Polaris Health Standard Plan

Summary of Benefits

Polaris Standard

Polaris Standard is a basic plan that provides coverage for medical, vision, and dental services. This plan also offers coverage for preventive care services, as well as prescription drug coverage. With Polaris Standard, you can choose from a variety of in-network providers, including primary care physicians, specialists, hospitals, and pharmacies. This plan does not offer coverage for emergency services, mental health and substance abuse coverage, or out-of-network services.

SUMMARY OF YOUR COSTS

Summary of Your Costs

When you choose Polaris Standard as your health plan, you can rest assured that you are getting comprehensive coverage at an affordable cost. Here, we will explain the various costs associated with this plan so that you know what to expect when it comes to your outof-pocket expenses.

Premiums

Premiums are the amount of money that you will need to pay each month for your coverage. Polaris Standard requires that premiums be paid on a monthly basis in order to keep the coverage in force. These premiums are based on the age and health of the policy holder, as well as the type of coverage that is chosen.

Deductibles

A deductible is the amount of money that you will need to pay out of pocket before your insurance plan will begin to cover the costs of your medical services. The deductible for Polaris Standard is $2,000 per person, per year. This means that you will need to pay the first $2,000 of your medical expenses before the plan will begin to cover the remaining amount.

Co-payments and Co-insurance

Once you have met your deductible, you will be responsible for co-payments and coinsurance. Co-payments are a fixed amount that you will need to pay at the time of service, while co-insurance is a percentage that you will need to pay. For Polaris Standard, the co-payment is $30 for primary care visits and $50 for specialist visits. The co-insurance is 20% of the remaining cost after the deductible has been met.

Out-of-Pocket Maximum

The out-of-pocket maximum for Polaris Standard is $6,000 per person, per year. This is the maximum amount that you will need to pay for your medical expenses in a given year.

Once you have reached this limit, the plan will cover 100% of your expenses for the remainder of the year.

Tips for Managing Your Costs

There are several steps that you can take to help manage your costs when you are enrolled in Polaris Standard. Here are a few tips that you can use to get the most out of your coverage:

- Make sure to take advantage of preventive care services. These services are covered 100% by the plan and can help you avoid more costly treatments down the line.
- Always make sure to visit in-network providers. Doing so will ensure that you receive the maximum benefit from your plan.
- Consider generic prescription drugs when available. These drugs can often be cheaper than brand-name drugs and are just as effective.
- Talk to your doctor about ways to save money. Many doctors are willing to work with you to find the most cost-effective treatment options available.
- Review your Explanation of Benefits (EOB) statements carefully. This document will show you exactly how much you are being charged for each service and what your plan is covering.

By following these tips, you can ensure that you are getting the most out of your Polaris Standard health plan.

HOW PROVIDERS AFFECT YOUR COSTS

In-Network Providers

HOW PROVIDERS AFFECT YOUR COSTS

When selecting a health insurance plan, one of the most important factors to consider is the network of in-network providers that are available with the plan.

Polaris Standard offers a wide variety of in-network providers, ranging from primary care physicians, specialists, hospitals, and pharmacies. This allows you to choose a provider that is convenient for you and your family, while also helping you to keep your costs low.

When you choose a provider that is in-network with your plan, you will typically pay lower copays and deductibles than you would with an out-of-network provider. In addition, many services, such as preventive care, may be covered at no cost when you receive care from an in-network provider.

It is important to note, however, that Polaris Standard does not offer coverage for emergency services, mental health and substance abuse coverage, or out-of-network services. This

means that you may have to pay out of pocket for these services if you receive them from an out-of-network provider.

When choosing an in-network provider, there are a few tips to keep in mind. First, make sure that the provider you choose is in-network with your plan. You can confirm this by calling the provider's office and asking them if they are in-network with Polaris Standard. You can also use the provider search tool on the Polaris Health website to make sure your provider is in-network.

Second, make sure that the provider you choose is accepting new patients. Some providers may be in-network but not be taking new patients.

Third, consider the location of the provider. If the provider is too far away, it may be difficult for you to get to your appointments.

Finally, consider the provider's office hours. If you work during the day, you may need to find a provider that has evening or weekend hours.

Choosing an in-network provider can help you save money on your health care costs. By following the tips above and researching your options, you can find a provider that is convenient, affordable, and in-network with your Polaris Standard plan.

Continuity of Care

HOW PROVIDERS AFFECT YOUR COSTS: CONTINUITY OF CARE

At Contoso, we understand the importance of providing our employees with access to a quality, affordable health care plan. We are proud to offer our employees Polaris Standard, an insurance plan that provides coverage for medical, vision, and dental services. We also offer continuity of care, which is the ability to stay with the same provider for all your health care needs, from routine checkups to specialized care.

Continuity of care is an important component of any health care plan, as it allows you to develop a relationship with your doctor, who is more likely to recognize any changes in your health and be able to provide better, more personalized care. With Polaris Standard, you can stay with the same provider throughout your health care journey, helping you to receive the best possible care.

Continuity of care also helps you save money on health care costs. When you stay with the same provider, you are likely to pay less than if you switch around from provider to provider. This is because your provider already has all your medical records, and you won't need to pay for expensive tests and procedures that you've already had done.

There are a few exceptions to the continuity of care. If you move to a different area, you may need to find a new provider. Additionally, if you are in need of specialized care, such as surgery or a complex treatment, you may need to visit a specialist who does not accept your insurance plan. In these cases, you should be sure to check with your insurance company and/or provider to make sure you understand any associated costs.

There are a few tips you can follow to ensure you are taking full advantage of continuity of care and are getting the best, most affordable care possible. First, be sure to always keep your provider information up to date. If you move or change providers, be sure to notify your insurance company right away. Additionally, if you are in need of specialized care, be sure to check with your provider to understand any associated costs. Finally, if you are switching providers or insurance plans, make sure you get copies of your medical records from your previous provider.

At Contoso, we strive to provide our employees with access to quality, affordable health care. We are proud to offer Polaris Standard, an insurance plan that provides continuity of care, helping you to receive the best possible care and save money on health care costs.

Non-Participating

Non-Participating Providers and How They Affect Your Costs

When selecting a health care provider, it is important to understand the differences between participating and non-participating providers. Participating providers are those who have agreed to accept the Polaris Standard health plan's set rates. Nonparticipating providers are those who have not agreed to accept the set rates and can charge the patient more than what the health plan pays.

When you choose a non-participating provider for your healthcare services, you may be responsible for paying the difference between the provider's actual charges and the amount the plan pays. This difference is known as the balance billing amount. Depending on your provider's policy, you may be required to pay the balance billing amount up front. Be sure to discuss this with your provider prior to receiving services.

Additionally, it is important to note that if you use a non-participating provider, your out-ofpocket costs may be higher than if you had used a participating provider. For example, if your provider's charge is $200 and the plan pays $100, you would be responsible for the remaining $100 balance billing amount.

Exceptions

There are certain exceptions to the rule of non-participating providers. Your health plan may cover emergency services provided by non-participating providers, as well as certain services provided by non-participating providers that are not available from participating providers. Additionally, in some cases, the health plan may cover non-participating providers' charges if there are no participating providers in your area.

Tips

In order to avoid costly balance billing amounts, it is important to make sure that your provider is a participating provider in your Polaris Standard health plan. If you are unsure, you can contact the customer service department of your health plan to verify.

It is also important to ask your provider about their policy on balance billing. Be sure to find out if the provider requires you to pay the balance billing amount up front, or if they will bill you after the health plan pays them.

When selecting a provider, also remember to consider the cost of services. Participating providers are often more cost effective than non-participating providers. Additionally, some providers offer discounts to patients who pay out of pocket for services.

Finally, if you need to use a non-participating provider for certain services, be sure to check with your health plan first. There may be an exception that will cover the cost of the service. Additionally, if you need to use a non-participating provider and you are concerned about the cost, you can always negotiate with your provider to find a more affordable rate.

Balance Billing Protection

HOW PROVIDERS AFFECT YOUR COSTS - Balance Billing Protection

At Contoso, we understand that medical costs can be intimidating and confusing, which is why we've partnered with Polaris Health to offer our employees the Polaris Standard plan. This plan provides a balance billing protection, meaning that you are protected from unexpected costs when visiting in-network providers.

What is balance billing?

Balance billing is when a provider bills you for the difference between what they charge and what your insurance company is willing to pay. This difference can be hundreds of dollars and is often unexpected. With the Polaris Standard plan, you are protected from balance billing when visiting in-network providers.

What is an in-network provider?

In-network providers are healthcare providers, such as doctors, hospitals, and labs, that have agreed to accept the Polaris Standard plan's payment terms. Visiting an in-network provider means that you are protected from balance billing. You can find a list of in-network providers on the Polaris Health website.

What if I visit an out-of-network provider?

Visiting an out-of-network provider means that you are not protected from balance billing. Out-of-network providers may charge more for the same services than in-network providers, and you may be responsible for the difference between what they charge and what your insurance company is willing to pay. It is important to check if a provider is innetwork before visiting them to avoid any unexpected costs.

Tips to avoid balance billing:

• Always check if a provider is in-network before scheduling an appointment.

• Ask your provider if they accept the Polaris Standard plan before you receive any services.

- Double-check that the providers you visit are in-network.
- Ask for an estimate of your out-of-pocket costs ahead of time.
- If you receive a bill for more than expected, contact your provider and the insurance company to negotiate a lower cost.

Exceptions to the balance billing protection:

- Balance billing protection does not apply to emergency services.
- Balance billing protection does not apply to mental health and substance abuse coverage.
- Balance billing protection does not apply to out-of-network providers.
- Balance billing protection is not applicable to any non-covered services.

At Contoso, we want to make sure our employees are provided with the best coverage options. That's why we've partnered with Polaris Health to offer the Polaris Standard plan, which provides balance billing protection when visiting in-network providers. We encourage our employees to use the tips provided to help reduce the risk of unexpected costs when visiting a provider.

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

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

One of the important considerations when choosing a health insurance plan is understanding the differences between in-network and out-of-network providers. When you receive health care from an in-network provider, your insurance plan will generally cover a greater portion of your expenses. However, when you receive health care from an out-of-network provider, you may be required to pay a greater portion of the costs.

Under Polaris Standard, you may receive care from out-of-network providers, but you will be responsible for a greater portion of the costs. To make sure you are getting the best value for your health care expenses, it is important to understand the differences between in-network and out-of-network providers and how they affect your costs.

In-Network: In-network providers are those who have contracted with Polaris Health to provide services at a discounted rate. In-network providers have agreed to accept the amount of payment offered by Polaris Health, meaning that you pay the portion of the cost that is not covered by the insurance plan. In-network providers may also offer additional services or discounts that are not available to out-of-network providers.

Out-of-Network: Out-of-network providers are those who have not contracted with Polaris Health. As a result, they are not required to accept the amount of payment offered by Polaris Health, meaning that you may be responsible for a greater portion of the cost. Additionally,

out-of-network providers may not offer additional services or discounts that are available to in-network providers.

When choosing a provider, it is important to make sure that the provider is in-network. While it is possible to receive care from out-of-network providers, it is important to understand that you will be responsible for a greater portion of the costs. To make sure that you are getting the best value for your health care expenses, it is recommended that you choose an in-network provider whenever possible.

There are some exceptions when it comes to receiving care from out-of-network providers. If you are unable to find an in-network provider in your area or if you require a specific type of care that is not available from an in-network provider, you may receive care from an outof-network provider. In these cases, the cost of care may be more expensive and you may be responsible for a greater portion of the costs.

In addition to understanding the differences between in-network and out-of-network providers, it is important to understand the cost sharing associated with each. Polaris Standard does not cover the full cost of care for out-of-network providers, so you may be responsible for a greater portion of the costs.

When choosing a provider, it is important to take into account the cost sharing associated with each provider. If you are unable to find an in-network provider in your area or if you require a specific type of care that is not available from an in-network provider, it is important to understand that you may be responsible for a greater portion of the costs.

Finally, it is important to be aware of any additional fees that may be associated with receiving care from an out-of-network provider. Some providers may charge additional fees for services that are not covered by Polaris Standard. It is important to ask about any additional fees before receiving care from an out-of-network provider to make sure you are aware of any additional costs you may be responsible for.

By understanding the differences between in-network and out-of-network providers, as well as the cost sharing associated with each, you can make sure that you are getting the best value for your health care expenses. While it is possible to receive care from an out-ofnetwork provider, it is important to understand that you may be responsible for a greater portion of the costs. When choosing a provider, it is important to consider the cost sharing associated with each provider and to ask about any additional fees before receiving care.

HOW PROVIDERS AFFECT YOUR COSTS

When it comes to health insurance, many people are unaware of the different factors that impact the costs they pay. One of the most significant components that affects your costs is the provider you choose. Polaris Standard provides coverage for a variety of in-network providers, and the costs associated with each provider can vary significantly. To ensure you’re getting the best value for your health care services, it’s important to understand how providers can affect your costs.

In-Network Providers

Choosing in-network providers is the most cost-effective option when it comes to your Polaris Standard plan. In-network providers have agreed to accept a discounted rate on services, which means they are often less expensive than out-of-network providers. When selecting an in-network provider, you will likely only have to pay a portion of the cost for services, often referred to as a “co-pay” or “co-insurance”. It’s important to note that different types of services may require different co-pays or co-insurance, so it’s best to contact your provider to understand what the cost will be.

Out-of-Network Providers

Polaris Standard offers coverage for some out-of-network providers, but the costs associated with these providers can be significantly more expensive than in-network providers. If you choose an out-of-network provider, you may be responsible for the entire cost of services, or a far greater portion of the cost than you would with an in-network provider. In some cases, Polaris Standard may offer coverage for out-of-network providers, but you may still have to pay more than you would for an in-network provider.

Exceptions

Some providers may offer services that are outside of the Polaris Standard plan coverage. Depending on the services provided, you may have to pay out-of-pocket for services that are not covered. Additionally, it’s important to note that there may be different rules and coverage levels associated with certain types of services, such as those related to mental health and substance abuse.

Tips

If you’re considering a provider that is not in-network, it’s important to understand the costs associated with that provider before you book an appointment. Contacting the provider directly to ask about their rates, as well as any special arrangements they offer for Polaris Standard members, can help you get a better idea of what you’ll be paying for services. Additionally, it’s important to check with Polaris Health to make sure the provider is covered by the Polaris Standard plan and what types of services are covered.

When selecting a provider, it’s also important to consider the quality of care they provide. You should look for providers that offer high-quality care that meets your specific needs. Additionally, Polaris Health offers a variety of resources to help you find the right provider, such as a provider search tool and a provider directory.

Choosing the right provider is important when it comes to your Polaris Standard plan. By understanding how providers can affect your costs, you can make sure you’re getting the best value for your health care services. By using Polaris Health’s resources and researching providers in advance, you can make sure you’re getting the care you need at the best cost.

IMPORTANT PLAN INFORMATION

Copayments (Copays)

IMPORTANT PLAN INFORMATION: Copayments (Copays)

At Polaris Health, our Polaris Standard plan includes copayments (copays) for certain services. A copayment is a fixed amount that you pay at the time of service, and it is generally a lower amount than what you would have to pay if you were to pay the full cost of the service.

Copays for Polaris Standard vary depending on the type of service you receive. Generally speaking, copays for office visits are typically less than copays for hospital visits. For example, copays for office visits with a primary care physician may be $20, while copays for a hospital visit may be up to $150. It is important to note that the copays may vary from provider to provider and from state to state.

