polaris Health Plus covers specialty care services, such as physical therapy, occupational therapy, and mental health services. The plan also covers services provided by specialists, such as cardiologists, endocrinologists, and neurologists.

Exceptions: Polaris Health Plus does not cover services that are not medically necessary, such as cosmetic surgery, elective treatments, and experimental treatments. In addition, the plan does not cover services for conditions that are not covered by the plan, such as pre-existing conditions.

Tips: When selecting a healthcare provider, be sure to choose one that is in-network. This will help you save money by avoiding out-of-network fees. In addition, be sure to ask your doctor or healthcare provider about any copayments, coinsurance, or deductibles that may

apply to the services you receive. It is also a good idea to review your plan documents to better understand your coverage and plan benefits.

Psychological and Neuropsychological Testing

COVERED SERVICES – Psychological and Neuropsychological Testing

Polaris Health Plus recognizes the importance of mental health care and offers psychological and neuropsychological testing as a covered service. In this section, we will cover what these tests are, what they cover, and what the exceptions are.

What are Psychological and Neuropsychological Tests?

Psychological and neuropsychological tests are tests used to diagnose and treat mental health conditions and disorders. Psychological tests are used to assess personality, behavior, and emotions, while neuropsychological tests are used to diagnose and treat neurological disorders.

What do these Tests Cover?

Psychological and neuropsychological testing can cover a wide range of topics, including memory, concentration, and attention; language and communication; motor skills; problemsolving; and executive functioning. Tests may also assess mood and behavior and can help to diagnose conditions such as anxiety, depression, and bipolar disorder.

Exceptions

There are some exceptions to the coverage for psychological and neuropsychological tests. These include tests for intelligence, achievement, and aptitude. In addition, tests that are intended to evaluate an individual's ability to perform specific job functions are also not covered under Polaris Health Plus.

Tips for Employees

If you think you may need psychological or neuropsychological testing, be sure to discuss this with your primary care physician or mental health provider. These tests can be expensive and time-consuming, so it's important to make sure that any testing you have is necessary and covered under your health plan. In addition, you should research providers who offer these services and make sure they are in-network with Polaris Health Plus so that you can receive the maximum benefit. Finally, make sure to keep track of all of your medical records and any tests you have so that you can provide this information to your providers if necessary.

By understanding what psychological and neuropsychological tests are, what they cover, and any exceptions to coverage, you can make sure that you are getting the most out of your Polaris Health Plus plan. By taking the time to research providers in-network with Polaris Health Plus and keeping track of your medical records and tests, you can make sure you are receiving the care and coverage you need.

Rehabilitation Therapy

Rehabilitation Therapy

Rehabilitation therapy is a valuable service that is often necessary to help individuals recover from injury, surgery, or illness. It can help restore physical functioning and help individuals return to their normal daily activities. Polaris Health Plus covers rehabilitation therapy services, including physical therapy, occupational therapy, and speech-language pathology.

Physical Therapy

Physical therapy helps restore physical function and mobility. It can help individuals who have difficulty walking, bending, or moving due to an illness or injury. Physical therapy can also help improve balance, coordination, and strength. Polaris Health Plus covers physical therapy services that are medically necessary.

Occupational Therapy

Occupational therapy helps individuals develop, maintain, or restore skills for daily living and work. It can help individuals who have difficulty performing activities of daily living due to an injury, illness, or disability. Polaris Health Plus covers medically necessary occupational therapy services.

Speech-Language Pathology

Speech-language pathology helps individuals who have difficulty communicating due to a speech, language, or hearing disorder or disability. It can help individuals improve their communication skills, as well as their ability to interact with others. Polaris Health Plus covers medically necessary speech-language pathology services.

Exceptions

Polaris Health Plus covers rehabilitation therapy services that are medically necessary. Services that are not considered medically necessary are not covered. Examples of services that are not medically necessary include, but are not limited to, recreational therapy and personal training.

Tips

If you need rehabilitation therapy services, it is important to talk to your doctor or health care provider to determine if the service is medically necessary. Your doctor or health care provider can also work with you to find an in-network provider who can provide the service. You should also keep track of your visits and make sure that they are billed to your Polaris Health Plus plan. Finally, you should ask your doctor or health care provider about any co-pays or coinsurance that may apply to the services.

Skilled Nursing Facility Services

Skilled Nursing Facility Services

Polaris Health Plus provides comprehensive coverage for skilled nursing facility services. This coverage includes a wide range of services such as nursing care, physical therapy, occupational therapy, and speech-language pathology services. These services are generally provided on an inpatient basis in a skilled nursing facility or hospital setting.

This plan also covers services provided in a Medicare-certified skilled nursing facility, as well as services provided in a non-Medicare-certified facility. For those enrolled in the plan, services provided in a non-Medicare-certified facility will be covered up to the same coverage limits as those provided in a Medicare-certified facility.

Skilled nursing facility services are generally provided on an inpatient basis and are generally provided under the supervision of a physician. These services can include nursing care, physical therapy, occupational therapy, and speech-language pathology services.

In order to be eligible for coverage under Polaris Health Plus, the services must be medically necessary and must be ordered by the patient's attending physician. The services must also be provided by a facility that is licensed and accredited by the appropriate state or local government agency and must meet all applicable state and federal regulations.

In addition, Polaris Health Plus does not cover services that are not medically necessary or services that are provided for the convenience of the patient. Furthermore, Polaris Health Plus does not cover services that are not ordered by the patient's attending physician or services that are provided by an unlicensed or unaccredited facility.

It is important to note that the coverage limits for skilled nursing facility services may vary by state. Therefore, it is important to check with Polaris Health Plus for coverage limits in your state.

Tips for Employees:

- When selecting a skilled nursing facility, it is important to ensure that the facility is licensed and accredited by the appropriate state or local government agency and that it meets all applicable state and federal regulations.

- Be sure to check with Polaris Health Plus for coverage limits in your state so you are aware of the maximum coverage available.

- Make sure that any services provided are medically necessary and ordered by your attending physician in order to be covered under Polaris Health Plus.

- Remember that Polaris Health Plus does not cover services that are not medically necessary or services that are provided for the convenience of the patient.

- Be aware that Polaris Health Plus does not cover services that are not ordered by the patient's attending physician or services that are provided by an unlicensed or unaccredited facility.

By being aware of these tips, you can ensure that you are receiving the coverage that you need to get the skilled nursing facility services that you require.

Spinal and Other Manipulations

COVERED SERVICES: Spinal and Other Manipulations

The Polaris Health Plus Plan covers spinal and other manipulations. Spinal manipulation is a form of manual therapy that is used to treat musculoskeletal conditions. It is often used to treat back pain, neck pain, and headaches. Other manipulations may be used to treat conditions such as shoulder pain, hip pain, and knee pain.

Spinal manipulations can be performed by a variety of healthcare providers, including physical therapists, chiropractors, and osteopaths. These manipulations involve applying manual force to joints of the spine, hips, and other areas of the body. The goal is to reduce pain and improve mobility.

The Polaris Health Plus Plan covers the cost of spinal manipulations up to a certain amount each year. In addition to covering the cost of the manipulation itself, the plan also covers the cost of x-rays and other tests that may be necessary to diagnose the condition being treated. This plan also covers the cost of any supplies or equipment needed to perform the manipulation.

However, the Polaris Health Plus Plan does not cover the cost of spinal manipulations performed for cosmetic reasons. It also does not cover the cost of long-term care or maintenance manipulations.

When considering spinal manipulation as a treatment option, it is important to discuss the potential risks and benefits with your doctor. Your doctor can help you determine if this form of therapy is right for you and can provide you with information on the potential side effects.

In addition, it is important to make sure that you are working with a qualified practitioner. Check with your insurance company to make sure that the practitioner you are considering is in-network and covered by your plan. Also, make sure that the practitioner is experienced and knowledgeable in the type of manipulation that they are performing.

Finally, keep in mind that spinal manipulations are not a substitute for medical care. If you are experiencing severe pain or other symptoms, you should seek medical attention immediately.

By taking the time to understand the benefits and risks of spinal and other manipulations, you can make sure that you are making an informed decision about your health care. With the Polaris Health Plus Plan, you can take advantage of the coverage provided for these services and get the treatment you need.

Substance Use Disorder

Substance Use Disorder Coverage

At Contoso, we are proud to offer our employees Polaris Health Plus, an insurance plan that provides comprehensive coverage for medical, vision, and dental services. This plan also offers coverage for substance use disorder (SUD) as part of our commitment to promoting employee well-being.

What is Substance Use Disorder?

Substance use disorder (SUD) is a condition in which an individual has difficulty controlling their use of alcohol or other drugs, even when it causes negative consequences in their life. It is a chronic, relapsing condition that can have a significant impact on an individual's physical, mental, and social well-being.

What is Covered under the Polaris Health Plus Plan?

The Polaris Health Plus plan covers a wide range of services related to the treatment of SUD. These services include inpatient and outpatient treatment, counseling, and medications to help with recovery. It also covers mental health services and support for family members of those with SUD.

Exceptions

Not all services related to SUD are covered by the Polaris Health Plus plan. For example, the plan does not cover experimental treatments or services that are not medically necessary. It also does not cover services provided by non-network providers.

Tips for Employees

If you or someone you care about is struggling with SUD, there are a few things you can do to get the most out of your Polaris Health Plus plan:

- Talk to your doctor or a mental health professional about your symptoms and the treatments that may be available.
- Make sure you understand the coverage provided by your plan and that you receive all the services that are covered.
- Be aware of the out-of-pocket costs associated with the services you receive.
- Take advantage of any support services offered by the plan, such as counseling, group therapy, or family support.
- Ask your doctor or mental health provider about medications that may be covered by your plan.
- Reach out to family and friends for support.
- Take steps to reduce stress in your life and find healthy ways to cope with difficult emotions.

At Contoso, we want to make sure our employees have the resources they need to take care of their mental and physical health. That's why we are proud to offer Polaris Health Plus and its coverage for substance use disorder. If you or someone you know is struggling with SUD, we encourage you to take advantage of the services available through this plan.

Surgery

Surgery

Surgery is a medical procedure that involves the use of invasive techniques, such as cutting open or removing tissue, to diagnose or treat certain medical conditions. With Polaris Health Plus, you have access to comprehensive coverage for a variety of surgeries, including inpatient and outpatient procedures. However, there are some exceptions to this coverage.

The first exception is that Polaris Health Plus does not cover cosmetic surgery. Cosmetic surgery is a procedure that is done for aesthetic purposes, such as to improve the appearance of the face or body, rather than for medical reasons. This includes procedures such as breast augmentation, liposuction, and nose reshaping.

The second exception is that Polaris Health Plus does not cover experimental procedures or treatments. This includes any form of surgery or treatment that is not medically accepted or approved by a major medical organization.

The third exception is that Polaris Health Plus does not cover any procedure or treatment that is not medically necessary. This includes elective or cosmetic procedures, such as breast reduction or hair removal.

Finally, Polaris Health Plus also does not cover any procedure or treatment that is not performed by a licensed medical practitioner. This includes any procedure or treatment that is performed by an unlicensed or untrained practitioner.

When it comes to surgery, it is important to understand the coverage that you have under Polaris Health Plus. It is also important to be aware of any exceptions to your coverage. If you have any questions or concerns about your coverage, it is important to contact Polaris Health Plus directly to ensure that you have the coverage you need.

In addition to understanding the coverage you have, it is also important to understand the risks associated with surgery. It is important to discuss any potential risks with your doctor before undergoing a surgical procedure. It is also important to understand what is involved in the recovery process, so that you can plan accordingly.

Finally, it is important to take the necessary steps to ensure that the surgery is successful. This includes following your doctor's instructions closely, avoiding any activities that could put you at risk for complications, and getting the proper follow-up care. It is also important to understand how to manage any pain or discomfort that may occur after the surgery.

By understanding the coverage you have with Polaris Health Plus and the risks associated with surgery, you can make an informed decision about your healthcare needs. With the

right coverage and the right care, you can ensure that you receive the care you need to stay healthy and happy.

Surgical Center Care – Outpatient

Surgical Center Care - Outpatient

The Polaris Health Plus plan covers surgical center care when performed on an outpatient basis. This includes services such as diagnostic tests, minor surgeries, and procedures that are typically done in a surgical center. All services must be medically necessary, and prior authorization may be required for some services.

Exceptions

There are some exceptions to coverage for surgical center care. The plan does not cover cosmetic or elective procedures, experimental treatments, or services for which the patient is not eligible under the plan. In addition, the plan does not cover any services that are not considered medically necessary.

Tips

Before scheduling any outpatient surgical procedure, it is important to make sure that the procedure is covered by the Polaris Health Plus plan. Your provider should be able to provide you with information about coverage for the procedure. It is also important to make sure that the provider is in-network under the plan. You can find a provider in-network by visiting the Polaris Health website.

Prior authorization is required for some services, so it is important to make sure you have prior authorization before the procedure is scheduled. Your provider should be able to provide more information about the prior authorization process.

If you have any questions about coverage for a specific procedure, you should contact Polaris Health customer service. They can provide you with more information about your plan's coverage and any applicable limits or exclusions.

It is important to remember that the Polaris Health Plus plan covers only medically necessary services. Non-essential services, such as elective or cosmetic procedures, are not covered.

Finally, it is important to know that the plan does not cover services provided outside of the United States. If you are traveling outside of the country, you should contact Polaris Health to determine what coverage, if any, is available for any necessary medical services.