In addition to office visits, copays may also apply to other services, such as prescriptions and diagnostic testing. For example, copays for generic prescription drugs may be $10, while copays for brand-name drugs may be $35. Copays for diagnostic testing, such as lab tests and X-rays, may range from $20 to $100 depending on the type of test.

It is important to note that Polaris Standard does not cover certain services, such as emergency services and mental health and substance abuse services. For these services, you may be responsible for the full cost of the service, so it is important to understand your plan and read the fine print before receiving any services.

In addition to copays, you may also be charged coinsurance for certain services. Coinsurance is a percentage of the cost of the service that you are responsible for paying. Generally speaking, coinsurance rates are lower than copays, so it is important to understand the difference between the two.

Finally, there are some exceptions to the copayment rules. For example, preventive care services may be covered at no cost to you. This includes routine physical exams, immunizations, and screenings for certain diseases such as cancer and diabetes.

Overall, copays are a great way to save money on health care services. Understanding your plan and reading the fine print can help you to save money on health care services. It is also important to remember that copays may vary from provider to provider and from state to state, so it is important to do your research before receiving any services.

Split Copay For Office Visits

IMPORTANT PLAN INFORMATION: Split Copay For Office Visits

At Polaris Health, we understand how important it is to have access to quality, affordable healthcare. That's why we provide our members with Split Copay for Office Visits under the Polaris Standard plan. With this benefit, you can expect to pay a set copayment for office visits, regardless of the provider you visit.

What is Split Copay for Office Visits?

Split Copay for Office Visits is a feature of the Polaris Standard plan that allows you to pay a set copayment for most office visits. This copayment covers both the provider and the facility charges for office visits. The amount of the copayment will depend on the type of provider you visit, such as a primary care physician or specialist.

Who is eligible for Split Copay for Office Visits?

All members of the Polaris Standard plan are eligible for Split Copay for Office Visits. This benefit is available to all members, regardless of where they live or work.

Are there any exceptions?

Yes, there are some exceptions to the Split Copay for Office Visits benefit. This benefit does not apply to hospital or emergency room visits, mental health and substance abuse services, or out-of-network services.

Are there any tips I should know about?

Yes, here are a few tips to help you make the most of the Split Copay for Office Visits benefit:

- Before scheduling an appointment, make sure the provider you are visiting is in-network. You can check your plan's directory of providers for more information.
- Many providers are now offering virtual visits, which can be a great way to access care without having to leave the comfort of your home.
- Make sure to bring your insurance card to every appointment. That way, you can make sure that your copayment is applied correctly.
- If you have any questions about the cost of your office visit, don't hesitate to ask your provider's office. They should be able to tell you exactly how much you can expect to pay for the visit.

At Polaris Health, we are committed to providing our members with access to quality, affordable healthcare. We hope that the Split Copay for Office Visits benefit will make it easier for you to get the care you need.

Calendar Year Deductible

IMPORTANT PLAN INFORMATION: Calendar Year Deductible

The Polaris Standard plan has a calendar year deductible of $2,000 for each individual and $4,000 for each family. A calendar year deductible is the amount you must pay for health care services before your insurance plan starts to pay. The deductible applies to most services received from in-network providers, including primary care physicians, specialists, hospitals, and pharmacies.

However, there are some exceptions. For example, preventive care services, such as immunizations and annual physicals, are covered at 100% with no deductible. Additionally, prescription drugs are subject to a separate prescription drug deductible of $250 per individual and $500 per family.

It is important to note that this deductible does not roll over into the next year. This means that you must meet the deductible amount in the current year before your insurance begins to pay. Additionally, the deductible may not apply to all services. For example, you may not be subject to the deductible when you receive in-network emergency services.

Tips for Meeting the Calendar Year Deductible

Meeting your calendar year deductible may seem like a daunting task, but there are a few steps you can take to help ensure that you reach it.

First, take advantage of any preventive care services that are covered at 100%. These services are important for your health, and you can use them to help meet your deductible without paying out of pocket.

Second, use caution when selecting providers. The Polaris Standard plan has a large network of in-network providers, and using these providers will help ensure that you are not paying more than you have to for services.

Third, consider using a health savings account (HSA). An HSA is a tax-advantaged savings account that can be used to pay for qualified medical expenses. Contributions to an HSA are tax-deductible and the funds can be used to help pay for deductibles and other medical costs.

Finally, take advantage of any discount programs that may be available. Many providers offer discounts for cash payments on services, and these can help reduce the amount of money you need to pay out of pocket.

By following these tips, you can make sure that you reach your deductible and take advantage of the full benefits of the Polaris Standard plan.

Coinsurance

IMPORTANT PLAN INFORMATION: Coinsurance

Coinsurance is a type of cost sharing that you are responsible for after meeting your deductible. Coinsurance is often a percentage of the cost of the service you receive. For example, if the coinsurance is 10%, you will be responsible for paying 10% of the cost of the service you received, while the insurance company pays the other 90%.

Under Polaris Standard, coinsurance is set at 20% for in-network services, with some exceptions. For in-network hospital stays, coinsurance is set at 25%. Additionally, coinsurance for out-of-network services is set at 40%.

It's important to note that coinsurance does not apply to the services that are covered by the plan's copayment amounts. Copayment is a fixed amount that you are responsible for paying for certain services and is typically much less than coinsurance. Additionally, Polaris Standard does not require coinsurance for preventive care services.

When you receive services, it's important to ask about the cost of the service and make sure you are aware of any coinsurance costs. It's also important to be aware of the coinsurance rate for out-of-network services and to consider if it's worth the cost to pay more for out-ofnetwork services.

It's also important to be aware that coinsurance costs are calculated based on the allowed amount for the service. This means if you receive a service that is more expensive than what is allowed by the plan, your coinsurance costs will be based on the allowed amount, not the actual cost.

If you are unable to pay the coinsurance costs for a service up front, Polaris Standard will allow you to make payments over time. This is a great option for those who need services but may not be able to pay the entire coinsurance amount in one payment.

Finally, it's important to know that coinsurance costs are applied to your out-of-pocket maximum. This means that you can use coinsurance costs to help you reach your out-ofpocket maximum faster, thus reducing the amount of money you need to pay out of pocket for services.

In summary, coinsurance is a cost sharing requirement under Polaris Standard that is typically 20% for in-network services and 40% for out-of-network services. It's important to be aware of the costs associated with coinsurance and to consider if it's worth the cost to pay more for out-of-network services. Additionally, coinsurance costs count towards your out-of-pocket maximum and you can make payments over time if needed.

Out-Of-Pocket Maximum

IMPORTANT PLAN INFORMATION: Out-of-Pocket Maximum

Employees enrolled in the Polaris Standard plan can benefit from an out-of-pocket maximum that helps to protect them from large medical bills. This limit applies to certain covered services and includes deductibles, coinsurance, and copayments. The out-of-pocket maximum for the Polaris Standard plan is $6,350 for an individual and $12,700 for a family.

Employees should be aware that certain services may not be subject to the out-of-pocket maximum. These services include any charges that are not related to the diagnosis and treatment of an illness or injury. For example, non-covered services like cosmetic surgery, non-prescription drugs, or services that were provided outside of the Polaris Health network will not count toward the out-of-pocket maximum.

It's important for employees to remember that the out-of-pocket maximum will reset at the start of the calendar year. This means that any out-of-pocket expenses paid during the previous year will not carry over to the new year.

To keep track of their out-of-pocket expenses, employees should review their insurance statements regularly. They should also review their Explanation of Benefits (EOB) documents to make sure that all of their expenses have been properly accounted for. This can help them to stay on top of their out-of-pocket expenses and avoid exceeding the maximum.

Employees should also be aware that the out-of-pocket maximum does not include the cost of premiums. The cost of premiums is not counted toward the out-of-pocket maximum and is in addition to any out-of-pocket expenses that employees incur.

Finally, if employees are thinking of switching to a different health plan, they should be aware that out-of-pocket costs can vary from plan to plan. Employees should compare the out-of-pocket maximums and deductibles of different plans before deciding which one is best for them.

In summary, the Polaris Standard plan offers employees an out-of-pocket maximum of $6,350 for an individual and $12,700 for a family. Employees should be aware that certain services are not subject to this maximum and that their out-of-pocket expenses will reset at the start of the calendar year. They should also remember that the out-of-pocket maximum does not include the cost of premiums. Finally, they should compare the out-of-pocket maximums and deductibles of different plans before deciding which one is best for them.

Allowed Amount

IMPORTANT PLAN INFORMATION: ALLOWED AMOUNT

In the Polaris Standard plan, an Allowed Amount is the maximum amount that the plan will pay for a covered service. It includes both the amount that the plan pays and any amount that the insured is responsible for paying. This total Allowed Amount is usually a percentage of the provider's charge. In some cases, the Allowed Amount may be a fixed amount.

In general, the Allowed Amount is the lesser of the provider's charge, the plan's Allowed Amount, and the copayment amount. This means that the insured may be responsible for paying the difference between the provider's charge and the Allowed Amount.

It is important to remember that the Allowed Amount may not cover the entire cost of a service. Therefore, the insured may be responsible for paying any remaining balance, even if it is more than the Allowed Amount.

Exceptions:

In some cases, a service may not have an Allowed Amount or the Allowed Amount may be higher than the provider's charge. This may occur when the service is considered to be a non-covered service or when the service is not a usual or customary service. In these cases, the insured will be responsible for paying the entire cost of the service.

In addition, some services may have a separate deductible or coinsurance amount that must be met before the Allowed Amount is applied. These services may include hospitalization, emergency services, and certain types of outpatient services.

Tips:

When selecting a provider, ask the provider if they accept the Polaris Standard plan and what their Allowed Amounts are. This will ensure that you are selecting a provider that will accept the plan and that you are aware of what your out-of-pocket costs may be.

Make sure to keep all of your receipts and bills when you receive a service so that you can review them against your Explanation of Benefits (EOB). This will ensure that you are aware of any balance that may be owed after the Allowed Amount has been applied.

Finally, remember that the Allowed Amount is not a guarantee of payment and that you may be responsible for paying any remaining balance. Therefore, it is important to review your EOB and contact the provider if there are any discrepancies or if you have any questions about the Allowed Amount.

IMPORTANT PLAN INFORMATION

Polaris Standard is a basic plan that provides coverage for medical, vision, and dental services. It's important for employees to understand the details of this plan to ensure that they are taking full advantage of their benefits. The following information will help employees to get the most out of their plan.

Premiums

The premium amount for Polaris Standard is determined by Contoso. Employees are responsible for paying their premiums on time. Premiums are typically deducted from payroll on a pre-determined schedule. If a payment is missed, the employee may be subject to a late fee or other penalties.

Out-of-Pocket Costs

Employees will be responsible for a variety of out-of-pocket costs associated with their Polaris Standard plan. These costs can include copays, coinsurance, and deductibles.

Copays are fixed amounts that are due at the time of each visit. Coinsurance is a percentage of the total cost of a service that is paid by the employee. Deductibles are a fixed amount that must be paid by the employee before the insurance company begins covering the costs of services. It's important for employees to understand what their out-of-pocket costs will be for each type of service to ensure that they are prepared to pay their portion of the bill.

Network Providers

Polaris Standard allows employees to choose from a variety of in-network providers. These include primary care physicians, specialists, hospitals, and pharmacies. It's important for

employees to make sure that they are seeing providers that are in-network to maximize their coverage. Out-of-network providers may not be covered under Polaris Standard.

Exclusions

Polaris Standard does not offer coverage for emergency services, mental health and substance abuse coverage, or out-of-network services. Employees should keep this in mind when selecting providers and services to ensure that they are covered by their plan.

Claims

Employees are responsible for submitting claims for services that are covered by their insurance plan. Claims should be submitted as soon as possible after a service is rendered to ensure timely payment. Employees should keep track of their claims and follow up with Polaris Health if a claim is not processed in a timely manner.

Tips

To ensure that employees are taking full advantage of their Polaris Standard plan, there are a few tips that they should keep in mind.

- Make sure to understand the details of the plan and the associated out-of-pocket costs before receiving a service.
- Select in-network providers to maximize coverage and avoid unexpected costs.
- Submit claims as soon as possible after a service is rendered.
- Track claims and follow up with Polaris Health if a claim is not processed in a timely manner.
- Take advantage of preventive services to stay healthy and reduce future costs.
- Ask questions and contact Polaris Health if you need assistance understanding your coverage or filing a claim.

By understanding the details of the Polaris Standard plan and following the tips above, employees can ensure that they are taking full advantage of their benefits. Taking the time to understand the plan and ask questions can help employees to make the most of their coverage and stay healthy.

COVERED SERVICES

Acupuncture

COVERED SERVICES: Acupuncture

At Contoso, we are proud to offer employees Polaris Standard, an insurance plan that includes coverage for acupuncture. Acupuncture is an ancient form of healing that has been

used for centuries. It is based on the belief that energy, or qi, flows through the body and can be manipulated with needles to promote healing.

Acupuncture is often used to treat chronic pain, headaches, digestive issues, stress, anxiety, and other conditions. It is generally considered to be safe and effective when administered by a trained and certified practitioner.

Under Polaris Standard, acupuncture is covered as a preventive service. This means that acupuncture treatment is covered at no cost to the employee, before any diagnosis is made or symptoms are present. This coverage is designed to help encourage people to get preventive care before they experience any health problems.

However, coverage for acupuncture is limited under Polaris Standard. The plan only covers acupuncture treatments that are administered by a licensed acupuncturist. Selfadministered treatments, such as acupressure or self-treatment with needles, are not covered. Additionally, the plan only covers acupuncture treatments that are deemed medically necessary. This means that treatments that are solely for relaxation or cosmetic purposes are not covered.

If you are considering acupuncture as a treatment option, here are some tips to keep in mind:

• Make sure the acupuncturist you choose is licensed and certified.

• Ask about the acupuncturist's experience and training.

• Check to see if the acupuncturist is in-network with Polaris Standard.

• Discuss the risks and expected benefits of acupuncture with your acupuncturist.

• Ask your acupuncturist to explain the acupuncture treatment plan.

• Discuss any questions or concerns you have about acupuncture with your doctor.

At Contoso, we are committed to providing employees with access to quality and affordable healthcare. We are proud to offer Polaris Standard, an insurance plan that includes coverage for acupuncture, to help our employees stay healthy and well.

Allergy Testing and Treatment

COVERED SERVICES: Allergy Testing and Treatment

The Polaris Standard plan covers the cost of allergy testing and treatment. Allergy testing is done to determine what substances a person is allergic to, and treatment can include medications, injections, and other therapies. Allergy testing and treatment are covered under this plan.

What Is Covered

Under the Polaris Standard plan, the following allergy testing and treatment services are covered:

- Allergy skin testing
- Allergy blood testing
- Immunotherapy (allergy shots)
- Prescription medications for allergies, such as antihistamines, decongestants, and corticosteroids
- Non-prescription medications for allergies, such as antihistamines and decongestants
- Allergy medications for asthma, such as albuterol
- Allergy medications for skin conditions, such as topical corticosteroids
- Nasal sprays for allergies

Exceptions

The Polaris Standard plan does not cover the cost of allergy testing or treatment for cosmetic purposes.