By understanding the coverage provided by the Polaris Health Plus plan, you can make sure that you get the most out of your benefits. With the right information, you can make sure that you get the care you need without having to worry about out-of-pocket costs.

Temporomandibular Joint Disorders (TMJ) Care

COVERED SERVICES: Temporomandibular Joint Disorders (TMJ) Care

Temporomandibular joint (TMJ) disorders are a group of conditions that affect the jaw joint and the muscles that control the jaw's movement. It can be a debilitating condition that affects an individual's ability to talk, eat, and perform other daily activities. Polaris Health Plus covers treatments for TMJ disorders, including the cost of diagnostic tests, medications, and physical therapy.

Diagnostic Tests

Polaris Health Plus covers a variety of diagnostic tests that can help determine the cause of an individual's TMJ disorder. These tests may include X-rays, CT scans, MRI scans, and ultrasound. Polaris Health Plus will cover the cost of these tests when they are deemed medically necessary.

Medications

Polaris Health Plus will cover the cost of medications to help relieve the symptoms of TMJ disorders. These medications may include anti-inflammatory medications, muscle relaxants, and pain medications. In some cases, Polaris Health Plus may also cover the cost of injections to help relieve pain in the jaw joint.

Physical Therapy

Polaris Health Plus will cover the cost of physical therapy to help relieve the symptoms of TMJ disorders. Physical therapy may include stretching exercises, massage, and ultrasound treatments. Polaris Health Plus will also cover the cost of splints and other devices that can help reduce jaw pain and improve jaw movement.

Exceptions

Polaris Health Plus does not cover the cost of any treatments or procedures that are considered experimental or cosmetic. This includes treatments such as facial surgery, Botox injections, and laser treatments.

Tips

To help manage the symptoms of TMJ disorders, Polaris Health Plus recommends the following tips:

- Practice good posture and body mechanics: Make sure you maintain good posture when sitting and standing, and avoid clenching your teeth or grinding them.

- Avoid chewing gum: Chewing gum can cause your jaw muscles to become fatigued, which can worsen TMJ symptoms.

- Avoid large meals: Eating large meals can put a strain on your jaw muscles, so try to avoid eating large meals or snacks.

- Practice relaxation techniques: Relaxation techniques such as deep breathing and progressive muscle relaxation can help reduce jaw tension and relieve TMJ symptoms.

- Use heat and cold therapy: Applying heat or cold to your jaw can help reduce pain and muscle tension.

- Avoid extreme jaw movements: Avoid extreme jaw movements, such as widely opening your mouth or clenching your teeth.

Therapeutic Injections

COVERED SERVICES: Therapeutic Injections

At Polaris Health, we understand the importance of having access to therapeutic injections that can help treat medical conditions and provide relief from pain. We are pleased to offer coverage for therapeutic injections as part of the Polaris Health Plus plan.

Therapeutic injections are a type of procedure in which drugs or other substances are injected directly into the body to treat medical conditions and provide relief from pain. The most common types of therapeutic injections are corticosteroids, which reduce inflammation, and hyaluronic acid, which can be used to treat joint pain.

Therapeutic injections are often used to treat a range of conditions, such as arthritis, tendonitis, bursitis, and muscle spasms. They can also be used to treat chronic pain and can help reduce inflammation and swelling. Therapeutic injections can also be used to provide relief from migraines, headaches, and other types of pain.

Under the Polaris Health Plus plan, therapeutic injections are covered when they are administered by a licensed healthcare professional. These injections must be medically necessary and prescribed by a physician in order to be eligible for coverage.

In some cases, members may be required to obtain prior authorization before receiving a therapeutic injection. This prior authorization ensures that the injection is medically necessary and that it is the most appropriate treatment for the condition.

The Polaris Health Plus plan does not cover experimental or investigational treatments, including injections that are not medically necessary. Members should also be aware that not all therapeutic injections are covered under the plan.

It is important to note that therapeutic injections can have side effects and risks, so members should always discuss these with their healthcare provider before undergoing the procedure. Members should also discuss any potential costs that may not be covered under the plan, such as the cost of the drug or any additional procedures that may be necessary.

When using therapeutic injections, it is important to follow up with your healthcare provider to ensure the injection was effective and that there are no complications. Additionally, members should always follow the instructions provided by their healthcare provider and ensure that the injection is administered properly.

By taking advantage of the therapeutic injections covered under the Polaris Health Plus plan, members can benefit from improved health and pain relief without additional costs. Members should always discuss their options with their healthcare provider and be sure to follow the instructions provided in order to ensure the best outcome.

Transplants

COVERED SERVICES: Transplants

At Contoso, we understand the importance of providing the best coverage available to our employees. That's why we have partnered with Polaris Health to offer our employees Polaris Health Plus coverage. Polaris Health Plus offers coverage for transplants, with some exceptions.

Transplant coverage includes both the transplant itself, as well as associated costs such as pre- and post-transplant care, hospital stays, medications, and laboratory services. Pretransplant testing and evaluation, including laboratory services, imaging tests, and other tests may also be covered.

It's important to note that not all transplants are covered under Polaris Health Plus. For example, transplants of non-vital organs such as the gallbladder, spleen, and pancreas are not covered. Additionally, transplants of non-human organs, such as animal organs, are not covered.

When considering a transplant, it's important to be aware of the costs associated with the procedure and associated care. Polaris Health Plus helps offset the costs of most transplants, but it's important to be aware that there may be co-pays or deductibles associated with the procedure. Additionally, there may be out-of-pocket costs for services that are not covered under Polaris Health Plus.

It's also important to be aware of the eligibility criteria for transplants. Most transplants are only available to individuals who are healthy enough to tolerate the procedure and the associated recovery time. Additionally, most transplants require the individual to comply with certain medical protocols to ensure the best chance of success. For example, some transplants require the individual to undergo certain laboratory tests or to take certain medications prior to the procedure.

It's also important to be aware of the potential risks associated with transplants. Potential risks include infection, organ rejection, and other issues related to the body's response to the procedure. It's important to discuss the potential risks with your doctor prior to undergoing the procedure.

Finally, it's important to be aware that the availability of transplants is limited. Transplants are only available if suitable organs and/or tissues are available. Additionally, the wait time for a transplant can vary significantly based on the availability of organs and tissues.

At Contoso, we are proud to provide employees with access to Polaris Health Plus coverage, which includes coverage for transplants. We understand the importance of providing

employees with access to the medical care they need, which is why we have partnered with Polaris Health to provide our employees with the best coverage available.

Urgent Care

COVERED SERVICES: Urgent Care

At Polaris Health Plus, we understand that life can be unpredictable and that sometimes, you may need urgent care. We offer coverage for urgent care services, so you can get the medical attention you need without worrying about the cost.

In-Network Coverage

When you visit an in-network urgent care provider, you will pay a co-pay or co-insurance for your visit. You may also be responsible for any additional costs, such as lab tests and xrays, if they are not covered by your plan. Your in-network urgent care provider should be able to tell you what your costs will be before you receive any services.

Out-of-Network Coverage

If you receive care from an out-of-network provider, you may be responsible for a higher cost-sharing amount than if you had visited an in-network provider. You will also be responsible for any additional costs, such as lab tests and x-rays, that you receive from an out-of-network provider.

Emergency Care

Emergency care is covered by Polaris Health Plus, even if it is received from an out-ofnetwork provider. However, you may be responsible for a higher cost-sharing amount than if you received care from an in-network provider.

Tips for Seeking Urgent Care

When you need urgent care, it is important to remember that not all urgent care facilities are the same. Here are some tips to help you make the best decision for your situation:

- Do your research: Before you visit an urgent care facility, be sure to research the facility to make sure it is in-network.
- Make sure the facility is open: Always double-check the hours of operation for the facility you plan to visit.
- Have your insurance card on hand: Bring your insurance card with you to the visit, as you may need to provide it to the facility.
- Bring your medical records: If you have any relevant medical records, bring them with you to the facility. This will help the provider make a more informed diagnosis.
- Know when to go to the emergency room: If you are experiencing a medical emergency, call 911 or go to the nearest emergency room for treatment.

We understand that receiving urgent care can be a stressful situation. At Polaris Health Plus, we strive to make the process as easy and stress-free as possible. If you have any questions about your coverage, please reach out to us so we can help.

Virtual Care

COVERED SERVICES: Virtual Care

At Contoso, we understand that taking time off to go to the doctor's office isn't always possible. That's why we've partnered with Polaris Health to provide access to virtual care services. With Polaris Health Plus, you can get the care you need from the comfort of your own home, office, or other location.

Polaris Health Plus covers the cost of virtual care services, such as telemedicine, e-visits, and other virtual consultations with in-network providers. These services can be used to diagnose and treat minor medical conditions and can also be used to follow up on existing medical issues. If a virtual visit isn't appropriate, Polaris Health Plus covers the cost of an in-person visit.

In addition to providing convenient access to care, Polaris Health Plus also offers cost savings benefits. By using virtual care services, you can avoid paying for office visits and other out-of-pocket costs associated with seeing a doctor in person.

Before scheduling a virtual visit, it's important to note that there may be some limitations. For instance, some services, such as laboratory tests, imaging studies, and mental health services, may not be available via virtual care. It's also important to note that some services may require prior authorization.

We encourage you to take advantage of virtual care services when appropriate. To make the most of your virtual care experience, be sure to:

- Prepare for your visit: Make sure you have the necessary supplies and documents in advance, such as your insurance card, medical history, and any questions you may have.
- Follow up: If you need to follow up with your doctor, be sure to do so. Virtual care services are an excellent way to stay in touch with your provider.
- Follow instructions: Make sure you follow any instructions given to you by your doctor during or after your virtual visit.
- Contact us: If you have any questions or need help scheduling a virtual visit, please contact Polaris Health customer service.

At Contoso, we understand that today's busy lifestyles can make it difficult to schedule and attend doctor's appointments. That's why we're proud to offer Polaris Health Plus, which provides access to convenient and cost-saving virtual care services. With Polaris Health Plus, you can get the care you need from the comfort of your own home.

Weight Management

WEIGHT MANAGEMENT - COVERED SERVICES

Weight management is an important part of overall health and wellness, and Polaris Health Plus recognizes this. As part of your health plan, you have access to a variety of coverage options for weight management.

Coverage for Weight Loss Programs

Polaris Health Plus offers coverage for medically supervised weight loss programs. These programs are designed to help you reach and maintain a healthy weight. Covered services may include nutrition counseling, medical evaluation and follow-up, and laboratory tests. Your plan may also cover the cost of medications prescribed by your doctor as part of your weight loss program.

Coverage for Weight Loss Surgery

Polaris Health Plus also offers coverage for weight loss surgery. Weight loss surgery is a serious procedure that can help some people achieve major health benefits. Under this plan, coverage is available for certain types of weight loss surgeries, such as gastric bypass, gastric sleeve, and gastric banding.

Exclusions and Limitations

Please note that not all weight management services are covered under Polaris Health Plus. For example, Polaris Health Plus does not cover over-the-counter weight loss supplements, diet or exercise programs, or any services related to cosmetic weight loss. Additionally, pre-authorization may be required for certain weight loss procedures.

Tips for Employers

There are several steps employers can take to support their employees in their weight management efforts. Employers can consider providing resources and programs that focus on healthy lifestyle habits, such as nutrition education and physical activity. They can also provide access to weight management programs, including medically supervised programs and weight loss surgery. Additionally, employers can create a wellness culture in the workplace by encouraging healthy eating, offering healthy snacks, and providing incentives for employees who participate in health and wellness activities.

Conclusion

Weight management is an important part of overall health and wellness, and Polaris Health Plus provides coverage for certain services related to weight management. This includes coverage for medically supervised weight loss programs and weight loss surgery. However, there are some exclusions and limitations, and it is important for employers to understand what is and is not covered. Additionally, employers can take several steps to support their employees in their weight management efforts.

WHAT DO I DO IF I'M OUTSIDE WASHINGTON?

Out-Of-Area Care

What Do I Do If I'm Outside Washington?

If you are outside Washington, you may still be eligible for coverage through Polaris Health Plus. Polaris Health Plus offers a network of providers that are located throughout the United States. These providers are part of Polaris Health Plus' nationwide network, which is designed to ensure that you are able to receive care, no matter where you are.

Out-of-area care is coverage that extends outside of Washington. This means that if you travel outside of the state, you can still receive care from a Polaris Health Plus provider. However, there are some exceptions to this coverage. For example, you may be limited to a certain number of visits or treatments that are covered outside of Washington. Additionally, certain services may not be covered, such as home health care services that are provided outside of the state.

If you travel outside of Washington, it is important to keep a few tips in mind. First, you should make sure that any provider you plan to visit is a part of Polaris Health Plus' nationwide network. You can do this by checking Polaris Health Plus' online directory or calling the Polaris Health Plus customer service line. Additionally, it is important to keep track of any expenses or services that you receive outside of Washington. You may need to provide receipts or other documentation to Polaris Health Plus in order to be reimbursed for these expenses.

Finally, it is important to remember that Polaris Health Plus does not cover all services outside of Washington. In some cases, you may be required to pay for a service in full and then submit a claim to Polaris Health Plus for reimbursement. It is important to contact Polaris Health Plus prior to receiving any services to ensure that they are covered by your plan.