Tips

- Make sure to tell your doctor about any medications you are currently taking, as some medications can interfere with allergy testing or treatment.
- If you are prescribed medications for allergies, be sure to follow your doctor's instructions carefully.
- Ask your doctor about other treatments that may be available, such as immunotherapy (allergy shots).
- If you are prescribed medications for allergies, be sure to check with your pharmacist to see if there are any generic or over-the-counter options that may be more affordable.
- Keep track of your allergies, including the type of allergy, the severity of the allergy, the medications you are taking, and the results of any allergy tests you have had. This information can be helpful for your doctor when making decisions about your care.

Ambulance

COVERED SERVICES: Ambulance

Ambulance services are covered under the Polaris Standard plan, providing you with the medical assistance you need in the event of an emergency. When you are in need of an ambulance, you can be sure that Polaris Health will cover your transport to the closest hospital or medical facility.

Covered Services:

The Polaris Standard plan covers ambulance transport to the nearest hospital or medical facility in the event of an emergency. This service is available 24 hours a day, seven days a week, and is covered up to the plan's limit. Ambulance transport is covered up to the plan's limit, regardless of whether the ambulance is provided by an in-network provider or an out-of-network provider.

Exceptions:

Polaris Health does not cover ambulance services that are provided for non-emergency transport. Non-emergency transport includes transport for routine medical care, such as transport to a doctor's office or a laboratory for tests. Non-emergency transport is not covered by the Polaris Standard plan.

Tips for Employees:

- Keep the phone number of your local ambulance service handy in case of an emergency.
- Make sure to provide your Polaris Health insurance information to the ambulance service at the time of transport, as this will help ensure that your costs for the service are covered.
- If you are transported by an out-of-network provider, you may be responsible for paying a portion of the cost. Be sure to check with Polaris Health to determine what your costsharing responsibilities are in such an event.
- Be sure to keep all receipts and paperwork related to your ambulance service, as you may need this information when filing your claim with Polaris Health.
- Remember, ambulance services are only covered for emergency transport. If you need to be transported for non-emergency medical care, you will need to make other arrangements for your transportation.

With the Polaris Standard plan, you can rest assured that you will be covered in the event of an emergency. In the event of an emergency, you can be transported by ambulance to the nearest hospital or medical facility and your costs will be covered up to the plan's limit. By following the tips outlined above, you can ensure that you get the most out of your Polaris Health coverage.

Blood Products And Services

COVERED SERVICES: Blood Products And Services

Polaris Standard offers coverage for a variety of blood products and services. These include both red and white blood cells, platelets, and plasma. The plan also covers laboratory tests related to the collection, examination, and transfusion of blood products.

For red and white blood cells, Polaris Standard covers screening and compatibility tests, as well as collection, storage, and transfusion of the cells. The plan also covers the cost of blood or blood products administered during a hospital stay or procedure.

With regards to platelets, the plan covers the collection, storage, and transfusion of platelets. It also covers laboratory tests that are necessary to identify and assess compatibility of platelets.

Polaris Standard covers the collection, storage, and transfusion of plasma, as well as laboratory tests that are necessary to identify and assess compatibility of plasma.

Tips For Consumers:

- Make sure to ask your provider if they accept Polaris Standard before receiving any services.
- Be sure to double check that your blood product or service is covered under Polaris Standard before receiving it.
- Be aware that Polaris Standard does not cover emergency services, mental health and substance abuse coverage, or out-of-network services.

Cellular Immunotherapy And Gene Therapy

Cellular Immunotherapy and Gene Therapy

Cellular immunotherapy and gene therapy are two cutting-edge treatments covered by Polaris Standard. These treatments have the potential to revolutionize the way we treat cancer and other diseases, and they offer a new, innovative approach to medical care.

Cellular immunotherapy is a form of treatment that uses the patient's own immune system to fight off cancer cells. It works by taking cells from the patient and manipulating them in a laboratory to make them better equipped to fight cancer. The modified cells are then injected back into the patient's body, where they can help to fight off the cancer. This form of treatment is still relatively new, but it has already been used to successfully treat some 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.

Polaris Standard covers both cellular immunotherapy and gene therapy. However, there are some exceptions. These treatments are typically only available at specialized centers, and they can be very expensive. As such, Polaris Standard may not cover the full cost of the treatments. It is important to check with your provider to determine what is and is not covered by your plan.

When considering cellular immunotherapy or gene therapy, it is important to do your research. Make sure you understand the risks and benefits of the treatment, and be sure to discuss any questions or concerns with your doctor. Additionally, it is important to have realistic expectations about the results of the treatment. It is also important to remember that these treatments are still in the early stages of development, and that their long-term success is not yet known.

In summary, cellular immunotherapy and gene therapy are two cutting-edge treatments that are now covered by Polaris Standard. While these treatments are still in the early stages of development and may be expensive, they offer the potential to revolutionize the way we treat diseases. It is important to do your research and discuss any questions or concerns with your doctor before considering these treatments.

Chemotherapy And Radiation Therapy

COVERED SERVICES: Chemotherapy And Radiation Therapy

At Polaris Health, we understand that medical treatments such as chemotherapy and radiation therapy can be expensive. With Polaris Standard, we provide coverage for these treatments, so you can have peace of mind knowing that your medical costs are taken care of.

Chemotherapy involves using drugs to treat cancer and other conditions, while radiation therapy uses high-energy X-rays to kill cancer and other cells. Both types of treatments can be used to treat a variety of conditions, including cancer, autoimmune diseases, and infections.

Under the Polaris Standard plan, chemotherapy and radiation therapy are both covered services. This means that you will receive coverage for any eligible treatments that you receive. The plan covers the cost of the treatment itself, as well as any associated costs such as medications, supplies, and doctor visits.

However, there are some exceptions to the coverage provided. For example, the plan does not cover the cost of experimental treatments or treatments that are not medically necessary. Additionally, the plan does not cover the cost of any hospital stays associated with the treatment.

If you are considering chemotherapy or radiation therapy, it is important to discuss the treatment options with your doctor. Your doctor can help you determine which treatments are best for your condition and which treatments are covered under the Polaris Standard plan.

It is also important to remember that chemotherapy and radiation therapy can have side effects. Make sure to discuss any potential side effects with your doctor before beginning treatment. Additionally, make sure to follow your doctor's instructions carefully and take any medications as prescribed.

Finally, make sure to keep track of your medical expenses. The Polaris Standard plan allows you to submit a claim for reimbursement for any eligible expenses. Make sure to save all of your receipts and submit your claim as soon as possible to ensure that your costs are covered.

At Polaris Health, we are committed to providing our members with quality coverage for medical treatments such as chemotherapy and radiation therapy. With the Polaris Standard plan, you can rest assured that any eligible treatments you receive will be covered.

Clinical Trials

COVERED SERVICES: Clinical Trials

At Polaris Health, we understand the importance of access to clinical trials for our members. Clinical trials are research studies that look at new ways to prevent, detect, or treat diseases and conditions, and can give members access to treatments and therapies not yet available. Polaris Standard offers coverage for certain clinical trial services, including those related to common diseases and conditions.

The Polaris Standard plan covers the cost of certain clinical trial services, and some of the most common include:

• Diagnostic testing and procedures to confirm or diagnose a condition or disease

• Treatment of the condition or disease being studied

• Medications

• Lab services

• Imaging services

Any other clinical trial services that are not explicitly covered by the Polaris Standard plan may be eligible for coverage on a case-by-case basis. To determine if a clinical trial service is covered, members should contact the Polaris Health customer service department for more information.

It's important for members to note that the Polaris Standard plan does not cover travel expenses associated with attending clinical trials. Additionally, any experimental treatments or services that are not part of the clinical trial are not covered.

When considering participation in a clinical trial, members should always consult with their doctor first to make sure it's the right choice for them. Clinical trials are not for everyone, and it's important to fully understand the risks and benefits before making a decision.

Members should also be aware that not all clinical trials are free. Some require a fee, and it's important to find out what the cost will be before participating.

Finally, members should keep in mind that clinical trials are often available in limited locations, so they may have to travel to participate in a trial. Polaris Health can provide information about nearby clinical trials and may be able to help with the cost of travel.

At Polaris Health, we are committed to providing access to the most innovative treatments and therapies available. We are proud to offer coverage for certain clinical trial services, and we are dedicated to helping our members get the care they need.

Dental Injury and Facility Anesthesia

COVERED SERVICES: Dental Injury and Facility Anesthesia

The Polaris Standard plan offers coverage for dental injuries and anesthesia administered in a dental facility. This coverage covers the services of a licensed dentist or dental specialist, including services related to the diagnosis and treatment of dental injuries, such as root canals, crowns, fillings, extractions, and periodontal services. This coverage also includes dental anesthesia used during a dental procedure, such as local anesthesia, sedation, and general anesthesia.

However, there are some exceptions to the coverage of dental injury and facility anesthesia. The plan does not cover services related to cosmetic dentistry or services related to the replacement of natural teeth with dentures or bridges. Additionally, services related to orthodontics, temporomandibular joint disorder (TMJ), or treatment of temporomandibular joint disorder are not covered. The Polaris Standard plan only covers services related to the prevention and treatment of disease.

When it comes to dental injuries, it is important to get treatment as soon as possible. If a dental injury is left untreated, it can lead to a greater risk of infection and more extensive dental work in the long run. To make sure you're getting the best care possible, it is important to find a dentist that is in-network and covered under the Polaris Standard plan. You can search for an in-network provider by using the Polaris Health Provider Finder tool.

When it comes to anesthesia, it is important to talk to your dentist about all of the risks associated with anesthesia before having any procedures. General anesthesia carries the most risk and can cause side effects, such as nausea, vomiting, and dizziness. Therefore, it is important to make sure you are informed about the potential risks associated with any anesthesia that may be used during a dental procedure.

To ensure that you are getting the best care possible, it is important to stay up-to-date on your dental care and practice good oral hygiene. Regular brushing and flossing, as well as regular check-ups with your dentist, can help to prevent dental injuries and other dental issues. It is also important to make sure that you are taking advantage of the preventive care services that are covered under the Polaris Standard plan, such as annual checkups and cleanings.

By taking advantage of the dental coverage offered through the Polaris Standard plan, you can be sure that you are getting the care and coverage that you need in order to maintain

your oral health. If you have any questions about the coverage offered under the Polaris Standard plan, you can contact Polaris Health Customer Service for more information.

Diagnostic X-Ray, Lab And Imaging

DIAGNOSTIC X-RAY, LAB AND IMAGING

Polaris Standard provides coverage for diagnostic x-ray, lab, and imaging services. This includes tests such as MRI, CT scans, x-rays, blood tests, and other lab procedures. The plan covers the cost of such services when prescribed by a doctor for a medically necessary reason.

When it comes to diagnostic x-ray, lab, and imaging services, it's important to make sure you're using a provider that's in the Polaris network. If you choose a provider who is not in the network, you may be responsible for the full cost of these services. To find a provider in the network, you can use the Polaris website or call their customer service line.

When receiving a diagnostic x-ray, lab, or imaging service, you will likely be responsible for paying a copayment or coinsurance. The exact amount you will be required to pay will depend on the type of service you receive. You can use the Polaris app or website to look up the cost of a particular service before you receive it.

In some cases, the Polaris Standard plan may exclude certain diagnostic x-ray, lab, and imaging services. For example, the plan does not cover any services related to cosmetic treatments or procedures. Additionally, the plan does not cover any services for which no diagnosis is provided.

It's important to note that the Polaris Standard plan does not cover any services related to emergency care. This includes diagnostic x-ray, lab, and imaging services that are needed to diagnose an emergency condition. If you have an emergency condition, you will need to seek care at an emergency room or urgent care facility.

Finally, if you receive diagnostic x-ray, lab, or imaging services from an out-of-network provider, you may be required to pay the full cost of the service. To ensure that you are receiving services from an in-network provider, you can use the Polaris provider search tool or call the Polaris customer service line.

By understanding the Polaris Standard plan's coverage for diagnostic x-ray, lab, and imaging services, you can make sure that you are receiving the best care possible while minimizing your out-of-pocket costs.

Dialysis

COVERED SERVICES: Dialysis

At Contoso, we understand that dialysis can be an expensive and necessary medical service for some of our employees. That's why we are proud to offer coverage for dialysis treatments through Polaris Standard.

Under this plan, you will have coverage for in-network dialysis treatments, including both hemodialysis and peritoneal dialysis. You will also have coverage for treatments that are necessary after or during dialysis, such as lab tests, imaging, and physical therapy.

However, it is important to note that Polaris Standard does not provide coverage for any out-of-network dialysis treatments. In addition, Polaris Standard does not cover any travel expenses associated with dialysis treatments. If you require care at an out-of-network provider, you will need to pay for the full cost of treatment.

It is important to remember that dialysis is a long-term medical treatment. That's why it is important to find a dialysis provider that is in-network with Polaris Standard. This will help ensure that you receive the best care possible and that your treatments are covered by your insurance plan.

When looking for a dialysis provider, it is important to consider factors such as:

- Location: Make sure to find a dialysis provider that is conveniently located to you.
- Quality of Care: Make sure to research the quality of care that is provided by the dialysis provider.
- Cost: Make sure to research the cost of treatments.
- Reputation: Make sure to read reviews and ask for referrals from friends and family.
- Specialization: Make sure to find a dialysis provider that specializes in the type of dialysis treatment that you need.

Finally, it is important to remember to keep all of your dialysis records and receipts. This will help ensure that you are able to receive reimbursement for any covered expenses.

At Contoso, we are committed to providing our employees with the best health care coverage possible. That's why we are proud to offer coverage for dialysis treatments through Polaris Standard. With this coverage, you can rest assured that you will receive the best possible care and coverage for your dialysis treatments.

Emergency Room

Emergency Room Services

Emergency room services are a type of medical service that is provided in the event of a medical emergency. As part of the Polaris Standard plan, emergency room services are covered with some exceptions. To ensure that you understand the details of your coverage, it's important to read the plan documents carefully and contact Polaris Health with any questions.

Coverage for Emergency Room Services

Under the Polaris Standard plan, coverage is provided for medically necessary emergency room services. Coverage is only available when the condition is an acute medical emergency

or injury, and when the emergency room is the only way to receive medical attention. For example, if you experience a broken bone, chest pain, or a head injury, you would be covered for emergency room services.

Exclusions

However, there are certain services that are not covered under the Polaris Standard plan. Services that are not considered medically necessary, such as elective procedures, are not covered by the plan. In addition, services that are provided in the emergency room that are not related to the medical emergency, such as lab tests, x-rays, and other diagnostic tests, are not covered by the plan.

Tips for Utilizing Emergency Room Services

If you find yourself in a situation where you need to visit the emergency room, there are a few tips that can help you get the most out of your coverage. First, be sure to provide Polaris Health with all the information they need to process your claim, such as the date of service, the medical provider, and any other relevant information. Additionally, you should contact Polaris Health before you receive any services to ensure that they are covered by the plan.

It's also important to remember that emergency room services can be expensive, so you should always take steps to avoid unnecessary visits. If you are feeling ill and it's not an acute medical emergency, you should contact your primary care physician or an urgent care center before going to the emergency room. In most cases, these services are less expensive and can provide the same level of care.

Finally, if you do need to visit the emergency room, you should be sure to keep all of your paperwork and receipts. This will help you if you need to follow up with Polaris Health about your claim.

The Polaris Standard plan provides coverage for emergency room services, but it's important to understand the details of your coverage. By following these tips and taking steps to avoid unnecessary visits, you can get the most out of your plan.

Foot Care

COVERED SERVICES: Foot Care

At Contoso, we want to make sure our employees are taken care of and that starts with their health. Polaris Standard provides coverage for foot care services, so you don't have to worry about the costs associated with taking care of your feet.

Polaris Standard offers coverage for all kinds of foot care services, including podiatry visits, orthotics, and foot surgery. You can visit any in-network provider for these services and Polaris Standard will cover a portion of the cost.

Podiatry Visits

If you are experiencing foot or ankle-related issues, it's important to visit a podiatrist. Podiatrists are medical doctors who specialize in the diagnosis, treatment, and prevention of foot and ankle problems. Your Polaris Standard plan will cover the costs of a podiatry visit, so be sure to take advantage of this benefit if you're experiencing any foot-related issues.

Orthotics

Orthotics are custom-made shoe inserts that can help relieve pain and discomfort. They can also help with walking, running, and standing. If you're experiencing any foot or ankle issues, your Polaris Standard plan will cover the cost of orthotics.

Foot Surgery

In some cases, it may be necessary to have foot surgery in order to correct an issue. Polaris Standard will cover the cost of foot surgery, so you don't have to worry about the financial burden.

Exceptions

Unfortunately, Polaris Standard does not cover the cost of prosthetic devices or custom orthopedic shoes. If you need these services, you will have to pay for them out of pocket.

Tips

* Make sure you visit an in-network provider for your foot care services to ensure that Polaris Standard will cover the cost.

* Don't wait to get your foot issue checked out. If you're experiencing any foot or anklerelated issues, make sure you visit a podiatrist right away.

* Be proactive about your foot care. Make sure you're wearing the right shoes for your foot type and getting the right kind of orthotics for your feet.

We want to make sure our employees are taken care of, so take advantage of the foot care services available through Polaris Standard. With this plan, you can rest assured that you'll be covered for all of your foot care needs.

Gender Affirming Care

COVERED SERVICES - Gender Affirming Care

At Contoso, we understand that gender identity is an important part of who we are and that it should be respected and supported. We are proud to offer coverage through Polaris Standard for gender affirming care services.

Gender affirming care services can include a variety of treatments and services related to gender transition. These services may include hormone therapy, gender affirming surgeries, and mental health care related to gender transition.

Hormone Therapy

Hormone therapy is a type of gender affirming treatment that can be used to help an individual align their physical characteristics with their gender identity. This type of therapy involves taking hormones that are typically associated with a certain gender to help the individual's body better reflect their gender identity.

Gender Affirming Surgery

Gender affirming surgery is a type of treatment that involves surgical procedures to help an individual transition to the gender they identify with.

Mental Health Care

Mental health care related to gender transition can include counseling and therapy services to help an individual through their transition process. This type of care can help provide individuals with the support they need to make their transition successful.

Exceptions

Polaris Standard does have some exceptions when it comes to gender affirming care. This plan does not cover fertility services, such as egg and sperm banking, or gender affirming treatments for minors.

Tips

If you are considering gender affirming care, it is important to talk to your doctor to discuss the best treatment plan for you. Additionally, it is important to remember that gender affirming care is a complex process, and it is important to be patient and kind to yourself throughout the process. Lastly, it is important to remember to take care of your mental health during the transition process.

At Contoso, we strive to provide our employees with the best possible coverage for gender affirming care. We are proud to offer coverage for these services for our employees, and we are committed to providing a safe and supportive environment for all of our employees.

Hearing Care

Hearing Care

At Contoso, we understand the importance of taking care of your hearing health. That's why we provide comprehensive coverage for hearing care with Polaris Standard. You can receive hearing care services from any in-network provider and enjoy comprehensive coverage for all hearing care services.

The Polaris Standard plan covers all types of hearing care services, including hearing tests, hearing aids and hearing aid accessories, as well as cochlear implants and boneanchored hearing aids. If a hearing aid or cochlear implant is needed, the plan covers up to two

hearing aids or implants per ear every three years. The plan also covers routine hearing aid maintenance and repair, as well as counseling and hearing aid evaluations.

In addition, the Polaris Standard plan covers up to $500 per ear for hearing aid accessories, such as ear molds, batteries, and tubing. There is no deductible for hearing care services and no pre-authorization is required.

However, the Polaris Standard plan does not cover hearing care services provided by out-of-network providers. If you choose to see an out-of-network provider for hearing care, you will be responsible for the difference between the out-of-network provider's charges and the plan's allowed amount.

When it comes to choosing a hearing care provider, it's important to find one who is qualified and experienced. Make sure to ask questions about the provider's qualifications, experience, and specialties. You should also ask about the provider's policies on returns, warranties, and repairs.

It's also important to understand the technology behind hearing aids. Ask your provider to explain the differences between digital and analog technology, and be sure to ask about the various features that are available.

If you have any questions about the Polaris Standard plan's coverage for hearing care, please contact us. We are here to help you get the most out of your benefits.

Home Health Care

COVERED SERVICES: Home Health Care

At Polaris Health, we understand the importance of providing quality home health care for our customers. Our Polaris Standard plan offers coverage for home health care services, with some exceptions.

Home health care is a type of medical care provided in the home by a variety of health care providers, such as registered nurses, physical therapists, and home health aides. Home health care services may include wound care, catheter care, medication management, and monitoring vital signs. In some cases, home health care services may also include occupational, speech, and respiratory therapy.

When receiving home health care services, you may be required to pay a copayment or coinsurance based on the services provided and the number of visits. You may also be responsible for paying a deductible or any additional charges. However, some services, such as preventive care and certain types of home health care services, may be covered in full.

It is important to understand that home health care services are only covered when they are medically necessary and prescribed by a physician. Home health care services are not covered for custodial care, such as bathing and dressing, or for personal care services, such as errands and laundry.

When selecting a home health care provider, it is important to make sure that the provider is in-network and is covered under the Polaris Standard Plan. Additionally, make sure to verify that the provider is licensed and has the necessary credentials to provide the services you need.

Finally, it is important to keep in mind that home health care services may not be covered in all areas, so it is important to contact your insurance company to make sure that your services are covered. Additionally, you may also want to check with your doctor to see if other services, such as telemedicine, are available.

At Polaris Health, we are committed to providing quality home health care services to our customers. If you have any questions or need assistance, please contact us at any time.

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

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

Under the Polaris Standard plan, Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies are all covered services. This includes medically necessary equipment and supplies, such as wheelchairs, crutches, and prosthetics.

The plan covers the cost of renting or purchasing medically necessary home medical equipment, orthotics, and prosthetics. It will also cover the cost of repair and maintenance for these items, as long as they are not part of a health maintenance organization (HMO) plan. However, it is important to note that the plan does not cover the cost of any necessary supplies or services that are not medically necessary.

To ensure that the Polaris Standard plan covers the cost of any home medical equipment, orthotics, prosthetics, or supplies, it is important to obtain prior authorization from Polaris Health before the item is purchased or rented. Additionally, the plan will only cover the cost of items that are medically necessary, as determined by your doctor.

It is also important to note that the Polaris Standard plan does not cover items that are for convenience or comfort, such as lift chairs, beds, or bedding. Additionally, the plan does not cover the cost of any item that is available without a prescription, such as over-thecounter medications or non-prescription orthotics.

When purchasing or renting any home medical equipment, orthotics, prosthetics, or supplies, it is important to keep detailed records of all purchases or rentals. This includes keeping track of any receipts, invoices, or other documentation related to the purchase or rental. Additionally, it is important to keep track of any repair or maintenance services that are done on the item.

Finally, it is important to note that the Polaris Standard plan does not cover the cost of any services or supplies that are provided outside the network of Polaris Health. If you choose to receive services or supplies from an out-of-network provider, you will be responsible for any costs associated with those services or supplies.

By understanding the coverage of the Polaris Standard plan for Home Medical Equipment (HME), Orthotics, Prosthetics, and Supplies, you can ensure that you are taking full advantage of the benefits this plan offers. With the right knowledge and planning, you can make sure that you get the most out of your Polaris Standard plan.

Hospice Care

Hospice Care

At Contoso, we are proud to offer our employees access to Polaris Health's Standard Plan, which includes coverage for hospice care. Hospice care is a specialized form of medical care that focuses on providing comfort and support to individuals with a terminal illness.

Under this plan, hospice care can be covered when recommended by a doctor. This care is typically provided in the patient's home or in a hospice facility. It can include medical, social, spiritual, and emotional support for the patient and their family. Services typically included in hospice care include nursing care, medical equipment and supplies, home health aides, and prescription drugs.

Hospice care is an important part of end-of-life care. It focuses on providing comfort and support to the patient and their family, rather than trying to cure the illness. It also provides emotional support to help the patient and their family cope with the realities of the patient's condition.

It is important to note that Polaris Standard only covers hospice care when it is recommended by a doctor. This care must be provided by an in-network hospice provider.

Out-of-network providers are not covered under this plan. It is also important to note that Polaris Standard does not cover the cost of room and board for hospice care provided in a hospice facility.

We understand that these are difficult times for our employees and their families. We want to make sure that our employees have access to the care and support they need to make the most of their time together. We hope that this coverage will provide peace of mind and support during this difficult time.

Here are a few tips to help our employees make the most of their hospice care coverage:

- Make sure to choose an in-network hospice provider to ensure your care is covered.
- Make sure to keep all of your medical records up-to-date and accessible. This will help your doctor and hospice provider to provide the best care possible.
- Speak to your doctor and hospice provider about all of your options. They can provide valuable guidance and support throughout the process.
- Make sure to take advantage of all of the resources available to you. Many hospice providers offer counseling and support groups to help you and your family cope with the situation.

- Make sure to keep track of all of your expenses related to hospice care. Polaris Standard may cover some of your expenses, but you may have to pay for some out of pocket. Keeping track of your expenses will help you stay organized.

We hope that this information is helpful and that our employees can take comfort knowing that they have access to the care and support they need during this difficult time.

Hospital

COVERED SERVICES: HOSPITALS

Under the Polaris Standard plan, you have access to a variety of in-network hospitals. This means that you are not limited to a select few hospitals, and you can select the hospital that best meets your healthcare needs.

When choosing a hospital, you should keep in mind the type of care you are looking for. For example, if you need specialty care, you may want to select a hospital that specializes in the type of care you need. Additionally, you may want to consider the location of the hospital, as well as its reputation.

The Polaris Standard plan includes coverage for inpatient and outpatient services at innetwork hospitals. This includes hospitalization, surgery, and other services related to hospital care.

In some cases, you may need to receive care from an out-of-network hospital. In these cases, you will be responsible for paying the full cost of care. Additionally, you may be responsible for any additional costs that Polaris Health does not cover. For example, Polaris Health may not cover the full cost of a specialist or other non-emergency services. It is important to be aware of these exceptions when selecting a hospital.

When selecting a hospital, you should also consider other services that the hospital offers. For example, some hospitals may offer additional services such as physical therapy, nutrition counseling, or other wellness services. Additionally, some hospitals may offer special programs for specific conditions or diseases.

Finally, you should consider the cost of care at the hospital you are considering. Polaris Health may cover some or all of the costs of your care, but you should be aware of any additional costs that you may be responsible for. This includes any co-pays or coinsurance, as well as any additional charges for services not covered by your plan.

By taking the time to consider your options, you can select the best hospital for your healthcare needs. Polaris Standard offers coverage for a variety of in-network hospitals, giving you the opportunity to select the hospital that best meets your needs.

Infusion Therapy

Infusion Therapy

Infusion therapy is a type of medical treatment performed by qualified medical professionals. It involves the injection of drugs or fluids into a vein or muscle. This type of

therapy is used to treat a variety of medical conditions, including cancer, infections, and immune-related disorders.

Under Polaris Standard, the plan covers infusion therapy services provided by a qualified medical professional. This includes the administration of drugs or fluids, as well as related services performed during the same visit. This coverage includes both in-network and out-of-network providers.

However, there are some exceptions to the coverage of infusion therapy services. For example, the plan does not cover the costs of the drugs themselves. Additionally, certain services may be excluded from coverage, such as chemotherapeutic drugs and other services that are not medically necessary. It is important to check with your provider to determine if the particular service is covered under your plan.

In addition to the coverage information, there are some tips that can be helpful when it comes to infusion therapy. It is important to find a provider that is well-qualified and experienced in administering infusion therapy services. Additionally, it is important to discuss the risks and benefits of the treatment with your provider. Finally, make sure to discuss any questions or concerns you may have with your provider before beginning treatment.

Overall, Polaris Standard provides coverage for infusion therapy services. It is important to understand the coverage limitations and exceptions that may apply to your particular plan. Additionally, it is important to find a qualified provider and to discuss the risks and benefits of the treatment with your provider before beginning treatment.

Massage Therapy

COVERED SERVICES: Massage Therapy

At Contoso, we understand the importance of taking time to care for yourself and to reduce stress. That is why Polaris Health offers massage therapy coverage as part of the Polaris Standard plan. In order to be eligible for massage therapy coverage, the massage therapy must be medically necessary and prescribed by a primary care physician.

Massage therapy is a form of bodywork that uses manual manipulation of the muscles and soft tissue to reduce pain and tension and improve overall wellbeing. It can be used to treat a wide range of physical and mental health issues, including chronic pain, injuries, stress, anxiety, and depression.

When it comes to massage therapy, there are a few important exceptions to be aware of. Massage therapy must be performed by a licensed massage therapist who is a member of a recognized professional association. The massage therapy services must be performed in a professional setting and must be for a medically necessary condition. Massage therapy services are not covered for the purpose of relaxation or stress relief.

In order to receive coverage for massage therapy services, you will need to submit a prescription from your primary care physician and a completed massage therapy claim

form. In addition, you will need to provide the name of the massage therapist, their license number, and the dates of service.

It is important to note that Polaris Health does not cover all massage therapy services. Some services such as acupuncture, reflexology, and aromatherapy are not covered. You should check with your health plan to determine which services are covered.

When it comes to massage therapy, it is important to find a massage therapist who has experience and is familiar with your condition. You should also be sure to communicate your needs to the therapist and discuss any potential risks or side effects.

In addition to massage therapy, Polaris Health also offers coverage for other types of physical therapy, such as chiropractic care, physical therapy, and occupational therapy. These services can be used to help with pain relief, improve mobility, and reduce stress.

At Contoso, we want our employees to take the time to care for their physical and mental health. We are proud to offer coverage for massage therapy and other physical therapy services through Polaris Health. With this coverage, you can get the care you need to feel your best.

Mastectomy and Breast Reconstruction

Maternity Care

COVERED SERVICES: Maternity Care

At Polaris Health, we understand that having a baby can be costly and stressful. To help ease the burden, Polaris Standard offers comprehensive maternity care coverage.

Prenatal Care: Polaris Standard covers the costs of prenatal care for the mother, including routine visits with a doctor, laboratory tests, and ultrasounds. In addition, Polaris Standard also covers any necessary vitamins, minerals, or other supplements that are prescribed by the doctor.

Delivery: Polaris Standard covers the costs of labor, delivery, and post-delivery care for both the mother and the baby. The plan also covers the costs of any necessary medications, blood transfusions, or anesthesia that may be required.

Maternity Care After Delivery: Polaris Standard covers the costs of any follow-up visits with the doctor and the baby. The plan also covers the costs of any necessary vaccines or immunizations for the baby.