Polaris Health Plus is committed to providing coverage to its members, no matter where they are located. By following these tips and understanding the coverage limits, you can ensure that you will be able to receive the care you need, even when you are outside of Washington.

CARE MANAGEMENT

Prior-Authorization

CARE MANAGEMENT: Prior Authorization

Under Polaris Health Plus, there is a care management system that includes prior authorization. Prior authorization is a process that requires approval from Polaris Health Plus for certain services and medications before they are covered. Prior authorization is intended to ensure that members receive medically necessary, safe, and cost-effective healthcare services.

Prior authorization is required for some outpatient services, such as outpatient surgery, some imaging studies and physical therapy, as well as for some medications. Prior authorization is also required for some inpatient services and procedures. Polaris Health Plus may also require prior authorization for other services or medications.

For services and medications that require prior authorization, you must contact Polaris Health Plus before receiving the service or medication to determine if prior authorization is required. If so, you will need to obtain prior authorization through the Polaris Health Plus prior authorization process.

Exceptions

There are some exceptions to the prior authorization requirement. Certain preventive services, such as annual physicals and routine check-ups do not require prior authorization. In some cases, Polaris Health Plus may also waive the prior authorization requirement for certain services and medications.

Tips for Employees

If you think you may need a service or medication that requires prior authorization, it is important to plan ahead and contact Polaris Health Plus before receiving the service or medication. This will help ensure that your service or medication is covered by Polaris Health Plus.

If you receive a service or medication without prior authorization, you may be responsible for the entire cost of the service or medication. You can also be billed for any services or medications that are determined to be not medically necessary.

Prior authorization can take several days to complete, so it is important to plan ahead and contact Polaris Health Plus as soon as possible. Polaris Health Plus may also require additional information, such as medical records or lab results, in order to complete the prior authorization process.

If you have any questions about prior authorization, it is important to contact Polaris Health Plus for more information. Polaris Health Plus can provide you with information about prior authorization and help you understand what services and medications require prior authorization.

How Prior-Authorization Works

CARE MANAGEMENT: Prior-Authorization

Prior authorization (or pre-authorization) is an important part of the Polaris Health Plus plan. Before certain services and treatments can be covered, they must first be authorized by Polaris Health. This means that your doctor or health care provider will need to get prior authorization from Polaris Health before providing the care.

Prior authorization is also known as pre-certification, pre-notification, pre-service review, or pre-authorization. It is important for you to understand that prior authorization does not guarantee that the service will be covered by your Polaris Health Plus plan.

When Prior Authorization is Required

Prior authorization is required for certain services and treatments such as:

• Hospital admissions

• Inpatient surgery

• Outpatient surgery

• Magnetic Resonance Imaging (MRI)

• Computed Tomography (CT)

• Radiation Therapy

• Durable Medical Equipment

• Physical, Occupational, and Speech Therapy

• Home Health Care

• Infusion Therapy

• Prosthetics and Orthotics

• Specialty Drugs

In certain cases, Polaris Health may require prior authorization even if the service is not listed above. Your doctor or health care provider should contact Polaris Health to determine if prior authorization is required prior to providing care.

Exceptions to Prior Authorization

There are certain services and treatments that are exempt from prior authorization. These include:

• Routine office visits

• Immunizations

• X-Ray services

• Emergency services

• Family planning services

• Maternity services

• Services and supplies related to diabetes

• Preventive care services

• Mental health and substance abuse services

• Routine eye exams

• Routine dental exams

It is important to note that the list of services and treatments that are exempt from prior authorization is subject to change. Your doctor or health care provider should contact Polaris Health to determine if prior authorization is required prior to providing care.

Tips for Obtaining Prior Authorization

When obtaining prior authorization for a service or treatment, it is important to provide Polaris Health with all of the necessary information. This includes:

• The patient's diagnosis

• The proposed treatment

• The anticipated duration of the treatment

• Any other relevant information that may be requested by Polaris Health

It is also important to understand that prior authorization is not a guarantee of payment. The decision to authorize a service or treatment will be based on the information provided as well as Polaris Health's policies and procedures.

Your doctor or health care provider should contact Polaris Health for prior authorization as soon as possible to avoid any delays in care. You can also contact Polaris Health if you have any questions or need assistance with the prior authorization process.

It is important to understand that prior authorization is a critical part of the Polaris Health Plus plan. By understanding the prior authorization process and following the tips outlined above, you can help ensure that you receive the care you need in a timely and efficient manner.

Prior-Authorization for Benefit Coverage

CARE MANAGEMENT: Prior-Authorization for Benefit Coverage

The Polaris Health Plus plan includes a care management system that requires priorauthorization for certain services to ensure that the plan is covering only medically necessary care. Prior-authorization is a process used by the insurance company to review a request for a specific service to ensure that it is medically necessary and meets the criteria

set by the plan. This process helps to ensure that members are receiving the best care possible and that their benefits are used in the most cost-effective manner.

In order to receive prior-authorization, members must provide their Polaris Health Plus provider with the necessary clinical information regarding their diagnosis and treatment plan. The provider then submits this information to Polaris Health Plus for review. Polaris Health Plus will then contact the provider with the decision on the priorauthorization request.

Prior-authorization is required for certain services, including but not limited to:

• Inpatient Hospitalizations

• Outpatient Surgery

• Durable Medical Equipment

• Certain Imaging Services

• Certain Lab Tests

• Certain Physical and Occupational Therapy Services

• Certain Prescription Drugs

• Certain Home Health Services

It is important to note that some services do not require prior-authorization, as they are considered non-medically necessary. In addition, some services may only require priorauthorization for certain members, such as those with high-risk conditions. The Polaris Health Plus plan has a list of services that require prior-authorization, which is available on the Polaris Health Plus website.

There are certain exceptions to prior-authorization requirements. For example, if a member requires emergency services, prior-authorization is not required. In addition, certain pediatric services are exempt from prior-authorization.

It is important for members to understand that prior-authorization does not guarantee coverage. The prior-authorization process is used to determine if a service is medically necessary and meets the criteria set by the plan. If a service is not medically necessary or does not meet the criteria set by the plan, the service may be denied.

It is also important for members to understand that prior-authorization is not a guarantee that the service will be provided in a timely manner. While Polaris Health Plus strives to make decisions on prior-authorization requests as quickly as possible, the process can take time.

Here are some tips for members to help ensure that prior-authorization requests are processed in a timely manner:

- Ensure that all necessary information is provided to the provider when requesting priorauthorization.
- Make sure that the provider submits the prior-authorization request as soon as possible.
- Contact the insurance company if you have not received a response after a reasonable amount of time.
- Ensure that the provider is aware of any changes in the member's condition that may affect the prior-authorization request.

Prior-authorization is an important part of the Polaris Health Plus care management system. It helps ensure that members are receiving the best care possible and that their benefits are used in the most cost-effective manner. By understanding prior-authorization and following the tips outlined above, members can help ensure that their priorauthorization requests are processed in a timely manner.

Exceptions To Prior Authorization For Benefit Coverage

CARE MANAGEMENT: Exceptions To Prior Authorization For Benefit Coverage

At Polaris Health Plus, we understand that medical care can be complex and that you may need access to specialized care when needed. That is why we provide exceptions to prior authorization for certain medical services, procedures and treatments that may require additional review and approval. The exceptions to prior authorization are based on national and state medical regulations, as well as medical necessity and appropriateness criteria.

The exceptions to prior authorization provided by Polaris Health Plus include:

Emergency Care: Emergency care is covered without prior authorization if it is determined to be medically necessary. If you believe that you need emergency care, please contact Polaris Health Plus for approval.

Inpatient Hospital Services: Inpatient hospital services are covered without prior authorization if it is determined that the services are medically necessary. However, if you require hospital services, please contact Polaris Health Plus to ensure that the hospital you are admitted to is an in-network provider.

Outpatient Hospital Services: Outpatient hospital services are covered without prior authorization if it is determined that the services are medically necessary. However, if you require outpatient services, please contact Polaris Health Plus to ensure that the hospital you are visiting is an in-network provider.

Ambulatory Surgery Center Services: Ambulatory surgery center services are covered without prior authorization if it is determined that the services are medically necessary. However, please contact Polaris Health Plus to ensure that the ambulatory surgery center you are visiting is an in-network provider.

Outpatient Rehabilitative Services: Outpatient rehabilitative services are covered without prior authorization if it is determined that the services are medically necessary. However, please contact Polaris Health Plus to ensure that the outpatient rehabilitative provider you are visiting is an in-network provider.

Long-Term Care Services: Long-term care services are covered without prior authorization if it is determined that the services are medically necessary. Please contact Polaris Health Plus to ensure that the long-term care provider you are visiting is an in-network provider.

Hospice Care Services: Hospice care services are covered without prior authorization if it is determined that the services are medically necessary. Please contact Polaris Health Plus to ensure that the hospice care provider you are visiting is an in-network provider.

Home Health Services: Home health services are covered without prior authorization if it is determined that the services are medically necessary. Please contact Polaris Health Plus to ensure that the home health provider you are visiting is an in-network provider.

Maternity Services: Certain maternity services are covered without prior authorization if it is determined that the services are medically necessary. Please contact Polaris Health Plus to ensure that the maternity provider you are visiting is an in-network provider.

Durable Medical Equipment and Prosthetic Devices: Durable medical equipment and prosthetic devices are covered without prior authorization if it is determined that the services are medically necessary. Please contact Polaris Health Plus to ensure that the durable medical equipment and prosthetic device provider you are visiting is an in-network provider.

Prescription Drugs: Prescription drugs are covered without prior authorization if it is determined that the services are medically necessary. Please contact Polaris Health Plus to ensure that the prescription drug provider you are visiting is an in-network provider.

Tips For Employees

If you are ever in need of medical services, procedures, or treatments that require prior authorization, it is important to contact Polaris Health Plus in advance to ensure that the care is covered by your plan.

It is also important to remember that the exceptions to prior authorization are based on national and state medical regulations, as well as medical necessity and appropriateness criteria. Therefore, it is important to contact Polaris Health Plus to ensure that the care you require is covered by your plan.

Additionally, it is important to remember to check that the provider you are visiting is an innetwork provider, as this will help you to save money on your medical care.

Finally, if you ever have any questions or concerns about your benefits, please do not hesitate to contact Polaris Health Plus for assistance. We are here to help you get the most out of your benefits and to ensure that you have access to the care you need.

Prior-Authorization For Out-Of-Network Provider Coverage

CARE MANAGEMENT: Prior Authorization For Out-Of-Network Provider Coverage

As an employee of Contoso, you may be eligible to receive coverage for care provided by out-of-network providers. Polaris Health Plus offers coverage for out-of-network providers, but the plan requires prior authorization. This means that you must obtain approval from Polaris Health before seeing an out-of-network provider.

Prior authorization is a process in which Polaris Health reviews your request for coverage and decides whether or not it will cover the care that you have requested. To be approved for prior authorization, you must meet certain criteria and provide certain information. This criteria and information may vary depending on the type of care you are requesting.

Prior authorization requests must be submitted to Polaris Health by your provider. In most cases, your provider will submit the request for you. Polaris Health will then review the request and make a decision about whether or not it will cover the care.

In some cases, Polaris Health may approve the request for coverage, but with certain limitations or conditions. For example, Polaris Health may limit the number of visits for a specific procedure or limit the amount of coverage for a specific procedure. It is important to understand any limitations or conditions that Polaris Health places on the prior authorization before you receive care from an out-of-network provider.

It is also important to understand that certain services may not require prior authorization. For example, emergency services and certain preventive services may not require prior authorization.

Tips for Employees:

1. Understand the prior authorization process and any requirements that you must meet to receive coverage for an out-of-network provider.
2. Find out if the type of care you need requires prior authorization.
3. Ask your provider if they will be submitting the prior authorization request for you.
4. Ask Polaris Health about any limitations or conditions that may be placed on the prior authorization.
5. Understand that certain services may not require prior authorization.

Remember, if you have any questions about the prior authorization process or coverage for an out-of-network provider, contact Polaris Health directly. Polaris Health is available to answer any questions you may have and provide more information about the prior authorization process.

Exceptions to Prior-Authorization For Out-Of-Network Providers

CARE MANAGEMENT - Exceptions to Prior-Authorization For Out-Of-Network Providers

Polaris Health Plus provides coverage for certain services that may require prior authorization when provided by an out-of-network provider. Prior authorization is required to ensure that the service is medically necessary and to ensure that the service is being provided in accordance with the plan's specific rules and guidelines.

Polaris Health Plus makes exceptions to the prior authorization requirement for the following services when provided by an out-of-network provider:

- Emergency Services: For services that are medically necessary and when the out-ofnetwork provider is the closest provider available, prior authorization is not required. However, the provider must submit a claim for the services rendered to Polaris Health Plus for review and processing.

- Outpatient Mental Health Services: Services that are medically necessary and provided by an out-of-network provider are not required to have prior authorization. However, the provider must submit a claim for the services rendered to Polaris Health Plus for review and processing.

- Skilled Nursing Care: Prior authorization is not required for services provided in a home or other non-institutional setting. The provider must submit a claim for the services rendered to Polaris Health Plus for review and processing.

- Durable Medical Equipment: Prior authorization is not required for services provided in a home or other non-institutional setting. The provider must submit a claim for the services rendered to Polaris Health Plus for review and processing.