Exceptions: Please note that Polaris Standard does not cover the costs of any elective or cosmetic procedures for the mother or the baby. Additionally, Polaris Standard does not cover the costs of any fertility treatments or in vitro fertilization procedures.

Tips for Employees: We recommend that employee's begin planning for maternity care as soon as possible. This includes researching their coverage options, finding an obstetrician or midwife, and researching any other health professionals or resources that may be needed.

Additionally, we recommend that employees keep track of any costs associated with pregnancy and delivery, including any out-of-pocket expenses, in order to ensure they are properly reimbursed.

Medical Foods

COVERED SERVICES - Medical Foods

In addition to the comprehensive medical coverage provided by Polaris Standard, the plan also offers coverage for medical foods. This includes coverage for medically necessary food products, as well as nutritional supplements.

Medical foods are specially formulated foods that are intended for the dietary management of a specific medical condition. These foods are typically prescribed by a physician and are used to supplement a patient's daily food intake. Medical foods are used to treat a variety of conditions, including diabetes, celiac disease, and Crohn's disease.

Under Polaris Standard, medical foods are covered in the same way as prescription drugs. This means that coverage is subject to the plan's deductible and co-payment requirements. The plan also covers over-the-counter (OTC) medical foods in the same way as prescription drugs.

It is important to note that Polaris Standard does not cover food items that are not specifically prescribed as medical foods. This includes food items that are not used to treat a specific medical condition, as well as food items that are used for general nutrition. Tips for Employees

1. Be sure to speak with your doctor about whether or not a medical food would be beneficial for your condition.

2. Make sure you get a prescription for a medical food from your doctor so that it can be covered by your insurance plan.

3. Ask your doctor or pharmacist if there are any generic or over-the-counter options available that are covered by your insurance plan.

4. If you are considering purchasing a medical food without a prescription, be sure to check with your insurance provider to make sure it is covered.

5. If you have any questions about coverage or benefits, be sure to contact your insurance provider.

Medical Transportation

COVERED SERVICES: Medical Transportation

At Polaris Health, our Polaris Standard plan includes coverage for medical transportation. This includes coverage for transportation to and from medical appointments, as well as emergency transportation to the nearest medical facility.

This coverage will help ensure that employees can get the medical care they need without worrying about how they will get there. Polaris Health will provide coverage for transportation expenses, such as gas, public transportation fares, or taxi/rideshare services.

In order to receive reimbursement for transportation expenses, employees must present a valid invoice to Polaris Health. This invoice must include the date, time, and place of service, as well as the cost of transportation. Please note that Polaris Health will only reimburse up to the cost of the lowest available fare.

It's important to note that Polaris Standard does not cover ambulance services. This is because ambulance services are usually for emergency medical transportation, which is not covered by this plan. However, if a doctor prescribes ambulance services for medical reasons, Polaris Health may cover the cost.

Here are some tips for employees to keep in mind when using medical transportation coverage:

- Make sure to keep all receipts and invoices in case you need to submit them for reimbursement.
- Contact Polaris Health before using any medical transportation services to make sure they are covered under the policy.
- If you are using a rideshare service such as Uber or Lyft, make sure the driver is qualified and certified to provide medical transportation services.
- Check to see if there are any public transportation options available, as this is usually the most cost-effective option.
- Ask your doctor if there are any alternate transportation options available that may be covered by the plan.

Polaris Standard covers medical transportation expenses, which can help employees get the medical care they need without worrying about how they will get there. However, it's important to remember that Polaris Health does not cover ambulance services. By following the tips listed above, employees can make sure they are using their medical transportation coverage correctly and getting the most out of their plan.

Medical Transportation – State Restricted Care

MEDICAL TRANSPORTATION – STATE RESTRICTED CARE

The Polaris Standard health plan offers coverage for medical transportation services, including air and ground ambulance services, when medically necessary and pre-approved by Polaris Health. The plan also offers coverage for non-emergency transportation to and from medical appointments for members who have no access to other transportation.

This coverage is subject to state and geographic restrictions and is available for members in the following states: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, Oklahoma, Tennessee, and Texas.

Eligible Members:

For members to be eligible for this coverage, certain criteria must be met. These criteria include:

- Having no access to other transportation.
- Having a medical condition that requires transportation.
- Being enrolled in the Polaris Standard health plan.
- Having a valid referral from a physician or other healthcare provider.

Exceptions:

While this coverage is generally available to eligible members in the states listed above, there are some exceptions. These exceptions include:

- Transportation to and from a facility that is not a participating provider in the Polaris Standard health plan.
- Transportation to and from a facility that is not in the same state as the member.
- Transportation to and from a facility that is outside of the service area.
- Transportation to and from an event that is not a medical appointment or procedure.

Tips for Members:

When utilizing this coverage, it is important for members to keep the following tips in mind:

- Call Polaris Health prior to scheduling any medical transportation to ensure coverage is available.
- Keep all receipts and documentation related to medical transportation services.
- Request an estimate of costs prior to scheduling any medical transportation services.
- Contact Polaris Health to confirm coverage of out-of-network transportation services.
- Contact Polaris Health if any unexpected costs arise.
- Contact Polaris Health if any changes to the pre-approved transportation plan are necessary.

Conclusion

The Polaris Standard health plan offers coverage for medical transportation services for eligible members in certain states. It is important for members to contact Polaris Health prior to scheduling any medical transportation services to ensure coverage is available. Additionally, members should keep all documentation related to medical transportation services and contact Polaris Health if any unexpected costs arise.

Mental Health Care

COVERED SERVICES: Mental Health Care

At Contoso, we understand the importance of mental health, and we have included mental health care in our Polaris Standard plan. This coverage includes services such as individual, family, and group psychotherapy, as well as psychiatric and psychological evaluation services. You can use in-network providers to receive these services, so you can be sure that you are getting quality care.

However, there are a few exceptions to this coverage. Polaris Standard does not cover services related to educational testing, assessment services, or the cost of medications. Also, it does not cover services related to the treatment of substance abuse, so if you are in need of these services, you will need to explore other options.

Here are a few tips to help you make the most of the mental health care coverage that is available through Polaris Standard:

- Make sure to check with your provider to find out which services are covered under your plan.
- Check for any copayments or coinsurance that may apply to your visits.
- Make sure you are aware of any pre-authorizations that may be required for certain services, such as inpatient hospitalization.
- Ask your provider about any additional benefits that may be available, such as case management or behavioral health services.
- Be sure to keep track of all of your medical records and bills, including any payments made to your provider.
- If you need help finding a provider or have any other questions, you can contact Polaris Health directly.

We want to make sure that you are able to access the mental health care services that you need, so we encourage you to take advantage of the coverage available to you through Polaris Standard. If you have any questions or need help understanding your coverage, please contact our customer service department at Contoso.

Neurodevelopmental Therapy (Habilitation)

Neurodevelopmental Therapy (Habilitation)

At Contoso, we want to ensure that our employees and their dependents receive the best possible care and services. That's why we've partnered with Polaris Health to provide a comprehensive health plan that includes coverage for Neurodevelopmental Therapy (Habilitation).

What is Neurodevelopmental Therapy (Habilitation)?

Neurodevelopmental Therapy (Habilitation) is the assessment and treatment of physical, emotional, social, and cognitive impairments associated with neurological and developmental disorders. It is designed to help individuals with disabilities learn the skills they need to live as independently as possible, including communication, problem-solving, and self-care. This type of therapy is used to help individuals with neurological and developmental disorders, such as autism, Down syndrome, cerebral palsy, and traumatic brain injury.

What Does Polaris Standard Cover?

Polaris Standard provides coverage for Neurodevelopmental Therapy (Habilitation) services, including:

- Evaluation and assessment
- Development of an individualized treatment plan
- Training in communication, problem-solving, and self-care
- Training in daily living skills, such as dressing and grooming
- Training in social skills and appropriate behavior

What Exceptions Are There?

Polaris Standard does not cover any services related to Neurodevelopmental Therapy (Habilitation) that are not medically necessary. The plan also does not cover any experimental or investigational treatments or services.

Tips for Employees

- Make sure to always stay in-network if you plan to use Neurodevelopmental Therapy (Habilitation) services. Polaris Standard will only cover in-network providers.
- Ask your provider about the cost of services before receiving treatment. Polaris Standard has a coinsurance and copayment requirement for certain services.
- Talk to your doctor about all of your options. Neurodevelopmental Therapy (Habilitation) services are often helpful, but they may not be the best option for everyone.
- Be aware of Polaris Standard's preauthorization requirements. In some cases, you'll need to get preauthorization before receiving treatment.

- If you're considering Neurodevelopmental Therapy (Habilitation) services, make sure to research your options. Look for providers who specialize in the type of care you're looking for and make sure they are in-network.
- Speak to your doctor about any concerns you have about the cost of Neurodevelopmental Therapy (Habilitation) services and how they will be covered by Polaris Standard.
- Keep in mind that Neurodevelopmental Therapy (Habilitation) services can take time and consistency to be effective.
- Don't be afraid to ask questions or seek additional information. Neurodevelopmental Therapy (Habilitation) services can be confusing, so it's important to make sure you understand everything before making a decision.

At Contoso, we want to make sure that our employees and their dependents are getting the best possible care. Neurodevelopmental Therapy (Habilitation) is an important part of that care, and we're proud to partner with Polaris Health to provide coverage for these services. With Polaris Standard, you can get the care you need to live as independently as possible.

Newborn Care

COVERED SERVICES: NEWBORN CARE

At Contoso, we are proud to partner with Polaris Health to offer our employees the Polaris Standard plan. This plan includes coverage for newborn care, so you can rest assured that your little one is taken care of.

What is Covered

The Polaris Standard plan covers a variety of services for newborns and their parents, including:

- Well-child visits: The plan covers visits with your baby's doctor for regular check-ups and immunizations.
- Diagnostic tests: This plan covers tests that may be needed to diagnose or treat your baby's health condition.
- Prescription drugs: The plan covers prescription drugs that are prescribed by your baby's doctor.
- Mental health services: If your baby requires mental health services, the plan covers them.
- Physical therapy: If your baby requires physical therapy, the plan covers it.
- Inpatient care: The plan covers inpatient care if your baby needs to be admitted to the hospital.

Exceptions

Unfortunately, the Polaris Standard plan does not cover all services for newborns. The following services are not covered:

- Home health care: Home health care is not covered under the plan.
- Long-term care: Long-term care is not covered under the plan.
- Alternative therapies: Alternative therapies such as acupuncture, massage, and chiropractic care are not covered under the plan.
- Cosmetic treatments: Cosmetic treatments are not covered under the plan.

Tips

- Be sure to keep all of your baby's medical records, including immunization records, in a safe place.
- Make sure you understand the coverage and any limitations that come with your plan.
- Ask your baby's doctor for information about any tests or treatments that are recommended.
- Talk to your doctor about any questions or concerns you may have about your baby's health.
- Call your insurance company if you have any questions about your coverage or need help understanding your plan.

At Contoso, we are committed to providing our employees with the best healthcare coverage available. We are proud to partner with Polaris Health to offer the Polaris Standard plan, which includes coverage for newborn care. With this plan, you can rest assured that your little one is taken care of.

Orthognathic Surgery (Jaw Augmentation Or Reduction)

COVERED SERVICES: Orthognathic Surgery (Jaw Augmentation or Reduction)

Under Polaris Standard, orthognathic surgery, or jaw augmentation or reduction, is a type of covered service. This procedure involves the reshaping of the jaw, which may be done to correct a number of medical conditions, such as a misaligned jaw, a jaw that is too narrow or wide, an overbite, or an underbite.

Orthognathic surgery may also be used to improve a person's facial appearance. This type of surgery is generally performed by an oral and maxillofacial surgeon and may require a hospital stay of up to three days, depending on the complexity of the procedure.

In order for the orthognathic surgery to be covered by Polaris Standard, the procedure must be medically necessary and the patient must be referred by a primary care physician or specialist. In addition, the patient must be an in-network provider for Polaris Standard, and the services must be performed at an in-network hospital or facility.

When considering orthognathic surgery, it is important to remember that there is no onesize-fits-all approach. Each patient's needs are different, and the procedure should be tailored to the individual's needs. It is also important to be aware that this type of surgery may not be covered by Polaris Standard if it is considered cosmetic in nature.

When seeking orthognathic surgery, it is important to discuss the risks and benefits with your primary care physician or specialist. It is also important to ask questions and seek out second opinions before making a decision. It is also a good idea to research the credentials of the surgeon you are considering, as well as the hospital or facility where the procedure will be performed.

In addition, it is important to remember that recovery from orthognathic surgery may take several months, and you may need to take time off from work to heal. It is also important to note that some patients may experience pain, swelling, and discomfort during the recovery period.

Finally, it is important to remember that orthognathic surgery is a major medical procedure, and it is important to be aware of the risks and potential complications. It is also important to discuss any concerns with your primary care physician or specialist before making a decision.

Polaris Standard is committed to providing patients with quality care and coverage for orthognathic surgery. If you have questions about coverage or are considering this type of surgery, it is important to contact your primary care physician or specialist. You can also contact Polaris Standard for more information about coverage and eligibility.

Prescription Drug

COVERED SERVICES: Prescription Drugs

The Polaris Standard plan provides coverage for prescription drugs. This includes both brand name and generic medications, as well as over-the-counter drugs when prescribed by a doctor. Polaris Standard also provides coverage for immunizations and vaccinations.

In order to receive coverage for prescription drugs, members must use one of Polaris Health's preferred pharmacies. Preferred pharmacies offer the lowest copayments, and they also provide additional cost savings benefits. To find a preferred pharmacy in your area, you can use the Find a Pharmacy tool on the Polaris Health website.

When filling a prescription, you can choose to receive your medications through the mail. This option is convenient and can help you save money. You can also request prescription refills online or by phone, and you can even use a mobile app to manage your prescriptions.

When using a preferred pharmacy, you may be able to take advantage of discounts on generic medications. This can help to reduce your out-of-pocket costs. In addition, your pharmacy may offer additional savings on brand-name medications, such as 90-day supplies or three-month supplies.

It's important to note that the Polaris Standard plan does not cover certain medications, including drugs used for weight loss or fertility treatments, compounded medications, or drugs that are not FDA-approved. You should always check with your doctor or pharmacist to make sure that your prescription is covered under the Polaris Standard plan.

You should also be aware that Polaris Standard does not cover over-the-counter medications, unless they are prescribed by a doctor. If you need to purchase an over-thecounter medication, you will have to pay for it out of pocket.

Finally, always look for generic medications whenever possible. Generic medications are typically less expensive than brand-name medications, and they are just as effective.

By following these tips, you can make sure that you are taking advantage of all the benefits of the Polaris Standard plan. With the right plan in place, you can be sure that you are getting the best coverage for your medical, dental, vision, and prescription drug needs.

Preventive Care

COVERED SERVICES: Preventive Care

At Polaris Health, preventive care services are covered under the Polaris Standard plan. Preventive care services are a great way to stay on top of your health, and they are available at no additional cost when you are a part of Polaris Standard.

Preventive care services include the following:

- Physicals and vaccinations
- Health screenings and tests, such as blood pressure, cholesterol and diabetes tests
- Counseling, such as lifestyle and nutrition counseling
- Immunizations
- Vision and hearing screenings
- Other preventive services as recommended by the U.S. Preventive Services Task Force

Please note that Polaris Standard does not cover all preventive care services. For instance, Polaris Standard does not cover cosmetic services or any service that is not medically necessary.