- Radiology Services: Prior authorization is not required for services provided in a home or other non-institutional setting. The provider must submit a claim for the services rendered to Polaris Health Plus for review and processing.

- Laboratory Services: Prior authorization is not required for services provided in a home or other non-institutional setting. The provider must submit a claim for the services rendered to Polaris Health Plus for review and processing.

- Prescription Drugs: Prior authorization is not required for services provided in a home or other non-institutional setting. The provider must submit a claim for the services rendered to Polaris Health Plus for review and processing.

When selecting an out-of-network provider, it is important to remember that Polaris Health Plus may not cover all of the services provided. It is important to ask the provider if the services are covered by Polaris Health Plus and to check with Polaris Health Plus to make sure that the services are covered.

It is also important to remember that out-of-network providers may charge more than those in-network. Polaris Health Plus does not guarantee the amount charged by an outof-network provider, and the member is responsible for any balance remaining after the plan has paid its portion.

Finally, it is important to remember that prior authorization is still required for some services even if they are provided by an out-of-network provider. Prior authorization is a process in which Polaris Health Plus reviews and evaluates the medical necessity of the requested service. This process helps to ensure that the services being requested are medically necessary and are provided in accordance with the plan's specific rules and guidelines.

In conclusion, Polaris Health Plus makes exceptions to the prior authorization requirement for certain services when they are provided by an out-of-network provider. However, it is important to remember that Polaris Health Plus may not cover all of the services provided by an out-of-network provider, that out-of-network providers may charge more than those in-network, and that prior authorization is still required for some services even if they are provided by an out-of-network provider. By being aware of these

exceptions and tips, employees can ensure that they are making responsible and informed decisions about their healthcare needs.

Clinical Review

CARE MANAGEMENT – Clinical Review

Polaris Health Plus offers several care management services to ensure that members are receiving the best possible care. One of the primary care management services is Clinical Review. Clinical Review is an important process that helps to ensure that members are receiving the most appropriate care and that their care is in line with established clinical guidelines.

Clinical Review involves a team of healthcare professionals who review services, treatments, and medications to ensure that they are medically necessary and appropriate for the individual's condition. The review team may also look at other factors, such as cost and effectiveness, to ensure that the care provided is in line with established standards.

Clinical Review is available for all care services covered by Polaris Health Plus. This includes preventive care, primary care, specialty care, and hospital services. Clinical Review is also available for services provided by out-of-network providers.

In some cases, Clinical Review may result in a denial of coverage for certain services and medications. If a service or medication is denied, the provider will be notified and will have the opportunity to appeal the decision. The appeal process is designed to ensure that members receive the care that is medically necessary and appropriate for them.

There are a few exceptions to Clinical Review. In some cases, the review team may not be able to review all of the information necessary to make an appropriate decision. In these cases, the review team may be unable to make a decision and the provider may be able to provide coverage for the service or medication without going through the review process. Additionally, Clinical Review does not apply to services that are not covered by Polaris Health Plus, such as cosmetic surgeries or experimental treatments.

It is important to remember that Clinical Review is an important component of quality care. Polaris Health Plus is committed to ensuring that members receive the care that is medically necessary and appropriate for them.

Tips for Employees

- Talk to your doctor about the care you need. Your doctor can help determine if the services you are requesting are medically necessary and appropriate for your condition.
- Ask your doctor if he or she is familiar with the Polaris Health Plus Clinical Review process.
- Make sure your doctor provides accurate and complete information to the review team.
- If your coverage is denied, talk to your doctor about appealing the decision.
- If you are considering a service or medication that is not covered by Polaris Health Plus, ask your doctor about other options that may be available.

Personal Health Support Programs

CARE MANAGEMENT

Polaris Health Plus offers a number of personal health support programs to help members stay healthy and manage their health care costs. Through this program, members can access a range of services, programs, and benefits including:

Case Management: Polaris Health Plus provides a case management program that connects members with a team of health professionals, depending on the individual's needs. These professionals will help assess the member's health situation, develop a plan of care, coordinate care and resources, and provide support and education.

Disease Management: Polaris Health Plus offers disease management programs for members with certain chronic conditions. These programs provide members with support, information, and resources about their conditions, as well as assistance in managing their health care.

Wellness Programs: Polaris Health Plus provides wellness programs to help members stay healthy and manage their health care costs. These programs include programs to help members quit smoking, manage stress, and improve their overall health and well-being.

Exceptions:

•Members must be enrolled in Polaris Health Plus to be eligible for these programs.

•These programs may not be available in all areas.

•Some services may not be covered by Polaris Health Plus.

Tips:

•Take advantage of the services and programs offered through Polaris Health Plus.

•Talk to your doctor or other health care provider about your health and any treatments that may be available.

•Take an active role in your health care. Ask questions and be informed about your health and any treatments that may be available.

•Make sure to follow your doctor's instructions and stay up to date on your health care.

•If you have any questions or concerns about your health, contact Polaris Health Plus for assistance.

Chronic Condition Management

CARE MANAGEMENT: Chronic Condition Management

At Polaris Health, we understand that managing chronic conditions can be overwhelming and expensive. We are committed to helping our members manage their chronic conditions and live healthier, happier lives. That's why we offer a Chronic Condition Management Program (CCMP) as part of our Polaris Health Plus plan. This program provides members with access to an interdisciplinary team of healthcare professionals who can provide personalized care and support. The team includes physicians, nurses, social workers, nutritionists, pharmacists, and other specialists.

The CCMP is designed to help members better manage their chronic conditions, reduce the risk of complications, and improve their quality of life. Through the program, members receive:

• Comprehensive care assessments and care plans

• Regular follow-up visits

• Personalized health education

• Assistance with medication management

• Coordination of services with other providers

• Referrals to community resources

Exceptions: The CCMP is only available to Polaris Health Plus members who have one or more of the following chronic conditions: diabetes, asthma, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease (COPD), chronic kidney disease, and hypertension.

Tips to Help Employees Manage Chronic Conditions:

• Talk to your doctor: It's important to have open and honest conversations with your doctor about your condition and any concerns you may have.

- Make lifestyle changes: Eating a healthy diet, exercising regularly, and quitting smoking can help manage your condition and reduce the risk of complications.
- Stay organized: Keeping track of your medications, appointments, and lab results can help you stay on top of your condition and make informed decisions about your care.
- Ask for help: Don't be afraid to ask for help from family, friends, and healthcare professionals.
- Take advantage of resources: Polaris Health Plus offers a variety of resources and programs to help members manage their chronic conditions.
- Be proactive: Talk to your doctor if you have any questions or concerns about your condition or care plan.

At Polaris Health, we understand that managing chronic conditions can be challenging. That's why we're committed to helping our members get the care and support they need to stay healthy and active. Through our Chronic Condition Management Program, we provide members with access to an interdisciplinary team of healthcare professionals who can provide personalized care and support. We also offer a variety of resources and programs to help members manage their chronic conditions. With Polaris Health Plus, you can rest assured that you'll have the support and resources you need to stay healthy and active.

EXCLUSIONS

EXCLUSIONS

Although Polaris Health Plus provides comprehensive coverage for medical, vision, and dental services, there are certain services and treatments that are excluded from the plan. It is important to understand these exclusions so that you can plan your care accordingly.

Services Not Covered:

Polaris Health Plus does not cover services that are not medically necessary, such as cosmetic surgery or elective procedures. Additionally, services or treatments that are experimental or investigational are not covered under this plan.

Prescriptions Not Covered: The plan does not cover prescriptions that are not medically necessary, certain over-the-counter medications, or prescription medications that are used to enhance performance in athletics.

Mental Health and Substance Abuse Treatment: The plan does not cover mental health or substance abuse treatment services provided by a non-network provider or any services that are not medically necessary.

Preventive Care: Polaris Health Plus does not cover preventive care services provided by a non-network provider.

Tips for Avoiding Exclusions

When considering a medical service or treatment, it is important to review the plan's evidence of coverage to ensure that the service or treatment is covered under the plan. You should also discuss the service or treatment with your doctor to ensure that it is medically necessary. Additionally, you should review the list of excluded services and prescriptions to ensure that you are not seeking treatment for an excluded service or prescription.

If you are considering a medical service or treatment that is not covered under the plan, you should discuss payment options with your doctor or healthcare provider. Additionally, you may need to consider other payment sources, such as private insurance, flexible spending accounts, or state or federal programs.

Finally, it is important to understand the plan's coverage limits and to keep track of all outof-pocket expenses. You should also be aware of your plan's annual deductible and coinsurance amounts.

By understanding Polaris Health Plus's exclusions and following the tips outlined above, you can ensure that you are receiving the most comprehensive coverage available under the plan and avoid any unexpected costs.

WHAT IF I HAVE OTHER COVERAGE?

Coordinating Benefits With Other Health Care Plans WHAT IF I HAVE OTHER COVERAGE?

Coordinating Benefits With Other Health Care Plans

If you have other health care coverage, such as Medicare or a health plan from another employer, you may be able to coordinate benefits with Polaris Health Plus. Coordinating benefits means that both plans work together to pay for covered services. This coordination helps to ensure that you don’t pay more than you should for your health care.

When coordinating benefits, one plan pays first and the other plan pays what is left after the first plan has paid. The plan that pays first is called the primary plan, and the plan that pays second is called the secondary plan. Generally, the primary plan pays up to the amount of its allowed amount for the services you received. The secondary plan then pays the difference between what the primary plan paid and the total cost of the services.

The way in which you coordinate benefits will depend on the type of coverage you have.

Coordinating Benefits with Medicare

If you have Medicare, you may be able to coordinate benefits with Polaris Health Plus. Medicare is a federal health insurance program for people 65 years of age and older, people with certain disabilities, and people with End-Stage Renal Disease (ESRD). Polaris Health Plus is a secondary payer to Medicare, meaning that Medicare will pay first and then Polaris Health Plus will pay the remaining balance after Medicare has paid its portion.

If you have Medicare, you will need to use an in-network provider within the Polaris Health Plus network to coordinate benefits with your Medicare coverage. Medicare will pay first and then Polaris Health Plus will pay the remaining balance.

Coordinating Benefits with Other Employer Plans

If you are covered under a health plan from another employer, that plan is usually considered the primary payer and Polaris Health Plus is considered the secondary payer. Your other employer plan will pay first and then Polaris Health Plus will pay the remaining balance after the other employer plan has paid its portion.

To coordinate benefits with your other employer plan, you must use an in-network provider within the Polaris Health Plus network. You will need to provide your other employer plan's information in order to coordinate benefits.

Exceptions

There are a few exceptions to coordinating benefits with other health care plans. For example, you cannot coordinate benefits with a health plan that is not a major medical plan. Also, if you are enrolled in a health plan that is a high-deductible plan, you cannot coordinate benefits with Polaris Health Plus until you have met the deductible.

Tips

If you have other health care coverage, here are a few tips to help you coordinate benefits with Polaris Health Plus:

- Make sure you have your other health care plan's information handy when you use Polaris Health Plus.
- Always use an in-network provider within the Polaris Health Plus network to ensure that your benefits are coordinated correctly.
- Make sure you understand your plan's rules for coordinating benefits.
- Ask your doctor or other health care provider about the cost of services before you receive them to make sure that you are not paying more than you should.
- Read your Explanation of Benefits (EOB) carefully to make sure that your benefits are being coordinated correctly.

By understanding how to coordinate benefits with Polaris Health Plus and other health care plans, you can make sure that you are getting the most out of your health care coverage.

COB Definitions

WHAT IF I HAVE OTHER COVERAGE?

The term "Other Coverage" is defined as any other insurance, health plan, or other coverage which provides benefits and services for medical care that is also provided under the Polaris

Health Plus plan. This includes, but is not limited to, Medicare, TRICARE, Medicaid, employer-sponsored plans, and government-sponsored plans.

When you have Other Coverage, Polaris Health Plus follows something called “Coordination of Benefits” (COB). This means that Polaris Health Plus coordinates its benefits with the Other Coverage in order to ensure that you receive the maximum amount of benefits available to you. Polaris Health Plus will pay benefits only after the Other Coverage pays its benefits.

To understand how COB works, it is important to understand the following terms:

- Primary Coverage: This is the coverage that pays benefits first.
- Secondary Coverage: This is the coverage that pays benefits after the Primary Coverage has paid out its benefits.
- Crossover Claims: These are claims that are submitted to both the Primary Coverage and the Secondary Coverage at the same time.

In order for Polaris Health Plus to serve as the Secondary Coverage, you must provide us with a copy of the Explanation of Benefits (EOB) that you receive from your Primary Coverage. This will help us determine the benefits that are available to you under Polaris Health Plus.

For Crossover Claims, you should submit the claim to both Polaris Health Plus and your Primary Coverage. You must provide Polaris Health Plus with a copy of the EOB for the Primary Coverage, as well as a copy of the claim that you submitted to your Primary Coverage. This will allow us to determine the benefits that are available to you under Polaris Health Plus.

It is important to note that Polaris Health Plus does not cover any expenses that are considered to be the responsibility of the Primary Coverage. Additionally, Polaris Health Plus does not cover any expenses that are outside of the scope of coverage of the plan. Here are some tips to help you make the most of your Coordination of Benefits:

- Make sure that you provide Polaris Health Plus with a copy of the EOB from your Primary Coverage in order to determine the benefits that are available to you.
- Submit Crossover Claims to both your Primary Coverage and Polaris Health Plus.
- Be aware of any expenses that are considered to be the responsibility of the Primary Coverage.
- Be aware of any expenses that are outside of the scope of coverage of the plan.

By understanding how Coordination of Benefits works and following these tips, you can maximize your Polaris Health Plus benefits.

Primary And Secondary Rules

WHAT IF I HAVE OTHER COVERAGE?

When you have other coverage, the Polaris Health Plus plan has primary and secondary rules. This means that the Polaris Health Plus plan is the primary payer, and the other coverage is the secondary payer. The Polaris Health Plus plan pays first, and the other coverage pays second.

Exceptions

There are exceptions to this primary and secondary rules with the Polaris Health Plus plan. These exceptions include:

- If you are covered by Medicare Part A and/or Part B, your other coverage is the primary payer and the Polaris Health Plus plan is the secondary payer.
- If you are covered by Medicaid, your other coverage is the primary payer and the Polaris Health Plus plan is the secondary payer.
- If you are covered by TRICARE, your other coverage is the primary payer and the Polaris Health Plus plan is the secondary payer.
- If you are covered by a State Children's Health Insurance Program (CHIP), your other coverage is the primary payer and the Polaris Health Plus plan is the secondary payer.

Tips

It's important to know the primary and secondary rules of the Polaris Health Plus plan, and to understand any exceptions that may apply. Here are some tips that can help:

- Make sure you understand what type of coverage you have. This will help you understand which provider is the primary payer and which is the secondary payer.
- Keep track of all your medical expenses and bills. This will help you understand how much you need to pay out of pocket, and how much the primary and secondary payers will cover.
- Make sure you understand the rules and regulations of each coverage plan. This will help you understand when claims will be covered and what benefits you are eligible for.
- Know the deadlines for filing claims. This will help you ensure that you get the coverage you need and that your claims are processed in a timely manner.
- Ask questions if you are unsure about anything related to the Polaris Health Plus plan. The customer service representatives at Polaris Health can help you understand the primary and secondary rules, as well as any exceptions that may apply.

It’s important to understand the primary and secondary rules of the Polaris Health Plus plan, and to understand any exceptions that may apply. Following these tips can help you get the coverage you need and ensure that your claims are processed in a timely manner.

COB's Effect On Benefits

WHAT IF I HAVE OTHER COVERAGE? - COB's Effect On Benefits

When you have more than one health insurance policy, the policies coordinate benefits through a process called Coordination of Benefits (COB). Coordination of Benefits is a process that helps to determine which plan pays first when there are multiple health plans available. This process is important because it affects how much you will pay out-of-pocket for care.

When Polaris Health Plus is the primary insurance (the plan that pays benefits first), any other insurance you may have will become the secondary insurance and only pays benefits if there are unpaid charges from the primary plan. However, if Polaris Health Plus is the secondary plan, then it pays benefits after the primary plan has paid its share.

The amount Polaris Health Plus pays for a covered service depends on the coverage of the primary plan and the total amount charged for the service. Polaris Health Plus may pay up to the amount of the maximum allowable charge, which is the maximum amount the plan pays for a service.

If you have more than one health insurance policy, you may need to provide proof of the other coverage, such as an insurance card or a letter from the other insurer, to verify which plan is primary and which is secondary.

When you receive care, you may need to provide both your Polaris Health Plus insurance card and your other insurance card to the provider, so they can coordinate the benefits correctly.

When you receive care, you may need to provide both your Polaris Health Plus insurance card and your other insurance card to the provider, so they can coordinate the benefits correctly. It is important to note that Polaris Health Plus does not coordinate benefits with Medicare, Medicaid, or TRICARE programs.

When coordinating benefits, there are a few important exceptions to keep in mind. If you are covered by a spouse's health plan, the primary plan is usually the plan that covers the spouse and the secondary plan is usually the plan that covers you. Additionally, if you are covered by more than one group plan, the primary plan is usually the plan of the employer who has the most employees.

Following these tips can help you understand how COB works and how to get the most out of your health coverage:

- Understand the coverage of all of your health plans so that you know which plan is primary and which is secondary.

- Contact your health care providers and make sure they are aware of all of your coverage and that they know how to coordinate benefits.

- Keep copies of your insurance cards, letters from insurers, and other documents that explain your coverage.

- Contact Polaris Health Plus if you have any questions or need help understanding how COB works.

By understanding your coverage and being aware of how COB works, you can ensure that you are getting the most out of your health plan and that you are not paying more out of pocket than you need to.

Subrogation And Reimbursement

Subrogation and Reimbursement

Subrogation and reimbursement are two important concepts to understand when it comes to Polaris Health Plus insurance. Subrogation is the process by which Polaris Health Plus can seek reimbursement from another insurance company if you have secondary medical coverage. In other words, if you have coverage through Polaris Health Plus and another insurance provider, Polaris Health Plus may be able to recoup the costs of medical services they paid for from the other insurance company.

Reimbursement works in the opposite way. It is the process by which Polaris Health Plus can reimburse you for certain medical expenses that you paid for out-of-pocket. This is beneficial if you received medical services that were not covered by Polaris Health Plus.

When it comes to subrogation and reimbursement, it is important to note that Polaris Health Plus reserves the right to subrogate and reimburse any payments made for medical services. This includes payments made directly by you and other insurance companies. In the event that Polaris Health Plus is able to subrogate or reimburse payments, you will be notified of this before any funds are exchanged.

When it comes to subrogation, it is important to remember that Polaris Health Plus will only seek reimbursement from another insurer if your primary insurance coverage does not cover the services that you received. This means that if your primary insurance covers the services that you received, Polaris Health Plus will not seek reimbursement.

When it comes to reimbursement, there are certain exceptions to Polaris Health Plus's policy. For example, Polaris Health Plus will not reimburse you for any medical services that were covered by another insurance provider. Additionally, Polaris Health Plus will not reimburse you for any medical services that you received from an out-of-network provider, unless the service was deemed medically necessary and was not available from an in-network provider.

Finally, it is important to remember that Polaris Health Plus may require that you submit certain documentation in order to receive reimbursement. This documentation may include itemized bills, proof of payment, and/or medical records.

In order to ensure that you are able to take full advantage of Polaris Health Plus's subrogation and reimbursement policy, it is important to keep detailed records of all medical services that you receive. This includes records of payments made by you, other insurance companies, and Polaris Health Plus. Additionally, it is important to keep a record of any documentation you submit to Polaris Health Plus to support your reimbursement claim. Keeping these records will help to ensure that you receive the full reimbursement that you are entitled to under the Polaris Health Plus policy.

Uninsured And Underinsured Motorist/Personal Injury Protection Coverage WHAT IF I HAVE OTHER COVERAGE?

Uninsured and Underinsured Motorist/Personal Injury Protection Coverage

Uninsured and Underinsured Motorist (UM/UIM) coverage is an optional form of coverage that may be included in Polaris Health Plus. This coverage will help protect you and your passengers if you're injured in an accident caused by an uninsured or underinsured driver.

If you have UM/UIM coverage, it will provide coverage for medical bills, lost wages, and other expenses that you may incur as a result of an accident. However, it is important to note that UM/UIM coverage only applies when the other driver is at fault, and does not cover damage to your vehicle or property.

There are a few exceptions to the coverage provided by UM/UIM coverage. For example, it does not cover intentional acts of another driver, damage caused by an uninsured or underinsured driver in a hit-and-run accident, or damage to your vehicle or property.

It is important to understand the limits of your UM/UIM coverage and any exclusions that may apply. You should make sure to review your policy thoroughly to ensure that you are properly covered.

In addition to understanding the limits of your coverage, there are other tips that you can use to help protect yourself in the event of an accident.

First, make sure that you have a valid driver's license and that the other driver does as well. It's also important to make sure that the other driver has valid insurance coverage. You may want to ask to see proof of insurance before you get in the car.

If you do get into an accident, it's important to stay calm and take down the other driver's name, contact information, and insurance information. You should also call the police and make sure to file a police report. This will help provide evidence of the accident and can be used to pursue a claim with your insurance company.

Finally, if you do find yourself in an accident, make sure to contact your Polaris Health Plus insurance provider as soon as possible to file a claim. Your insurance company will be able

to help you understand the limits of your coverage and provide you with the resources you need to pursue a claim.

Having Uninsured and Underinsured Motorist/Personal Injury Protection Coverage through Polaris Health Plus can provide you and your passengers with peace of mind in the event of an accident. It's important to understand the limits of your coverage and any exclusions that may apply. It's also important to stay vigilant and always make sure that the other driver has valid insurance coverage. By following these tips, you can help protect yourself and your passengers in the event of an accident.

HOW DO I FILE A CLAIM?

Timely Filing

HOW DO I FILE A CLAIM?

Timely Filing

At Polaris Health Plus, it is important to file a claim within the set time frame in order to ensure that your claim is processed and you receive the benefits you are entitled to. Generally, you must file a claim within 90 days after you receive services or supplies.

Exceptions

There are some exceptions to the 90-day filing requirement. If you are filing a claim for a hospital stay, the claim must be filed within one year of the date of service. In addition, if you are filing a claim for a mental health, substance abuse, or preventive care services, the claim must be filed within one year of the date of service.

Tips

When filing a claim, it is important to submit all the necessary information, including the Polaris Health Plus claim form, the Polaris Health Plus ID card, and the provider's bill. In addition, make sure that the provider's bill includes the diagnosis and the service codes. It is also important to keep copies of the claim form, the provider's bill, and any other documents that you submit with the claim.

If you have any questions about the claims process, contact Polaris Health Plus customer service at 1-800-123-4567. Polaris Health Plus customer service representatives are available 24 hours a day, 7 days a week.

If you are filing a claim for a hospital stay, make sure to get a copy of the discharge summary from the hospital. This document should include the date and type of services provided, the diagnosis, and the service codes.

If you are filing a claim for a mental health, substance abuse, or preventive care services, make sure to get a copy of the summary of services from the provider. This document should include the date and type of services provided, the diagnosis, and the service codes.

It is also important to keep track of the claims you have submitted. Make sure to keep copies of all documents related to the claim, including the claim form, the provider's bill, and any other documents that you submit with the claim.

If you receive a denial of your claim, make sure to review the denial letter to understand why your claim was denied. If you still have questions, contact Polaris Health Plus customer service at 1-800-123-4567.

Finally, if you are filing a claim for a service that has already been paid for by another insurance company, make sure to include a copy of the Explanation of Benefits (EOB) from the other insurance company. This document should include the date and type of services provided, the diagnosis, and the service codes.

By following the tips outlined above, you can ensure that your claim is filed on time and that you receive the benefits you are entitled to. If you have any questions about the claims process, contact Polaris Health Plus customer service at 1-800-123-4567.

COMPLAINTS AND APPEALS

What You Can Appeal

COMPLAINTS AND APPEALS

What You Can Appeal

When you receive a denial of a claim or service under Polaris Health Plus, you have the right to appeal. This means you can challenge a decision made by Polaris Health Plus or your provider. You can appeal a coverage decision, including a denial of a claim, a denial of service, a determination of medical necessity, or a determination of out-of-network coverage. You can also appeal a payment decision regarding the amount of payment or the balance billed.

It is important to note that you may only appeal a decision made by Polaris Health Plus or your provider. You cannot appeal a decision made by your employer.

Here are some tips and exceptions to help you understand the appeals process.

- You must file your appeal within 60 days of the date of the denial letter or other written notification from Polaris Health Plus, unless Polaris Health Plus has given you more time.
- You should include all relevant medical and other information with your appeal. This may include medical records, test results, and/or other supporting documents.
- Polaris Health Plus will review your appeal and notify you in writing of their decision. The decision must be made within 30 days of receipt of your appeal.
- If Polaris Health Plus does not make a decision within the 30 day timeframe, you may consider the appeal to be denied and may file an external appeal to the California Department of Managed Health Care.

- If Polaris Health Plus denies your appeal, you may be able to file a second appeal with Polaris Health Plus.
- If Polaris Health Plus denies your second appeal, you may file an external appeal with the California Department of Managed Health Care.
- You may be able to get help with the appeals process from your employer or the benefits department.
- You may also want to contact a legal professional to help you with the appeals process.
- If Polaris Health Plus denies your appeal, you may be able to file a lawsuit against them.
- If Polaris Health Plus denies your appeal, you may be able to file a complaint with the California Department of Managed Health Care.

Understanding the appeals process can help you get the coverage and care you need. It is important to remember that you have the right to appeal a decision made by Polaris Health Plus or your provider. It is also important to remember that you must file your appeal within 60 days of the date of the denial letter or other written notification from Polaris Health Plus, unless Polaris Health Plus has given you more time. You should also include all relevant medical and other information with your appeal and contact a legal professional if you need help.

Appeal Levels

COMPLAINTS AND APPEALS

At Polaris Health Plus, we take complaints and appeals seriously, and we strive to provide our members with the highest quality of care. We have a multi-level process in place to ensure that any grievances are addressed and resolved quickly and fairly.

Level 1: Initial Review

This is the first step in the appeals process. If you have a problem with a service or product received, contact the plan's Customer Service team. The team will review your complaint to determine if a solution can be reached or if the complaint should be escalated to the next level.

Level 2: Formal Complaint

If a satisfactory resolution is not reached at Level 1, you may submit a formal written complaint to Polaris Health Plus. This should include details of the issue, the date and time of the incident, and the names of any involved personnel. It should also include any relevant documentation or other evidence that supports your claim.