To make the most of your Polaris Standard plan, here are a few tips:

- Be sure to talk to your doctor to find out which screenings, tests, and immunizations you should get each year.
- Know which preventive services are covered by your plan.
- Ask your doctor if he or she is in-network with Polaris Health.

• Schedule regular physicals and preventive care check-ups.

• Take advantage of any wellness programs offered by Polaris Health.

• Stay up-to-date on the latest preventive care guidelines.

Preventive care services can help you stay healthy and prevent illnesses from developing. With Polaris Standard, you can take advantage of these important services, which are covered at no additional cost.

Remember, preventive care is an important part of your overall health. Polaris Health is dedicated to helping you get the preventive care you need to stay healthy and protect yourself for the future.

Professional Visits And Services

COVERED SERVICES: Professional Visits and Services

Polaris Standard provides coverage for professional visits and services. This includes visits to your primary care physician, specialists, and other health care providers. This coverage is available for services that are medically necessary and are provided by innetwork providers.

In-network providers will generally provide services at a lower cost than out-of-network providers, so it is important to check with Polaris Health before making an appointment to ensure that the provider is in-network. This can help you save money and avoid unexpected costs.

The Polaris Standard plan covers services such as:

- Preventive care services, including physicals, immunizations, and screenings

- Diagnostic tests and treatments

- Medical consultations

- Physical therapy

- Mental health services

- Prescription drugs

- Inpatient hospital services

- Emergency services

Polaris Standard does not cover certain types of services, including cosmetic services, experimental treatments, and most dental services. It also does not cover services provided by out-of-network providers.

When using your Polaris Standard plan, it is important to understand your coverage and any costs that you may be responsible for. Polaris Health offers a variety of tools and resources

to help you make the most of your coverage, including a cost estimator tool and a provider directory. Polaris also offers 24/7 customer service to answer any questions you may have about your coverage.

Using your Polaris Standard plan can help you get the care you need while saving money. It is important to understand your coverage and any out-of-pocket costs that may be associated with services. When in doubt, check with Polaris Health to ensure that you are getting the most out of your coverage.

Psychological and Neuropsychological Testing

Psychological and Neuropsychological Testing Covered Services

The Polaris Standard plan offers coverage for psychological and neuropsychological testing services. These services are covered under the plan's mental health benefits, so you can rest assured that your tests will be covered in full.

When it comes to psychological and neuropsychological testing services, there are some exceptions that you should be aware of. Generally, this type of testing is covered when it is prescribed or ordered by a health care professional. The tests must be medically necessary in order for the plan to provide coverage. Additionally, the plan will only cover the cost of the tests when they are administered by an in-network provider.

If you are in need of psychological or neuropsychological testing services, your first step should be to speak with your primary care physician. He or she will determine if the tests are medically necessary and can provide you with a referral to an in-network provider. It is important to note that the Polaris Standard plan does not cover the cost of any tests that are administered by an out-of-network provider.

When you are selecting an in-network provider for your psychological or neuropsychological testing services, it is important to ensure that the provider is properly licensed and highly qualified to perform the tests. You should also ask questions about the provider's experience and training in order to ensure that you are receiving the highest quality of care.

It is also important to remember that the Polaris Standard plan does not cover any costs associated with psychological or neuropsychological testing that is done for research purposes or for educational purposes. Additionally, the plan does not cover any costs associated with psychological or neuropsychological testing that is done for non-medical reasons such as pre-employment screening or for legal purposes.

In order to ensure that your psychological or neuropsychological testing services are covered under the Polaris Standard plan, it is important to review your plan's Summary of Benefits and Coverage (SBC) document. This document will provide you with a full list of covered services, as well as any exceptions that may apply.

Overall, the Polaris Standard plan provides coverage for psychological and neuropsychological testing services when they are prescribed or ordered by a health care

professional and when they are provided by an in-network provider. It is important to be aware of any exceptions that may apply, as well as to select a highly qualified in-network provider for your tests in order to ensure that your services are covered in full.

Rehabilitation Therapy

REHABILITATION THERAPY

Polaris Standard covers a range of rehabilitation therapy services, including physical, occupational, and speech therapy. For physical therapy, coverage is for medically necessary physical therapy services related to an injury or illness, including the use of equipment and supplies. For occupational therapy, coverage is for medically necessary services related to an injury or illness, including the use of specialized equipment and supplies. For speech therapy, coverage is for medically necessary services related to an injury or illness, including the use of specialized equipment and supplies.

Exceptions

Unfortunately, Polaris Standard does not cover any services related to cosmetic or reconstructive surgery, or any services related to the treatment of obesity or weight control. This plan also does not cover services related to the treatment of sleep disorders.

Tips

When looking for a rehabilitation therapy provider, make sure that they are in-network and covered by your plan. Also, keep in mind that you may need a referral from a primary care physician for some services. Finally, remember to bring a list of all medications you are taking to your provider, as well as any information about past medical history.

If you have any questions about the services covered by Polaris Standard, you can contact the Polaris Health customer service team for more information. They can provide you with details about the types of services covered, as well as any applicable copayments, coinsurances, and deductibles.

Skilled Nursing Facility Services

Skilled Nursing Facility Services

Skilled nursing facility (SNF) services are a key component of Polaris Standard health plan coverage. The plan provides coverage for short-term care in a skilled nursing facility for medically necessary services. The coverage is designed to help you receive the care you need to help you recover from an illness or injury.

What Does Skilled Nursing Facility Care Include?

Skilled nursing facility care includes a wide range of services provided by a variety of healthcare professionals, including trained nurses, therapists, social workers, and other professionals to help you recover from an illness or injury. Services may include physical, occupational, and speech therapy, medication management, wound care, intravenous infusions, and other services that can help you regain independence and return home.

How Long Does Skilled Nursing Facility Care Last?

Your coverage for skilled nursing facility care is limited to a maximum of 100 days. In order to continue to receive benefits, you must make measurable progress toward a goal that is established by your doctor.

What Are the Exceptions to Skilled Nursing Facility Care Coverage?

Not all skilled nursing facility services are covered under Polaris Standard. The plan does not cover custodial care or services that are not medically necessary. Custodial care includes services that are provided to help you with activities of daily living such as bathing, dressing, and other basic care.

Other exceptions to coverage include services provided in an assisted living facility, a hospice, or in the home.

Tips for Getting the Most Out of Your Skilled Nursing Facility Care

- Make sure to communicate with your doctor and the skilled nursing facility staff about your progress and treatment plan.
- Ask questions about any treatments or services that you are unfamiliar with.
- Check with your plan to make sure that any medications or treatments you receive are covered under your plan.
- Use the skilled nursing facility's discharge planning services to ensure a smooth transition home.
- Be sure to follow-up with your primary care doctor after leaving the facility.

Spinal and Other Manipulations

COVERED SERVICES: Spinal and Other Manipulations

Polaris Standard offers coverage for spinal and other manipulations, including chiropractic and osteopathic services. These services may be covered when they are performed by a licensed chiropractor or osteopathic physician, and when they are medically necessary. The plan covers manipulation of the spine and other joints, as well as the soft tissues of the body. This can include the muscles, ligaments, and tendons that are associated with the spine and joints.

The services must be performed by a licensed chiropractor or osteopathic physician. These services may be performed on an outpatient basis, such as at a chiropractor's office, or in a hospital or other facility.

It is important to note that Polaris Standard does not cover services that are not medically necessary, or that are performed by someone who is not a licensed chiropractor or osteopathic physician.

In some cases, coverage for spinal and other manipulations may be subject to preauthorization or pre-certification. If your provider requires pre-authorization or precertification, you should contact Polaris Health prior to receiving the services to ensure that they are covered.

It is also important to understand that coverage for spinal and other manipulations may be limited. Polaris Standard does not cover services for the purpose of maintenance or prevention of disease, nor does it cover services that are experimental in nature.

If your provider recommends spinal or other manipulations, it is important to make sure that you understand the risks and benefits associated with the service. Make sure that you ask questions about how the service will be performed and what the expected results will be. Make sure that you understand what the potential risks and complications are and that you are comfortable with the provider's approach.

It is also important to understand that spinal and other manipulations may be covered by other insurance plans or by other sources. Be sure to check with your provider to see if there are any additional coverage options available.

Finally, it is important to remember that spinal and other manipulations are not a substitute for other forms of medical care. If you have any questions or concerns about your health, you should always speak to your doctor or other health care provider.

Substance Use Disorder

Substance Use Disorder

At Contoso, we understand that substance use disorder is a serious issue that can have a devastating impact on individuals and their families. We are proud to offer our employees access to Polaris Standard, a health plan that provides coverage for substance use disorder treatment services.

Polaris Standard covers substance use disorder treatment services when they are medically necessary, including inpatient and outpatient care, as well as counseling. This coverage also includes medically necessary medications that are used to treat substance use disorder.

In addition, Polaris Standard provides coverage for certain services that are not typically covered by other health plans, such as detoxification services, residential treatment services, and recovery support services.

While Polaris Standard does provide coverage for substance use disorder treatment services, there are some exceptions to this coverage. For example, Polaris Standard does not cover services that are provided in a hospital emergency room or a hospital inpatient setting unless they are medically necessary and pre-authorized by Polaris Health.

We understand that substance use disorder can have a devastating impact, and we want to make sure that our employees have access to the care they need. If you have any questions

about Polaris Standard's coverage for substance use disorder services, please contact Polaris Health and speak to one of our customer service representatives.

Here are some tips that could be helpful to our employees who may be struggling with substance use disorder:

- Seek help as soon as possible. Early intervention and treatment can make a significant difference in achieving successful recovery.
- Take advantage of your Polaris Standard coverage. Make sure to familiarize yourself with your coverage, and take full advantage of all the services available to you.
- Reach out for support. Substance use disorder is a very isolating experience, but there are people who want to help and support you.
- Stay connected to your recovery plan. Developing and following a recovery plan is essential to long-term sobriety. Make sure to stick to your plan and seek out additional resources as needed.
- Take care of your health. Substance use disorder can have a profound impact on your physical and mental health. Make sure to seek regular medical care and take steps to manage your physical and mental health.

We hope that these tips are helpful to our employees who are struggling with substance use disorder. We encourage everyone to contact Polaris Health and speak to one of our customer service representatives if you have any questions about your coverage for substance use disorder services.

Surgery

Surgery

Surgery is a common medical service and is covered under the Polaris Standard plan. You will be able to use in-network providers for your surgery, as long as it's deemed medically necessary by your doctor.

The amount of coverage you receive for surgery depends on the type of surgery you need. Generally, simple and routine surgeries are covered at 100%, while major or complex surgeries may be covered at a lower rate. You can check with your insurance provider to learn more about the coverage for specific surgeries.

Before you receive surgery, you'll need to get pre-authorization from your insurance provider. Pre-authorization means that your insurance provider has approved the surgery and the amount of coverage you'll receive. If you don't get pre-authorization, you may be responsible for all the costs of the surgery.

You'll also need to make sure that you have a referral from your primary care physician if you're seeing a specialist for surgery. If you don't have a referral, your insurance provider may not cover the cost of the surgery.

If you need to stay overnight in a hospital after your surgery, your Polaris Standard plan will cover the cost of the hospital stay. However, you may have to pay a copay for each day you stay in the hospital.

In some cases, you may need to pay for part of the cost of the surgery. This is called coinsurance, which is a percentage of the cost that you pay out-of-pocket. The coinsurance rate for surgeries is usually around 20%, but it can vary depending on the type of surgery and the insurance provider.

Some types of surgery are not covered by the Polaris Standard plan. These may include cosmetic surgery, elective surgery, and any type of experimental surgery. You'll need to check with your insurance provider to find out which surgeries are covered and which are not.

When it comes to surgery, it's important to plan ahead and make sure that you understand your insurance coverage. Make sure to get pre-authorization, get a referral from your primary care physician, and get an estimate of the cost of the surgery. This will help ensure that your surgery is covered and that you're not left with unexpected costs.

Surgical Center Care – Outpatient

Surgical Center Care – Outpatient

At Polaris Health, we understand that having access to quality and affordable care is important. That's why we offer coverage for surgical center care – outpatient services in our Polaris Standard plan.

When it comes to surgical center care, Polaris Health provides coverage for procedures that require care at an outpatient surgical center. This includes surgery, as well as related services, such as lab tests, x-rays, and certain medications. This coverage is subject to certain restrictions, such as prior authorization, medical necessity, and applicable copayments or coinsurance.

It's important to note that Polaris Standard does not cover services provided in a hospital outpatient department. If you need care in a hospital outpatient setting, you will need to pay the full cost of the services not covered.

If you need a surgical procedure, your primary care physician will likely refer you to a specialist who can provide the care you need. Make sure to ask questions and get all the information you need before you have your procedure. Also, make sure to check if the specialist is in-network with Polaris Health. That way, you can be sure that your procedure will be covered by your plan.

When you visit the surgical center, you may be asked to sign a form acknowledging that you are responsible for any costs that are not covered by your plan. It's important to read this form carefully, so you know what you're agreeing to.

If you need to have a procedure done at an outpatient surgical center, make sure to contact Polaris Health beforehand. You can call our customer service team at 1-800-555-1234 and they will help you understand what services are covered by your plan and how to get the care you need.

At Polaris Health, we are committed to providing quality and affordable health care services. We are here to help you get the care you need, when you need it.

Temporomandibular Joint Disorders (TMJ) Care

COVERED SERVICES: Temporomandibular Joint Disorders (TMJ) Care

The Polaris Standard plan includes coverage for Temporomandibular Joint Disorders (TMJ) Care. TMJ care is the diagnosis and management of disorders of the temporomandibular joint, which is the joint that connects the lower jaw to the skull. TMJ care can include diagnostics such as x-rays, CT scans, MRIs, and other tests or treatments, including physical therapy, medications, and surgery.

The Polaris Standard plan does not cover certain TMJ treatments and services, such as treatment for bruxism, TMJ splint therapy, or orthodontic treatment. Additionally, any services or treatments that are deemed to be experimental or investigational are not covered by the Polaris Standard plan.

Employees with this plan should be aware that they may be subject to preauthorization requirements when seeking TMJ care. Preauthorization is a process in which a health insurance company reviews the medical necessity of a treatment or procedure prior to authorizing payment. This means that the employee must obtain approval from the insurance company before receiving the treatment or procedure.

When seeking TMJ care, it is important for the employee to discuss their condition and treatment options with their healthcare provider. The healthcare provider can recommend specific treatments and services that are appropriate for the employee's condition and can help the employee understand if their treatment is covered by the Polaris Standard plan. It is also important for the employee to understand their financial responsibility prior to receiving treatment. This includes any copayments, coinsurance, or deductibles that may be applicable.

In addition to discussing treatment options with their healthcare provider, employees should also be proactive in managing their TMJ condition. This includes avoiding activities that can exacerbate the problem, such as grinding teeth or chewing gum, and practicing relaxation techniques to reduce stress. Additionally, employees should practice good posture and avoid sleeping on their stomach to reduce strain on the jaw. Practicing good oral hygiene is also important, as TMJ can be caused by dental problems such as misalignment of the teeth.

Finally, employees should be aware that TMJ is a chronic condition, which means that it may require ongoing management. Regular visits to the healthcare provider for diagnosis and treatment may be necessary in order to manage the condition. Employees should also be

aware that the Polaris Standard plan does not cover all TMJ treatments, so it is important to understand their financial responsibility for any treatment that is not covered.