Level 3: External Review

If the issue is not resolved at Level 2, you may request an external review to be conducted. This review will be conducted by an independent organization that is not affiliated with Polaris Health Plus. The external review will consider all facts and evidence that have been submitted in the appeal and make a final decision on the matter.

Exceptions

There are some exceptions to the appeals process. If the issue involves a claim that is more than one year old, the appeal must be denied. Additionally, if the claim was filed more than two years after the date of service, the appeal must also be denied.

Tips

If you have a complaint or appeal, it is important to remember the following tips:

- Gather all relevant evidence and documents that support your claim.
- Submit your complaint or appeal in writing and keep a copy for your own records.
- Be sure to include all relevant details such as the date and time of the incident.
- Follow the timeline outlined in the appeals process to ensure your complaint is addressed in a timely manner.
- Be patient and follow up with the plan if you have not heard back within a reasonable amount of time.

How To Submit An Appeal COMPLAINTS
AND APPEALS:

How To Submit An Appeal

At Polaris Health Plus, we understand that sometimes the coverage you receive is not what you expected or hoped for. If you believe that Polaris Health Plus has not properly applied a coverage determination or payment to your claim, you may submit an appeal.

What Is an Appeal?

An appeal is a formal request to reconsider a decision or action taken by Polaris Health Plus. This includes decisions on coverage and payment of services, supplies, or drugs. You or your healthcare provider can submit an appeal to Polaris Health Plus. In order to submit an appeal, you must provide information that supports your appeal.

How to Submit an Appeal

If you disagree with a coverage determination or payment made by Polaris Health Plus, you can appeal the decision. Here are the steps you need to take to submit an appeal:

Step 1: Gather Information

The first step in submitting an appeal is to gather the information you need. This includes any documents that support your appeal, such as receipts, doctors' notes, and lab test results. It is also important to have a copy of the explanation of benefits (EOB) that shows the decision made by Polaris Health Plus.

Step 2: Prepare Your Appeal

Next, you need to prepare your appeal. You will need to include a written request that explains why you are appealing the decision and any supporting documents. Be sure to include the claim number and the name of the service or drug that was denied. You should also include a copy of the EOB that shows the decision made by Polaris Health Plus.

Step 3: Submit Your Appeal

Once you have prepared your appeal, you can submit it to Polaris Health Plus. You can submit your appeal online, mail it to Polaris Health Plus, or fax it to the number provided in your EOB.

Step 4: Wait for a Response

Once you have submitted your appeal, Polaris Health Plus will review it and make a decision. You will receive a letter in the mail within 30 days of the date Polaris Health Plus received your appeal.

Exceptions

In certain situations, Polaris Health Plus may waive the normal time frames for appeals. This includes situations where waiting for a decision could result in a serious health risk or cause severe financial hardship. If this is the case, you can submit a request for an expedited appeal.

Tips for Submitting an Appeal

When submitting an appeal, keep these tips in mind:

- Make sure to include all relevant information, such as receipts, doctors' notes, and lab test results.
- Be sure to include a copy of the explanation of benefits (EOB) that shows the decision made by Polaris Health Plus.
- Be sure to include your claim number and the name of the service or drug that was denied.
- Submit your appeal online, mail it to Polaris Health Plus, or fax it to the number provided in your EOB.
- If you need an expedited appeal, be sure to include information that explains why you need it.

- You will receive a letter in the mail within 30 days of the date Polaris Health Plus received your appeal.

We understand that appealing a decision can be a confusing and time-consuming process. If you have any questions about submitting an appeal, please contact Polaris Health Plus for more information.

Once The IRO Decides

COMPLAINTS AND APPEALS: Once The IRO Decides

Once the Internal Review Officer (IRO) has made a decision on a complaint or appeal, the decision is final and binding. However, there are exceptions to this rule that employees should be aware of.

An exception to the IRO decision being final and binding may occur if an employee can prove that the decision was made in error. In this case, the employee may be eligible to file a grievance with the insurance company. The grievance must be filed within 180 days of the IRO's decision. The grievance must be in writing and should include supporting documentation that proves the decision was made incorrectly.

If the grievance is approved, the employee may be eligible to receive a refund of any premiums paid or benefit payments received in error. The employee should also be aware that an approved grievance may also result in changes to their coverage or benefits.

Another exception to the IRO decision being final and binding may occur if an employee can prove that the decision was based on incomplete or inaccurate information. In this case, the employee may be eligible to file an appeal with the insurance company. The appeal must be filed within 60 days of the IRO's decision. The appeal must be in writing and should include supporting documentation that proves the decision was based on incomplete or inaccurate information.

If the appeal is approved, the employee may be eligible to receive a refund of any premiums paid or benefit payments received in error. The employee should also be aware that an approved appeal may also result in changes to their coverage or benefits.

In addition to exceptions to the IRO decision being final and binding, employees should also be aware of tips to help ensure that the IRO decision is accurate. Employees should be sure to provide any and all supporting documentation when filing a complaint or appeal. This documentation should include medical records, prescriptions, bills, and any other relevant information. Employees should also be sure to provide contact information for any other providers involved in the complaint or appeal.

Employees should also be sure to provide a clear and concise explanation of their complaint or appeal. This explanation should include the dates of service, the providers involved, and the reason for the complaint or appeal. Employees should also be sure to provide any and all supporting documentation when filing a complaint or appeal.

Finally, employees should be sure to follow up on their complaint or appeal. Employees should contact the insurance company if they have not received a response within 30 days. Employees should also contact the IRO if they have any questions or concerns about the decision.

By understanding the exceptions and tips for making sure the IRO decision is accurate, employees can ensure that their complaint or appeal is heard and that the decision is made in their favor.

Additional Information About Your Coverage COMPLAINTS AND APPEALS

Polaris Health Plus offers a variety of ways for members to submit complaints and appeals. These procedures are designed to ensure that all members have the opportunity to have their issues addressed in a timely manner.

If you have a complaint or grievance about your coverage or care, you can contact Polaris Health Plus directly. You can submit a complaint or appeal by phone, mail, or online. You can also contact your insurance provider directly or the state insurance commissioner in your state.

If you have a complaint or grievance about the quality of care or services you received, you can contact Polaris Health Plus directly. You can submit a complaint or appeal by phone, mail, or online. You can also contact the state insurance commissioner in your state.

You may also be able to file a complaint or appeal with an external review organization. An external review organization is an independent entity that reviews complaints or appeals from members and makes a decision based on the facts of the case.

It's important to remember that the Polaris Health Plus plan does not cover some services, such as cosmetic surgery. In addition, some services may require prior authorization before being covered by the plan. If you have questions about what is covered, you should contact Polaris Health Plus directly.

If you are not satisfied with the outcome of a complaint or appeal, you may be able to file a lawsuit in a court of law. You should contact an attorney for more information about this option.

Finally, if you have a complaint or grievance about your rights as a member, you can contact the Polaris Health Plus Member Services Department. This department is dedicated to ensuring that all members have access to the services and benefits that they are entitled to under the plan.

Tips for Submitting Complaints and Appeals

When submitting a complaint or appeal to Polaris Health Plus, it's important to provide as much information as possible. This includes any documentation or evidence that may be

relevant to your case. Be sure to include your contact information and the details of your complaint or appeal.

It's also important to be patient. Polaris Health Plus typically responds to complaints and appeals within 30 days. However, some cases may take longer to resolve.

Finally, be sure to keep a record of all correspondence with Polaris Health Plus. This includes any phone calls, emails, or letters you send or receive. This will help ensure that your complaint or appeal is being addressed in a timely manner.

OTHER INFORMATION ABOUT THIS PLAN

Conformity With The Law

OTHER INFORMATION ABOUT THIS PLAN – CONFORMITY WITH THE LAW

Polaris Health Plus is in compliance with applicable state and federal laws and regulations, including the Employee Retirement Income Security Act (ERISA). This plan is also compliant with the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA).

Under ERISA, the plan must provide certain benefits, such as protection from discrimination, vesting rights, and reasonable notice of plan changes. The plan must also provide detailed information to participants, such as a Summary Plan Description (SPD), which outlines plan provisions and benefits.

Under the ACA, Polaris Health Plus must provide essential health benefits, such as ambulatory patient services, hospitalization, maternity and newborn care, preventive and wellness services, mental health and substance abuse services, and prescription drugs. The plan also must provide coverage for preventive services without cost sharing.

Under MHPAEA, the plan must provide comparable benefits for mental health and substance abuse services as it does for medical and surgical benefits. This includes covering services that are medically necessary, such as inpatient and outpatient services, medication management, and psychological and psychosocial therapies.

It is important to note that the plan may not provide coverage or impose any limits or exclusions that are not in compliance with applicable laws and regulations. Additionally, the plan may not discriminate against individuals based on their medical condition or health status. Individuals who feel they have been discriminated against should contact the Department of Labor, who can investigate the issue.

Finally, it is important to note that the plan may not provide coverage or impose any limits or exclusions that are not in compliance with applicable laws and regulations. Additionally, the plan may not discriminate against individuals based on their medical condition or health status. Individuals who feel they have been discriminated against should contact the Department of Labor, who can investigate the issue.

Tips for Employees:

1. Read your Summary Plan Description (SPD) carefully to understand the benefits available to you under Polaris Health Plus.

2. Familiarize yourself with the applicable laws and regulations, such as ERISA, the Affordable Care Act (ACA), and the Mental Health Parity and Addiction Equity Act (MHPAEA).

3. Be aware of the coverage and limits your plan provides.

4. Be aware of any exclusions or exceptions that may apply to your plan.

5. If you feel you have been discriminated against, contact the Department of Labor.

By understanding the applicable laws and regulations and the coverage and limits of your plan, you can ensure that you are getting the most out of your Polaris Health Plus benefits.

Entire Contract

OTHER INFORMATION ABOUT THIS PLAN - Entire Contract

The Polaris Health Plus plan is a contract between you and Polaris Health. It is important to understand that this document contains the entire contract. This contract includes the plan documents that you receive from Polaris Health, the Polaris Health Plus plan summary, and any additional contracts or documents that you may have received from Polaris Health.

It is important to remember that any changes made to this plan must be in writing and signed by both you and Polaris Health. Additionally, if something in the plan is not included in the plan documents or summary, then it does not apply to the plan.

You should also be aware that the Polaris Health Plus plan may contain certain exceptions, exclusions, and limitations. It is important to familiarize yourself with the plan documents to make sure that you understand what services are covered and which are not covered. If you have any questions, Polaris Health has customer service representatives who are available to answer your questions.

Additionally, Polaris Health may make changes to the plan at any time. You should make sure to check the plan documents or summary regularly to stay informed of any changes that have been made to the plan.

Finally, it is important to remember that the Polaris Health Plus plan is not a substitute for a regular health insurance plan. This plan is intended to supplement your existing health insurance coverage. It is important to make sure that you have adequate coverage for all of your medical needs.

These are just a few tips to help you understand the Polaris Health Plus plan and to make sure that you are taking advantage of all the benefits it offers. Remember, it is important to

read the plan documents carefully and to ask questions if you have any. By doing so, you can make sure that you are getting the most out of your Polaris Health Plus plan.

Evidence Of Medical Necessity

OTHER INFORMATION ABOUT THIS PLAN: Evidence of Medical Necessity

Evidence of medical necessity is an important component of health insurance coverage. It is an indication that a certain service or treatment is medically necessary for a patient's health and wellbeing. The Polaris Health Plus plan requires evidence of medical necessity when a service or treatment is being requested.

What Is Evidence of Medical Necessity?

Evidence of medical necessity is documentation that is provided by a healthcare provider or other healthcare professionals to support a request for a specific service or treatment. This documentation should provide detailed information about the patient's medical condition, the recommended service or treatment, and why it is medically necessary.

Evidence of medical necessity is typically required when requesting services or treatments that are not commonly used or are more costly than other services or treatments. This requirement helps to ensure that the patient is receiving the most appropriate care and that the services or treatments being requested are medically necessary.

What Types of Services and Treatments Require Evidence of Medical Necessity?

The Polaris Health Plus plan requires evidence of medical necessity for a variety of services and treatments, including:

- Durable medical equipment (DME)
- Home health services
- Skilled nursing services
- Physical, occupational, and speech therapy services
- Mental health services
- Substance abuse services
- Infertility treatments
- Bariatric surgery
- Sleep studies
- Inpatient hospital services

It is important to note that the Polaris Health Plus plan may require additional documentation for certain services or treatments, such as preauthorization or prior

authorization. It is also important to note that the Polaris Health Plus plan may not cover certain services or treatments, such as those deemed to be experimental or investigational.

Tips For Obtaining Evidence of Medical Necessity

The following tips can help you obtain evidence of medical necessity for services or treatments that are covered by the Polaris Health Plus plan:

- Talk to your healthcare provider about the services or treatments you are requesting. Your provider should be able to provide you with the necessary documentation to support your request.
- Make sure that you provide your healthcare provider with all of the relevant information about your medical condition, such as your medical history, any recent lab tests or imaging studies, and any other pertinent information.
- Make sure that the documentation you provide is complete and accurate.
- Contact your healthcare provider if you have any questions or concerns about the services or treatments you are requesting.
- Make sure that the documentation you provide is submitted to Polaris Health in a timely manner.
- Contact Polaris Health if you have any questions or concerns about the evidence of medical necessity requirements for the services or treatments you are requesting.

By following these tips, you can help ensure that your request for services or treatments is approved in a timely manner and that you are receiving the most appropriate care.

Conclusion

Evidence of medical necessity is an important component of health insurance coverage, and it is important to understand the requirements of the Polaris Health Plus plan in order to obtain the services or treatments you need. By following the tips outlined above, you can help ensure that your request for services or treatments is approved in a timely manner and that you are receiving the most appropriate care.

The Group And You

OTHER INFORMATION ABOUT THIS PLAN

The Group and You

The Polaris Health Plus plan is a group health plan that is sponsored by Contoso and administered by Polaris Health. As a participant in this group plan, you will have access to a wide range of health benefits and services.

Your employer, Contoso, pays a portion of the premium for the plan, and you are responsible for paying the remaining portion. This will be deducted directly from your paycheck each

month. In addition to the premium, you may be responsible for certain costs when you receive health care services.

Your contributions to the plan are based on the type of coverage you choose. For example, if you choose a single plan, you will pay a lower premium than if you choose a family plan. The premium and other costs you may incur when you receive health care services may change from year to year.

It is important to note that you may be subject to certain exclusions or limitations on your coverage, such as pre-existing condition exclusions and/or waiting periods. You should review your plan documents carefully to make sure you understand exactly what is covered and what is excluded.

It is also important to understand that the plan is not a substitute for health insurance. You should still maintain health insurance coverage through an employer, a private plan, or a government-sponsored plan. The Polaris Health Plus plan is intended to supplement the coverage you have from other sources.

Tips for Making the Most of Your Plan

- Make sure you understand your plan documents and know what is covered and what is excluded.
- Take advantage of preventive care services, such as check-ups and screenings, as these will help you stay healthy and avoid more costly treatments down the road.
- Consider signing up for the Polaris Health Plus online portal, which allows you to view your health plan information, make payments, and access other resources.
- Take advantage of Polaris Health's 24/7 nurse hotline, which can provide you with medical advice and other assistance.
- Use your plan's in-network providers whenever possible, as this will help you save money.
- Utilize Polaris Health's online pharmacy service, which allows you to easily order and manage your prescriptions without leaving home.
- When you receive health care services, make sure to check that the provider is in-network and that the services are covered by your plan.
- Keep track of your claims and other plan information, as this will help you to better understand your plan and stay on top of your health care expenses.
- Utilize Polaris Health's customer service to answer any questions or address any concerns you may have about your plan.

Healthcare Providers - Independent Contractors OTHER INFORMATION ABOUT THIS PLAN

Healthcare Providers - Independent Contractors

The Polaris Health Plus plan includes coverage for healthcare services provided by independent contractors. This means that services provided by independent contractors may be covered under the Polaris Health Plus plan, provided that the service is medically necessary.

Independent contractors are healthcare providers that are not employed by Polaris Health or any other company or organization. They are self-employed and provide services on a contract basis. These services can include medical, vision, and dental services, as well as prescription drug coverage and mental health and substance abuse coverage.

It is important to note that services provided by independent contractors are not covered under the Polaris Health Plus plan unless they are necessary to treat an illness or injury. For example, a physical therapist who is an independent contractor may be covered under the plan if the services are necessary to treat an illness or injury. However, services provided by an independent contractor that are not medically necessary, such as a massage therapist or acupuncturist, are not covered under the plan.

When selecting a healthcare provider, it is important to make sure that the provider is an independent contractor and is covered under the Polaris Health Plus plan. You can do this by checking the provider's website or calling the provider's office to confirm that they are an independent contractor and that their services are covered under the Polaris Health Plus plan.

It is also important to note that any services that you receive from an independent contractor may be subject to a deductible or coinsurance. This means that you may be responsible for a portion of the cost of the service. It is important to check with the provider to confirm the cost of the service before receiving any services.

Finally, it is important to remember that services that are provided by an independent contractor are not covered under the Polaris Health Plus plan unless they are necessary to treat an illness or injury. If you have any questions about whether a service is covered under the plan, it is important to contact Polaris Health or the healthcare provider to confirm coverage.

Intentionally False Or Misleading Statements

OTHER INFORMATION ABOUT THIS PLAN: Intentionally False or Misleading Statements

It's important to be aware of intentionally false or misleading statements when it comes to health insurance plans. Intentionally false or misleading statements about Polaris Health Plus can be found in any form of advertisement, marketing material, or other communication that is intended to influence a person's decision to purchase the plan.

In order to protect yourself from being misled, it's important to read all the materials you receive from Polaris Health Plus carefully. This includes any emails, mailers, brochures, website materials, or other communications. Be sure to read the plan's Summary of Benefits and Coverage (SBC) for a complete description of the plan's coverage, benefits, and limitations.

Some of the statements that may be considered intentionally false or misleading include:

- Claiming that the plan covers services that it does not cover, such as cosmetic surgery or experimental treatments.
- Claims that the plan has "no deductible" or "no out-of-pocket costs."
- Claims that the plan covers "all" medical services or "everything."
- Claims that the plan has lower premiums than other plans.
- Claims that the plan will cover medical expenses that are not covered by other plans.
- Claims that the plan covers pre-existing conditions.
- Claims that the plan covers all prescription drugs.

It's also important to be aware of statements that are misleading because of their omission of important information. For example, a statement that the plan has "low copays" may be misleading if it does not also mention the fact that the plan has high deductibles.

It's also important to remember that Polaris Health Plus may have restrictions on certain services or treatments. Be sure to read the plan's Summary of Benefits and Coverage (SBC) for a complete description of the plan's coverage, benefits, and limitations.

If you become aware of any intentionally false or misleading statements about Polaris Health Plus, be sure to report it to the plan administrator immediately. You can also contact the North Carolina Department of Insurance to file a complaint.

It's important to remember that Polaris Health Plus is a complex plan and you should always ask questions and read all materials carefully before making any decisions. It's important to be aware of the coverage that is available to you, as well as any restrictions or limitations. Be sure to contact the plan administrator if you have any questions or concerns.

Member Cooperation

MEMBER COOPERATION

Polaris Health Plus requires that members cooperate with their plan and use the services covered by the plan in the most cost-effective manner. This includes following the rules and regulations of the plan and using services in the most appropriate and beneficial way.

It is the members' responsibility to make sure they are using the plan in the most costeffective manner. This includes understanding the plan's benefits and coverage

including any limitations, exclusions, and exceptions. Members are expected to use in-network providers and to get pre-authorization or prior approval when required by the plan. Members must also use generic medications when available, and they must also follow the plan's rules for referrals and second opinions.

Members are also expected to provide accurate information to Polaris Health Plus and the plan's providers. This includes medical history, current medical condition, and any other information that is requested by the plan or providers. Failing to provide accurate information can result in the denial of coverage or benefits.

In addition, members must keep the plan informed of any changes in their contact information or other personal information. This includes changes in address, phone number, and insurance coverage.

EXCEPTIONS

The plan may make exceptions to some of its requirements in certain circumstances. For example, the plan may waive its pre-authorization or prior approval requirements in certain cases. Members must speak directly with the plan in order to request a waiver.

TIPS

Here are some tips to help members get the most out of Polaris Health Plus:

• Become familiar with the plan's coverage and any limitations, exclusions, or exceptions.

• Make sure to use in-network providers and to get pre-authorization when required.

• Use generic medications when available.

• Follow the plan's rules for referrals and second opinions.

• Provide accurate information to the plan and its providers.

• Keep the plan informed of any changes in personal information.

• Contact the plan when requesting a waiver.

By following these tips and understanding the plan's coverage, members can make sure they are getting the most out of Polaris Health Plus.

Notice Of Information Use And Disclosure

OTHER INFORMATION ABOUT THIS PLAN: Notice of Information Use and Disclosure

At Polaris Health, we understand that your personal health information and health plan information is important to you and must be handled responsibly. This section of the document outlines the information use and disclosure practices of Polaris Health Plus.

Notice of Information Use and Disclosure

Polaris Health Plus is required to protect the privacy of your protected health information (PHI) and provide you with notice of our legal duties and privacy practices.
Polaris Health Plus must follow the terms of the Notice of Information Use and Disclosure currently in effect and will not use or disclose your PHI without your authorization, except as described in this Notice.

Your PHI includes information that can be used to identify you and that relates to your past, present, or future physical or mental health or condition, and related health care services. This includes information such as your name, address, telephone number, date of birth, and Social Security number. Polaris Health Plus may use and disclose your PHI for the following purposes:

Treatment: Polaris Health Plus may use and disclose your PHI to provide you with treatment, including coordination and management of your health care and payment for your health care services. This includes making referrals to specialists and other health care providers, and providing follow-up care.

Payment: Polaris Health Plus may use and disclose your PHI to obtain payment for your health care services. This includes billing, collecting payment, and determining eligibility for benefits.

Health Care Operations: Polaris Health Plus may use and disclose your PHI for health care operations. This includes quality assessment and improvement activities, customer service, legal and compliance activities, and business planning and development.

Exceptions: In certain circumstances, Polaris Health Plus may use or disclose your PHI without your authorization. These exceptions include:

- Disclosures required by law
- Public health activities
- Victim of abuse, neglect, or domestic violence
- Health oversight activities
- Organ and tissue donation
- Research
- Marketing
- Inmates
- Judicial and administrative proceedings
- Law enforcement

Your Rights Regarding Your PHI

You have the following rights regarding your PHI:

- Right to inspect and copy. You have the right to inspect and copy your PHI.
- Right to amend. You have the right to amend your PHI.
- Right to request restrictions. You have the right to request restrictions or limitations on Polaris Health Plus' use or disclosure of your PHI.
- Right to receive an accounting. You have the right to receive an accounting of Polaris Health Plus' disclosures of your PHI.
- Right to receive confidential communications. You have the right to receive communications of your PHI from Polaris Health Plus by alternative means or at alternative locations.
- Right to file a complaint. You have the right to file a complaint with Polaris Health Plus or the Secretary of the Department of Health and Human Services if you feel that Polaris Health Plus has violated your privacy rights.

Tips for Employees

- Make sure to keep your records up-to-date and accurate.
- Be aware of the exceptions to the Notice of Information Use and Disclosure.
- Understand your rights regarding your PHI.
- Be aware of the possible uses and disclosures of your PHI.
- Be sure to read the Notice of Information Use and Disclosure before signing any authorizations for the use or disclosure of your PHI.
- Ask questions if you do not understand anything in the Notice of Information Use and Disclosure.
- Know that you have the right to file a complaint if you feel your privacy rights have been violated. Conclusion

Polaris Health Plus is committed to protecting the privacy of your PHI. We will use and disclose your PHI only as allowed by law and in accordance with the terms of the Notice of Information Use and Disclosure. We urge you to read and understand the Notice of Information Use and Disclosure before signing any authorizations for the use or disclosure of your PHI. If you have any questions or concerns, please do not hesitate to contact Polaris Health Plus.

Notice Of Other Coverage

OTHER INFORMATION ABOUT THIS PLAN:

Notice Of Other Coverage

If you have coverage under another health insurance plan, you should determine which plan is primary and which is secondary. The plan that pays first is called the primary payer, and the plan that pays second is called the secondary payer. Generally, the primary payer pays up to the limits of its coverage and the secondary payer then pays any remaining balance.

However, there are certain exceptions that should be noted:

- If you are covered by Medicare, it will generally be the primary payer and Polaris Health Plus will be the secondary payer.
- If you are covered by Medicaid, Polaris Health Plus will generally be the primary payer, and Medicaid will be the secondary payer.
- If you are covered by a Health Maintenance Organization (HMO), Polaris Health Plus will generally be the secondary payer.
- If you are covered by a Preferred Provider Organization (PPO), Polaris Health Plus will generally be the primary payer.

It is important to note that if the other coverage is not properly disclosed, Polaris Health Plus may deny payment of a claim, or may require you to pay back any payments made on your behalf. In order to avoid this, you should always provide accurate and up-to-date information regarding any other coverage you may have.

Tips for Employees

- Be sure to inform Polaris Health Plus of any other coverage you may have.
- If you have any questions about which plan is primary and which is secondary, contact Polaris Health Plus or the other insurance plan to get clarification.
- Make sure to keep track of all the services you receive and the payments you make.
- Understand your coverage limits, and know what services are covered and what services are not covered.
- If you receive services from an out-of-network provider, you may be responsible for paying the full cost of those services.
- If you have any disputes with Polaris Health Plus, you should contact them immediately to resolve the issue.

By familiarizing yourself with the details of the Polaris Health Plus plan and understanding the Notice of Other Coverage, you can make informed decisions about your coverage and ensure that you are making the most of your benefits.

Notices

OTHER INFORMATION ABOUT THIS PLAN: Notices

Polaris Health Plus requires members to provide certain notices and acknowledgments in order to receive services. It is important that members are aware of these, as they can affect the coverage they receive.

Pre-Service Notices:

Polaris Health Plus requires members to provide a pre-service notice before receiving any services. This notice should include the name, address, and phone number of the provider, the type of service to be provided, and the estimated cost of the service. This notice should be provided to the insurance company at least 30 days before the date of service, or as soon as reasonably possible if the service is an emergency.

Post-Service Notices:

Polaris Health Plus also requires members to provide a post-service notice after receiving any services. This notice should include a description of the services provided, the date of service, the cost of the service, and any applicable discounts or adjustments. This notice should be provided to the insurance company within 180 days of the date of service.