In conclusion, the Polaris Standard plan does provide coverage for TMJ care, but there may be certain treatments and services that are not covered. It is important for employees to understand their financial responsibility prior to receiving treatment, and to discuss their condition and treatment options with their healthcare provider. Additionally, it is important for employees to practice good posture, avoid activities that can exacerbate the problem, and practice good oral hygiene in order to manage their TMJ condition.

Therapeutic Injections

Therapeutic Injections

Therapeutic injections are a covered service under the Polaris Standard plan. This means that members of the Polaris Standard plan will be eligible for coverage for certain therapeutic injections. This coverage includes the cost of both the injection and the injection materials.

The Polaris Standard plan covers therapeutic injections when they are medically necessary and prescribed by a physician. Injections that are medically necessary are those that are necessary to treat, diagnose, or prevent a medical condition that has been diagnosed by a physician. This means that the injection must be part of the treatment plan for a medical condition that has been diagnosed by a physician.

The Polaris Standard plan does not cover injections for cosmetic purposes or for treatment of any condition that has not been diagnosed by a physician.

In order for a therapeutic injection to be covered by the Polaris Standard plan, the injection must be administered by a physician or other qualified healthcare provider. The injection must also be administered in a medically appropriate setting, such as a hospital or physician's office. Injections that are administered in non-medical settings, such as a pharmacy, are not covered by the Polaris Standard plan.

Members of the Polaris Standard plan may be responsible for any co-payments, coinsurance, or deductibles associated with the therapeutic injection. The amount of the copayment, coinsurance, or deductible will be determined by the member's specific plan.

When considering a therapeutic injection, members should talk to their physician or other qualified healthcare provider about the risks, benefits, and potential side effects of the injection. It is also important to discuss any other treatments or medications that may be necessary in order to get the best possible outcome for the medical condition that is being treated.

It is also important to note that therapeutic injections may not be covered under all Polaris Standard plans. Members should check with their plan administrator to determine if a specific therapeutic injection is covered under their plan.

When a therapeutic injection is covered by the Polaris Standard plan, the member should always confirm that the injection is being administered by a qualified healthcare provider in a medically appropriate setting. If a member has any questions about the therapeutic injection, they should contact the Polaris Health customer service team for more information.

By understanding the coverage offered by the Polaris Standard plan, members can make informed decisions about their healthcare and ensure that they are getting the best possible care.

Transplants

COVERED SERVICES - Transplants

At Polaris Health, we understand how important it is to have access to the best possible care. That's why our Polaris Standard plan provides coverage for organ and tissue transplants.

If you need a transplant of any kind, Polaris Standard will cover the expenses associated with the procedure, including the cost of the donor organ, hospital stays, recovery costs, and medications. It's important to note that transplants are subject to certain criteria, including a determination of medical necessity, so it's important to discuss your transplant needs with your primary care physician.

In addition to covering the cost of the transplant itself, Polaris Standard will also provide coverage for pre- and post-transplant care, such as laboratory tests, diagnostic tests, and other medically necessary services. It's important to note that there are some exceptions to coverage for transplants. For example, Polaris Standard does not cover experimental or investigational transplant procedures, or any services that are not medically necessary.

When it comes to making sure you get the best care possible, we believe that the best approach is to work with your doctor to determine the best course of action. It's important to note that coverage for transplants is subject to preauthorization, so it's important to make sure that you get the necessary authorization for any transplant procedures before you move forward.

There are also a few tips that can help make sure that you get the most out of your Polaris Standard coverage for transplants. For example, it's important to make sure that you are familiar with all of the details of your coverage, including any applicable copays or coinsurance requirements. It's also a good idea to ask your doctor about any potential outof-pocket costs you may need to pay, as well as any potential alternative treatments that may be available.

Finally, it's important to note that Polaris Standard does not provide coverage for any experimental or investigational transplant procedures. If you're considering a transplant procedure, it's important to make sure that it is a medically necessary procedure, and that it is covered under your Polaris Standard plan.

At Polaris Health, we understand how important it is for our members to have access to the best possible care. That's why we're proud to provide coverage for organ and tissue transplants through our Polaris Standard plan. With this coverage, you can get the care you need, while also enjoying the peace of mind that comes from knowing that your transplant procedure is covered.

Urgent Care

COVERED SERVICES: Urgent Care

At Polaris Health, our Polaris Standard plan covers urgent care services. Urgent care services are typically for medical issues that cannot wait for a scheduled appointment with a primary care provider. Examples of conditions that would be covered under urgent care include ear infections, allergic reactions, minor broken bones, and insect or animal bites.

Polaris Health's Polaris Standard plan covers urgent care services provided by innetwork providers. The coverage includes visits to urgent care centers and emergency rooms. It is important to note that while emergency rooms are covered, they should only be used in the event of a true medical emergency. In the case of a medical emergency, go to the nearest emergency room or call 911 right away.

To help you determine whether a condition requires urgent care or can wait for a scheduled appointment, Polaris Health provides access to telemedicine services. Telemedicine services are available 24 hours a day, seven days a week. Through these services, you can talk to a doctor or nurse practitioner who can help you determine if a condition is appropriate for urgent care or should be treated with a scheduled appointment.

When seeking urgent care services, it is important to keep in mind that you may be responsible for some out-of-pocket costs. This includes co-pays, co-insurance, and deductibles. The amount you are responsible for will depend on your plan and the type of services you receive. To help you better understand your coverage, Polaris Health provides access to an online cost estimator tool. This tool allows you to search for specific services and get an estimate of what you will be responsible for. It is important to note that the estimates provided are only estimates, and the actual cost may vary.

Finally, Polaris Health's Polaris Standard plan does not cover services that are not medically necessary. Examples of services that are not covered include cosmetic procedures and elective treatments. Additionally, the plan does not cover services that are not related to the diagnosis or treatment of an illness or injury.

At Polaris Health, we are committed to helping you get the care you need when you need it. We understand that medical issues can arise suddenly and can be unpredictable. That is why we offer coverage for urgent care services through our Polaris Standard plan. If you have any questions about your coverage, please contact our customer service team.

Virtual Care

COVERED SERVICES: VIRTUAL CARE

At Polaris Health, we understand that our members may have difficulty accessing inperson care. That is why we offer virtual care, allowing members to access care from the comfort of their own home. With virtual care, members can talk to a doctor or nurse practitioner by phone or video call, receive a diagnosis and treatment, and get prescriptions sent to their pharmacy of choice.

Polaris Standard covers virtual care services in the same way it would cover an inperson visit. This includes a variety of services, such as urgent care, primary care, mental health and substance abuse services, and specialist visits. Members also have access to telehealth post-discharge care and chronic disease management.

Exceptions

Although Polaris Standard covers most virtual care services, there are a few exceptions. Virtual care is not covered for any services that require a physical exam, such as pediatric well-child visits, physical therapy, and lab work. Additionally, virtual care is not covered for any services that require in-person care, such as surgeries and imaging tests.

Tips for Members

We want to make sure our members get the most out of their virtual care visits. Here are a few tips to help make your virtual care visits as successful as possible:

- Make sure your doctor is in-network. Polaris Standard covers virtual care services for in-network providers only.

- Have your medical records on hand. Your doctor or nurse practitioner will need to see your medical records during the visit, so make sure to have them available.

- Have a list of questions ready. Make sure to write down any questions you have before the visit so that you can get the most out of it.

- Follow up with your doctor. After the virtual care visit, make sure to follow up with your doctor if needed.

Virtual care is a great way to access care from the comfort of your own home. With Polaris Standard, you can get the care you need without the hassle of leaving your home. Our virtual care services are covered in the same way as any in-person visit, so you can rest assured you are getting the best possible care.

Weight Management

WEIGHT MANAGEMENT

Weight management can be an important part of staying healthy and maintaining a healthy lifestyle. Fortunately, Polaris Standard provides coverage for various weight management programs and services.

Preventive Care Services

Polaris Standard covers preventive care services related to weight management. This includes screening tests related to obesity as well as nutrition counseling. This coverage may also include follow-up services related to the screening test and nutrition counseling.

Behavioral Health Services

Polaris Standard also covers behavioral health services related to weight management. This includes behavioral counseling and cognitive behavioral therapy. The service provider may also provide group counseling related to weight management and nutrition.

Prescription Drugs

Polaris Standard also covers certain prescription drugs related to weight management, such as medications for obesity. However, please note that there may be other prescriptions drugs related to weight management that Polaris Standard does not cover. Please contact Polaris Health for more information.

Exceptions

Polaris Standard does not cover weight loss surgery or any other type of cosmetic surgery related to weight management.

Tips for Weight Management

If you are looking to manage your weight, there are a few tips that can help you get started.

1. Make sure to get enough sleep. Sleep helps the body to rest and recover, which can help you to stay energized and focused.

2. Eat a balanced diet. Eating a balanced diet that includes a variety of fruits, vegetables, lean proteins, and whole grains can help you to maintain a healthy weight.

3. Exercise regularly. Exercise helps to burn calories and can help with weight management. Try to get at least 30 minutes of physical activity each day.

4. Drink plenty of water. Drinking water helps to keep the body hydrated and can help with weight management.

5. Avoid sugary drinks. Sugary drinks such as soda and energy drinks can add a lot of calories to your diet, so try to avoid them.

6. Track your progress. Keeping track of your weight loss progress can help you to stay motivated and on track.

7. Seek support. Having a support system of friends, family, or a healthcare professional can help you to stay accountable and motivated.

By following these tips and taking advantage of the coverage available through Polaris Standard, you can take steps towards managing your weight and improving your overall health.

WHAT DO I DO IF I'M OUTSIDE WASHINGTON?

Out-Of-Area Care

WHAT DO I DO IF I'M OUTSIDE WASHINGTON?

If you find yourself outside of Washington and in need of medical care, Polaris Standard provides coverage for out-of-area emergency services. You will be covered for medically necessary services and supplies to treat a sudden and unexpected illness or injury. You are also covered for emergency services related to a pre-existing condition.

It is important to know that Polaris Standard does not provide coverage for nonemergency services outside of Washington. That means you may be responsible for the full cost of care if you seek out care for a condition that could have been treated in Washington.

In order to receive coverage for out-of-area care, you must meet the following criteria:

• You must be outside of Washington for no more than 12 consecutive months

• You must be more than 100 miles away from your primary care provider

• Your plan must have been in effect for at least 6 months before you receive out-of-area care

If you meet the criteria listed above, you may be eligible for coverage of out-of-area services. In order to receive coverage, you must contact Polaris Health in advance of receiving care. You must also obtain prior authorization for any care you wish to receive. If prior authorization is not obtained, you may be responsible for the full cost of care.

If you are outside of Washington for more than 12 consecutive months, you may not be eligible for coverage of out-of-area services. In this case, you may need to seek out a new plan that offers coverage in the state where you are living.

It is important to note that Polaris Standard does not cover out-of-network services outside of Washington. This means that you will need to find in-network providers in the state where you are living to receive coverage.

It is also important to keep in mind that the cost of care can vary widely outside of Washington. You should contact Polaris Health to get an estimate of the cost of care for services you may need. This can help you make an informed decision about where to obtain care.

Finally, it is important to keep your Polaris Standard plan active while you are out of state. This will ensure that you remain eligible for coverage if you need to receive out-ofarea care.

By following the tips outlined above, you can ensure that you are prepared if you find yourself needing care outside of Washington. Polaris Standard provides coverage for out-of-area emergency services, but it does not provide coverage for non-emergency services, out-of-network services, or care received outside of Washington for more than 12 consecutive months. Prior authorization must also be obtained in order to receive coverage. Keeping your plan active while out of state will also ensure that you remain eligible for coverage.

CARE MANAGEMENT

Prior-Authorization

CARE MANAGEMENT: Prior Authorization

Polaris Standard includes Care Management services, which are designed to provide support, information, and proactive care for members. Specifically, this plan includes a Prior Authorization (PA) process for certain services.

Prior Authorization is a process used by Polaris Health to make sure that a covered service is medically necessary and is the most cost-effective way to receive the service.
Before certain services are approved and covered, an authorization must be requested from Polaris Health. This authorization can be requested by either the provider or the member.

If you require a service that requires prior authorization, you must make sure that it is requested and approved before you receive the service. If prior authorization is not obtained, Polaris Health may not cover the service.

Exceptions

There are certain services that are exempt from the prior authorization process. These include:

- Preventive care services, such as annual physicals or vaccinations

- Services provided in an emergency care setting

- Services provided in an outpatient hospital setting

- Services provided in an urgent care setting

- Services provided in a skilled nursing facility

Tips

If you have any questions about the prior authorization process, Polaris Health recommends that you contact them at least five business days before the scheduled service. This will allow you to receive the necessary authorization in a timely manner.

You can contact Polaris Health by calling their customer service number or sending an email. If you call, make sure to have your health plan identification number handy.

Additionally, if you receive a service without prior authorization, you may be responsible for the full cost of the service. Therefore, if you are unsure about whether a service requires authorization, contact Polaris Health for more information.

In order to make the prior authorization process as easy as possible, Polaris Health has made it possible to submit requests online. You can access this service through the Polaris Health website.

If you would like to make a prior authorization request via mail, you can send the request to:

Polaris Health Prior Authorization Department

PO Box 1234

Anytown, USA 00000

Polaris Health also offers a patient advocacy program to help you with the prior authorization process. This program can provide assistance with filing appeals, finding specialists, and understanding insurance terms.

By understanding the prior authorization process, you can ensure that your services are covered by your Polaris Health plan. If you have any questions about the services that require authorization or about the process itself, contact Polaris Health for more information.

How Prior-Authorization Works

CARE MANAGEMENT: How Prior-Authorization Works

Prior authorization is a process that Polaris Standard uses to help ensure that members receive medically necessary, cost-effective, and appropriate services. With prior authorization, services must be approved by Polaris Health before you can receive them. This process helps ensure that members receive the right care at the right time.

There are certain services that require prior authorization before the service is rendered. These services can include, but are not limited to, hospital stays, certain laboratory tests, certain imaging services, physical therapy, and durable medical equipment. Polaris Health may also require prior authorization for drugs that are not on the Polaris Standard formulary.

When you or your doctor request a service that requires prior authorization, Polaris Health will review the request. Polaris Health will then decide if the service is medically necessary and covered under Polaris Standard. Polaris Health will notify you and your doctor of the decision within three business days.

If Polaris Health approves the service, you may receive the service without any additional pre-authorization. However, if Polaris Health denies coverage, you may be able to appeal the decision. You can contact Polaris Health by phone or mail to submit an appeal.

Polaris Health may also review claims after the services have been provided. This process is called retrospective review and is used to ensure that the services provided were medically necessary and appropriate. Polaris Health may also use this process to detect fraud and abuse.

When requesting prior authorization, it is important to provide Polaris Health with all the necessary information. This includes a complete medical history and diagnosis, as well as any other relevant information. Polaris Health may also request additional information or tests to make a decision.

When requesting prior authorization, it is important to plan ahead. Polaris Health must receive all the necessary information before the requested service is provided. If Polaris Health does not receive all the necessary information, the prior authorization request may be denied.

When requesting prior authorization, it is also important to check with your doctor to make sure the service is covered under Polaris Standard. Some services may not be covered, even if prior authorization is approved.

Finally, if the service is approved, make sure to keep a copy of the authorization. This will help ensure that you receive the coverage you are entitled to.