Exceptions and Tips:

There are a few exceptions to the pre-service and post-service notices requirements. For services related to mental health, substance abuse, and preventive care, members are not required to provide a pre-service notice. Additionally, members who receive services from an out-of-network provider are not required to provide a post-service notice.

It is important for members to be aware of these notice requirements and to submit the required notices in a timely manner. If a member does not provide the required notice, the insurance company may deny or reduce the claim. In order to ensure that claims are processed correctly and quickly, members should always provide the required notices in a timely manner. Additionally, members should keep copies of all notices for their own records.

Right Of Recovery

OTHER INFORMATION ABOUT THIS PLAN: Right of Recovery

The Right of Recovery provision in Polaris's Health Plus plan allows you to file a claim with the insurance company if you have already paid a bill for a medical service that is covered under the plan. This is important because it can help you recover any expenses that you have already paid out-of-pocket, including co-pays, co-insurance, and deductibles.

Under this provision, you must first file a claim with the insurance company, and then the insurance company can attempt to recover the money that you have already paid from the

provider who charged you. In some cases, if you have already paid the provider, they may be willing to reimburse you directly.

However, there are some restrictions and exceptions to this provision that you should be aware of. First, the Right of Recovery provision only applies to services that are covered under the plan. It does not apply to services that are not covered or services that are subject to limitations or exclusions. Second, the Right of Recovery provision only applies to claims that are filed within six months of the date of service.

Also, keep in mind that the Right of Recovery provision does not guarantee that the insurance company will be able to recover the money that you have already paid. The insurance company may be unable to recover the money that you have paid, or they may not be able to recover the entire amount. In these cases, the insurance company may offer to reimburse you for some portion of the money that you have already paid.

Finally, if you have already paid a provider for a service that is covered under the plan, it is important to keep any receipts or other documentation. This documentation will be necessary if you decide to file a Right of Recovery claim with the insurance company.

To sum up, the Right of Recovery provision in Polaris's Health Plus plan is a great way to help you recover any money that you have already paid for medical services that are covered under the plan. However, there are some restrictions and exceptions to this provision, so be sure to review the plan documents carefully before filing a claim.
Additionally, if you have already paid a provider for a service that is covered under the plan, be sure to keep any receipts or other documentation, as this may be necessary if you decide to file a claim.

Right To And Payment Of Benefits

OTHER INFORMATION ABOUT THIS PLAN: Right To And Payment Of Benefits

Under the Polaris Health Plus plan, members are entitled to receive the benefits listed in the plan documents. These benefits can be received from any in-network provider, as long as all eligibility requirements are met. The plan pays for covered health care services and supplies, including preventive care services, at the rates specified in the plan documents.

The plan pays for covered services only after the member has met their annual deductible. The plan pays for covered services after the member has met the annual deductible, up to the maximum out-of-pocket limit. The maximum out-of-pocket limit will be specified in the plan documents. For covered services, Polaris Health Plus pays either a percentage of the cost or a fixed dollar amount, whichever is less.

Polaris Health Plus also pays for services that are not listed in the plan documents, if the health care provider determines that such services are medically necessary. This includes services that are not covered under the plan, such as experimental treatments and services for cosmetic purposes.

Polaris Health Plus also pays for emergency services, both in-network and out-ofnetwork. To be eligible for coverage, the emergency must meet certain criteria, as specified in the plan documents. If the emergency services do not meet the criteria, the member may be responsible for the full cost of the services.

In addition, Polaris Health Plus may pay for services that are not covered under the plan, if the health care provider determines that such services are medically necessary. The plan will pay for these services at the rates specified in the plan documents.

It is important to note that all payments are subject to the terms and conditions of the plan, including any applicable copayments, coinsurance, and deductible amounts. Members should always check with their health care provider to determine if a service is covered under the plan and the amount that will be paid for the service.

It is also important to note that Polaris Health Plus does not pay for any services that are not medically necessary. Any services that are deemed to be for cosmetic purposes, experimental treatments, or not medically necessary will not be covered under the plan.

Members should also keep in mind that the plan may not cover certain services if the member has not met certain requirements, such as obtaining a referral from a primary care physician or pre-authorization from Polaris Health Plus.

Finally, Polaris Health Plus may require pre-certification or pre-authorization for certain services. It is the responsibility of the member to ensure that pre-certification or pre-authorization is obtained prior to receiving services. Failure to obtain pre-certification or pre-authorization may result in the member being responsible for the full cost of the services.

In summary, Polaris Health Plus provides comprehensive coverage for medical, vision, and dental services, as well as prescription drug coverage, mental health and substance abuse coverage, and coverage for preventive care services. The plan pays for covered services after the member has met the annual deductible, up to the maximum out-of-pocket limit. The plan may also pay for services that are not listed in the plan documents, if the health care provider determines that such services are medically necessary. It is important to note that all payments are subject to the terms and conditions of the plan, and that members should always check with their health care provider to determine if a service is covered under the plan and the amount that will be paid for the service.

Venue

OTHER INFORMATION ABOUT THIS PLAN

Venue

Under the terms of Polaris Health Plus, if you or Polaris Health disagree about the terms of your coverage or benefits, either of you may choose to start a formal legal process. If this happens, it is important to understand the venue of a legal action. This section will describe the venue of such a legal action.

In general, the venue of any legal action brought against Polaris Health will be the state where the policyholder resides. This means that if a policyholder lives in San Francisco, California, then the legal action will be brought in state of California. In cases where the policyholder does not live in the state where the policy is issued, the venue will be determined by the law of the policyholder's home state.

However, there are some exceptions to this rule. For example, if the policyholder resides in a state that does not have a law that provides for venue selection, then the venue will be determined by the law of the state where the policy was issued. Additionally, if the policyholder and Polaris Health have agreed to another venue in writing, then that venue will be the one used.

It is important to note that when it comes to legal actions, the venue selected may have an impact on the outcome of the case. Therefore, it is important to understand the venue rules before bringing a legal action against Polaris Health.

Tips

When it comes to selecting a venue for a legal action against Polaris Health, there are a few tips that may be helpful. First and foremost, it is important to understand the laws of the state in which the policyholder resides. This will help to determine which state's laws the venue should be selected by.

It is also important to remember that Polaris Health and the policyholder can agree to a different venue in writing. If both parties agree to a different venue, then that venue will be the one used.

Lastly, it is important to note that the venue of a legal action may have an impact on the outcome of the case. Therefore, it is important to understand the venue rules and make sure that the venue is selected carefully.

Women's Health and Cancer Rights Act of 1998 OTHER INFORMATION ABOUT THIS PLAN Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that requires certain group health plans and health insurance issuers that provide coverage for mastectomy-related services to provide coverage for certain post-mastectomy procedures. This includes prostheses and reconstructive surgery, as well as other services that are medically necessary for the completion of the mastectomy.

Under the WHCRA, Polaris Health Plus plans must provide coverage for the following services:

- All stages of reconstruction of the breast on which the mastectomy was performed, including reconstruction of the other breast to produce a symmetrical appearance, and surgery and reconstruction of the other breast to produce a symmetrical appearance.

- Surgery and reconstruction of the breast and chest wall, including surgery and reconstruction of the chest wall to correct conditions caused by the mastectomy.
- Prostheses and physical complications of the mastectomy, including lymphedemas.
- Treatment of physical complications of the mastectomy, including lymphedemas.

In addition, plans must provide coverage for all stages of mastectomy, including:

- Surgery on the affected breast, including partial and total mastectomy, lymph node removal, and lymph node dissection.
- Surgery on the other breast to produce a symmetrical appearance.
- Reconstructive surgery, including breast reconstruction, breast implants, and flap surgery.
- Treatment of physical complications at all stages of the mastectomy, including lymphadenectomy and lymph node dissection.

The WHCRA also requires that Polaris Health Plus plans cover necessary services that are provided in connection with a mastectomy, including:

- Hospitalization
- Second surgical opinions
- Surgical dressings
- Patient education

Exceptions

There are some exceptions to the WHCRA requirements. Plans are not required to cover services that are:

- Experimental or investigational
- Not medically necessary
- Cosmetic
- Not related to the mastectomy
- Provided by a family member
- Not covered by the plan or health insurance issuer

Tips for Employees

The WHCRA is an important law that provides protections for women who have undergone a mastectomy. Here are a few tips for employees to remember when it comes to the WHCRA:

- Make sure to understand the coverage provided by your Polaris Health Plus plan for mastectomy-related services.
- Understand that plans are not required to cover services that are experimental or investigational, not medically necessary, or cosmetic.
- Remember that you may be able to receive a second opinion from another doctor if you are considering a mastectomy.
- Don't be afraid to ask your doctor or health care provider questions about the services that are covered under the WHCRA.
- Be sure to keep all receipts and paperwork related to your mastectomy and postmastectomy procedures. This can help to ensure that you are being properly reimbursed for your care.
- If you have any questions or concerns about your coverage, contact your Polaris Health Plus plan administrator.

Workers' Compensation Insurance

OTHER INFORMATION ABOUT THIS PLAN:

Workers' Compensation Insurance

Employees of Contoso are protected by Polaris Health Plus's Workers' Compensation Insurance. This insurance provides compensation for medical and wage loss expenses should an employee be injured or become ill as a result of their job duties.

When an employee is injured or becomes ill due to job-related activities, they are entitled to receive medical and wage loss benefits. The medical benefits may include medical and hospital care, prescription drugs, medical appliances, and other related services. Wage loss benefits include compensation for the time that the employee is unable to work due to the injury or illness.

It is important to note that Workers' Compensation Insurance does not cover personal injuries that are not related to an employee's job duties, such as an injury resulting from a car accident. Also, if an employee is injured while engaging in illegal activities, they are not eligible for Workers' Compensation Insurance coverage.

Employees should report any injuries or illnesses to their supervisor as soon as possible in order to ensure that their claim is handled in a timely manner. Employees should also be aware that their employer must have the appropriate paperwork on file in order for them to be eligible for Workers' Compensation Insurance coverage.

In some cases, an employee may be able to receive additional benefits beyond what is provided by Workers' Compensation Insurance. These benefits may include disability benefits, unemployment benefits, or Social Security benefits. It is important for employees

to research these options in order to determine if they are eligible for any additional benefits.

When an employee is injured or becomes ill, they should contact the Workers' Compensation Insurance provider immediately. The provider will provide the employee with information on the process and how to file a claim. The provider may also provide additional resources to help the employee understand their rights and responsibilities.

It is important for employees to remember that Workers' Compensation Insurance is a benefit that is provided by the employer. It is the employer's responsibility to ensure that employees are aware of the Workers' Compensation Insurance coverage and to make sure that employees are taking advantage of the coverage.

Finally, it is important for employees to remember that Workers' Compensation Insurance does not cover all injuries or illnesses. If an employee has any questions or concerns about their coverage, they should contact their employer or the Workers' Compensation Insurance provider for more information.

DEFINITIONS

Definitions

It is important for employees to understand the definitions of certain terms when it comes to their health insurance plan. The following definitions will help employees obtain a better understanding of Polaris Health Plus.

Copayment: A copayment, also known as a copay, is the fixed amount that an employee pays for a covered service. This amount is usually a flat fee and is due at the time of service.

Deductible: A deductible is the amount of money that an employee must pay out-of-pocket before the plan begins paying for covered services. Polaris Health Plus has a deductible of $2,000 per year.

Coinsurance: Coinsurance is the percentage of the cost of a covered service that an employee must pay after the deductible is met. Polaris Health Plus has a coinsurance of 20%.

Out-of-Pocket Maximum: The out-of-pocket maximum is the maximum amount of money that an employee has to pay for covered services in a plan year. This amount includes the deductible, coinsurance, and copayments. Polaris Health Plus has an out-of-pocket maximum of $4,000 per year.

In-Network Provider: An in-network provider is a health care provider or facility that is contracted with the insurance company. Employees who use an in-network provider will have lower copayments and coinsurance amounts than those who use an out-of-network provider.

Out-of-Network Provider: An out-of-network provider is a health care provider or facility that is not contracted with the insurance company. Employees who use an out-of-network

provider will have higher copayments and coinsurance amounts than those who use an innetwork provider.

Exceptions

Polaris Health Plus does have some exceptions to the rules regarding copayments, deductibles, coinsurance, and out-of-pocket maximums.

Preventive Care: Preventive care services such as annual physicals and vaccinations are covered at 100% with no copayment, deductible, or coinsurance.

Prescription Drugs: Prescription drugs are generally subject to a copayment, and the amount varies depending on the type of drug. Generic drugs typically have a lower copayment than brand-name drugs.

Mental Health and Substance Abuse Services: These services are subject to a copayment and deductible. The copayment and deductible amounts can vary depending on the type of service.

Emergency Services: Emergency services are subject to a copayment and deductible, but the amount can vary depending on whether the services are received in-network or out-ofnetwork.

Tips

- Always check to see if a provider is in-network or out-of-network before receiving services.
- Ask your doctor about generic drugs if you are prescribed a medication.
- Contact Polaris Health if you have any questions about your coverage or benefits.
- Keep track of your out-of-pocket expenses to ensure you do not exceed the out-of-pocket maximum.
- Be aware of any copayments, deductibles, and coinsurance amounts that apply to your health care services.
- Take advantage of preventive care services as they are covered at 100% with no out-ofpocket costs.