Prior authorization can be a complicated process. However, it is important to remember that it is in place to help ensure that members receive the right care at the right time. Polaris Health is committed to helping members make informed decisions about their health care.

Prior-Authorization for Benefit Coverage

CARE MANAGEMENT: Prior-Authorization for Benefit Coverage

At Polaris Health, Contoso's employees have access to a variety of healthcare benefits, including coverage for medical, vision, and dental services. With Polaris Standard, employees can also choose from a variety of in-network providers for their care. However, in order to get the most out of their benefit coverage, employees should be aware of the prior-authorization process for certain services and treatments.

Prior-authorization is a process in which Polaris Health requires Contoso's employees to get approval from their plan before receiving certain services or treatments. This process helps ensure that the care is necessary and medically appropriate. If prior-authorization is not obtained, the employee may be responsible for the full cost of any services or treatments that are received without approval.

Some services or treatments that may require prior-authorization include, but are not limited to, hospital stays, certain medical procedures, durable medical equipment, and certain prescription drugs. In order to obtain prior-authorization, the employee's physician must submit a request to Polaris Health. The request will then be reviewed by Polaris Health to determine if the service or treatment is medically necessary and if it is a covered benefit under the Polaris Standard plan.

In some cases, Polaris Health may also require that the employee meet certain criteria in order to be approved for a service or treatment. These criteria may include specific medical tests or treatments, lifestyle changes, or other requirements. If the employee is unable to meet the criteria, prior-authorization may not be granted.

There are some exceptions to the prior-authorization process. For example, preventive care services and emergency services are not subject to prior-authorization. In addition, mental health and substance abuse coverage is not subject to prior-authorization. However, out-ofnetwork services are subject to prior-authorization and may require additional cost to the employee.

Here are some tips for Contoso's employees to help them navigate the prior-authorization process:

- Contact your physician's office to determine if prior-authorization is required before receiving a service or treatment.
- Contact Polaris Health to determine if a service or treatment is a covered benefit under Polaris Standard.
- Ask your physician to submit a request for prior-authorization as soon as possible.
- Understand the criteria that may be required for prior-authorization and be prepared to meet those criteria if necessary.
- Be aware of any exceptions to the prior-authorization process, such as preventive care and emergency services.

By understanding the prior-authorization process and following these tips, Contoso's employees can ensure that they get the most out of their benefit coverage.

Exceptions To Prior Authorization For Benefit Coverage

CARE MANAGEMENT: Exceptions To Prior Authorization For Benefit Coverage

At Polaris Health, we understand the importance of providing quality care for our members. That is why we offer certain exceptions to prior authorization for benefit coverage. This means that you may be able to access certain medical services without having to get prior approval from your primary care physician.

Some of the exceptions to prior authorization for benefit coverage that Polaris Health provides include:

1. Emergency Services: Emergency services are an important part of receiving the care you need when you need it. That is why Polaris Health provides an exception to prior authorization for emergency services. If you require emergency care, you will not need to get prior approval from your primary care physician.

2. Maternity Care: Polaris Health understands the importance of providing quality care for expectant mothers. That is why Polaris Health provides an exception to prior authorization for maternity care. This means that you will not need to get approval from your primary care physician for services related to your pregnancy.

3. Mental Health and Substance Abuse Services: Mental health and substance abuse services are vital for ensuring that our members are able to get the care they need when they need it. That is why Polaris Health provides an exception to prior authorization for mental health and substance abuse services. This means that you will not need to get approval from your primary care physician for these services.

4. Out-of-Network Services: In some cases, it may be necessary for you to seek care from an out-of-network provider. Polaris Health understands this and provides an exception to prior authorization for out-of-network services. This means that you will not need to get approval from your primary care physician for services provided by an out-of-network provider.

It is important to note that while Polaris Health provides exceptions to prior authorization for certain services, you may still be responsible for a portion of the costs associated with these services. It is important to consult your member handbook for more information regarding coverage and costs associated with these services.

In addition to the exceptions to prior authorization for benefit coverage, Polaris Health also provides tips for members on how to make the most of their coverage. Here are just a few of the tips that Polaris Health provides to its members:

1. Understand your coverage: It is important to understand your coverage and the services that are covered. This will ensure that you are able to access the care you need when you need it.

2. Ask questions: If you have any questions about your coverage or the services that are covered, it is important to ask questions. Polaris Health provides customer service representatives who are available to answer your questions and provide additional information.

3. Know when to get prior authorization: Even though there are certain exceptions to prior authorization for benefit coverage, it is important to know when you need to get prior authorization for services. This will ensure that you are able to access the care you need when you need it.

At Polaris Health, we understand the importance of providing quality care to our members. That is why we provide exceptions to prior authorization for certain services, as well as tips to help our members make the most of their coverage. If you have any questions about your coverage or the services that are covered, please do not hesitate to contact Polaris Health customer service.

Prior-Authorization For Out-Of-Network Provider Coverage

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

Out-of-network providers are not included in the Polaris Standard plan, but you may be able to receive coverage for certain services by obtaining prior authorization. Prior authorization is a process that ensures that the service or medication you receive is medically necessary, and that it is covered by your plan.

In order to get coverage for out-of-network services, you must make sure to get prior authorization from Polaris Health. This is done by contacting the Polaris Health Customer Service team, who will review the request and provide you with a decision. If your request is approved, you will be covered for the service or medication. If it is not approved, you will not be covered.

When requesting prior authorization for an out-of-network provider, you should make sure to provide Polaris Health with all the necessary information, including:

• The name, address, and contact information of the out-of-network provider.

• The date of service.

• The diagnosis or reason for the service.

• The type of service or medication requested.

• The estimated cost of the service or medication.

It is important to note that, in some cases, Polaris Health may require additional information in order to make a decision. Additionally, Polaris Health may deny a request for prior authorization if the service or medication is not medically necessary, or if it is not covered by your plan.

When requesting prior authorization for an out-of-network provider, it is important to keep in mind that the process can take up to several days or even weeks. Therefore, it is important to start the process as soon as possible. Additionally, it is important to remember that you will be responsible for paying for the service or medication if Polaris Health does not approve the request.

If you have any questions about the prior authorization process, or if you need assistance with obtaining prior authorization, you can contact the Polaris Health Customer Service team at any time. They are available 24 hours a day, 7 days a week and will be happy to answer any questions or provide assistance.

Finally, it is important to note that there are some exceptions to the prior authorization process. For example, if you are receiving emergency services, you do not need to obtain prior authorization. Additionally, some services may require precertification rather than prior authorization. If you are unsure whether a service requires prior authorization or precertification, you can contact the Polaris Health Customer Service team for assistance.

In summary, prior authorization is required for out-of-network services that are covered by the Polaris Standard plan. It is important to make sure to contact Polaris Health as soon as possible in order to start the process, and to provide all the necessary information. If you have any questions or need assistance with obtaining prior authorization, the Polaris Health Customer Service team is available 24/7 to help. Additionally, there are some exceptions to the prior authorization process, such as emergency services, which do not require prior authorization.

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

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

At Polaris Health, we offer a variety of options for care management and prior authorization of out-of-network providers. We understand that there are circumstances when the care needed is not available through an in-network provider, and so we make exceptions to the prior-authorization requirement.

First and foremost, it's important to note that prior authorization is not required for emergency services. If you find yourself in an emergency situation, you can immediately seek out the care you need without worrying about getting prior authorization.

In addition, prior authorization is not necessary for emergency services provided in a foreign country. This includes both medical and dental services. However, it's important to remember that Polaris Standard does not cover out-of-network services in foreign countries.

In rare cases, prior authorization may also be waived for services that are not available innetwork. If the care you need is not available through an in-network provider, you can seek out an out-of-network provider without obtaining prior authorization. However, you should be aware that you may be responsible for any costs associated with out-of-network services.

In order to ensure that you are receiving the best care possible, it's important to understand the basics of prior authorization. Prior authorization is a process in which your insurance company reviews the request and verifies the need for the service or procedure. This helps to ensure that you receive the appropriate care and that the costs associated with the care are covered by your plan.

If you're considering seeking care from an out-of-network provider, it's important to remember that prior authorization is required for out-of-network services. You should call Polaris Health to obtain prior authorization before you receive care from an out-ofnetwork provider.

It's also important to know that prior authorization may be denied if the service or procedure is not medically necessary or not covered under your plan. If prior authorization is denied, you may be responsible for any costs associated with the care.

At Polaris Health, we understand that there are times when care is not available through an in-network provider. That's why we make exceptions to the prior-authorization requirement for certain services and procedures. However, it's important to remember that prior authorization is still required for most out-of-network services.

If you have any questions about prior authorization for out-of-network providers, please contact Polaris Health. We're here to help you get the care you need, and we're here to help you understand the process of prior authorization.

Clinical Review

CARE MANAGEMENT: Clinical Review

The Polaris Standard plan offers a variety of care management services to help ensure that members receive quality, cost-effective care. These services include clinical review, which is a process that evaluates the medical necessity and appropriateness of a proposed course of treatment, as well as any adjustment or changes to existing treatments.

Clinical review is conducted by Polaris Health's Medical Management Department, which is staffed by licensed clinicians who are experienced in the various medical conditions and treatments that are covered by the Polaris Standard plan. These clinicians use evidence-based guidelines and other important criteria to evaluate the proposed course of treatment and make sure that it is medically necessary and appropriate.

Polaris Health utilizes a three-level clinical review process. The first level of review involves a Registered Nurse (RN) or Medical Doctor (MD) evaluating the proposed course of treatment. If the RN or MD determines that the proposed course of treatment is medically necessary, then the case is approved and the member can proceed with the treatment. If the RN or MD determines that the proposed course of treatment is not medically necessary, then the case is referred to the next level of review.

At the second level of review, the case is evaluated by a Medical Director, who is an MD or Doctor of Osteopathic Medicine (DO). The Medical Director reviews the case and makes a final determination as to whether the proposed course of treatment is medically necessary or not. If the Medical Director approves the case, then the member can proceed with the treatment. If the Medical Director does not approve the case, then the case is referred to the third level of review.

At the third and final level of review, the case is evaluated by a Medical Review Officer, who is an MD or DO. The Medical Review Officer reviews the case and makes a final determination as to whether the proposed course of treatment is medically necessary or not. If the Medical Review Officer approves the case, then the member can proceed with the treatment. If the Medical Review Officer does not approve the case, then the member is not eligible to receive the treatment.

The Polaris Standard plan also offers several exceptions to the clinical review process. For example, certain types of medical services are exempt from clinical review and can be approved without going through the process. Additionally, certain time-sensitive services

may be approved without going through the clinical review process if the member's health is in immediate danger.

It is important for members to understand the clinical review process and the exceptions that are available. Members should be aware that some medical services may require preauthorization before they can be approved, and that the clinical review process may take some time. Additionally, members should keep in mind that the clinical review process is designed to ensure that medically necessary treatments are provided in a timely and costeffective manner.

To help ensure that the clinical review process runs smoothly and quickly, members should provide accurate and detailed information about their medical needs when requesting treatment. This includes a complete list of their current medications, as well as all relevant medical history. Additionally, members should provide any necessary documentation that may be required, such as test results or lab reports. Finally, members should make sure that they understand the process and any exceptions that may apply.

Overall, the clinical review process is an important component of the Polaris Standard plan, and it helps to ensure that members receive high-quality, cost-effective care. The process is designed to be straightforward and efficient, and the exceptions that are available can help to ensure that members receive the care they need in a timely manner. By understanding the clinical review process and the exceptions that are available, members can help to ensure that they receive the care they need in a timely and cost-effective manner.

Personal Health Support Programs

CARE MANAGEMENT

At Polaris Health, we understand that making sure you get the care you need is an essential part of your overall health. That's why we offer a range of personal health support programs that are part of the Polaris Standard plan.

Personal Health Support Programs

Polaris Health's personal health support programs are designed to help you achieve your health goals and optimize your care. Our programs provide you with access to specialized care teams and tailored resources to help you manage chronic illnesses, injuries, and other health-related issues.

Our personal health support programs are designed to help you get the most out of your health benefits. Through our programs, you can access:

• Care Coordinators who can help you find the right care and services

• Health Coaches to help you develop a personalized plan to achieve your health goals

• Care Managers who can help you manage chronic conditions

- Health Educators who can provide you with the knowledge, skills, and tools to manage your health
- Specialists who can provide additional support, such as nutrition and lifestyle counseling

Exceptions

It's important to note that Polaris Standard does not cover emergency services, mental health and substance abuse services, or out-of-network services.

Tips

If you're looking to take advantage of Polaris Health's personal health support programs, here are a few tips to keep in mind:

- Take advantage of the Care Coordinators who can help you find the right care and services
- Make sure you develop a personalized plan with your Health Coach to achieve your health goals
- Utilize the Care Managers who can help you manage chronic conditions
- Use the Health Educators who can provide you with the knowledge, skills, and tools to manage your health
- Make sure you get the support you need from Specialists who can provide additional support, such as nutrition and lifestyle counseling
- Don't forget to check if your plan covers emergency services, mental health and substance abuse services, or out-of-network services before you receive care

At Polaris Health, we understand that taking charge of your health is essential. Our personal health support programs are there to help you get the most out of your health benefits and to ensure that you get the care you need. With our programs, you can access personalized care teams, tailored resources, and additional support to help you manage chronic illnesses, injuries, and other health-related issues.

If you have any questions about Polaris Health's personal health support programs, please don't hesitate to contact us. Our team is here to help you make the most of your plan and get the care you need.

Chronic Condition Management

CARE MANAGEMENT: Chronic Condition Management

At Contoso, we understand the importance of providing quality health care for our employees, and that's why we've partnered with Polaris Health to offer Polaris Standard, a comprehensive health insurance plan that includes chronic condition management.

Chronic condition management is a comprehensive approach to managing chronic conditions, including developing a plan of care that's tailored to your individual needs. This plan of care focuses on the long-term management of your condition, including lifestyle changes, medications, and other treatments. With chronic condition management, you can work closely with your health care provider to ensure that your condition is being managed effectively.

Chronic condition management is covered under the Polaris Standard plan, so you can access the care you need without worrying about out-of-pocket expenses. However, please note that the plan does not cover services related to emergency care, mental health and substance abuse, or care provided by out-of-network providers.

By taking advantage of the chronic condition management services available through Polaris Standard, you can work closely with your health care provider to develop a plan of care that's tailored to your individual needs. This plan of care focuses on the long-term management of your condition, including lifestyle changes, medications, and other treatments.

It's important to remember that chronic conditions can take time to manage and may require regular follow-up visits with your health care provider. Additionally, it's important to keep track of your symptoms and any changes you may experience, so that you can communicate this information to your provider.

It's also important to note that chronic condition management is not a substitute for emergency care. If you experience a serious or life-threatening condition, you should seek emergency care immediately.

To make sure that you're getting the most out of your chronic condition management, here are a few tips to keep in mind:

- Make sure to keep your health care provider up-to-date on any changes in your condition or symptoms.
- Make sure to follow the plan of care prescribed by your health care provider.
- Take advantage of any educational resources available to you.
- Make sure to keep up with any recommended lifestyle changes.
- Make sure to take your medications as prescribed.
- Make sure to track your symptoms and any changes you may experience.
- Don't hesitate to ask questions and seek clarification if you're unsure about something.

At Contoso, we want our employees to be as healthy as possible, and that's why we've partnered with Polaris Health to offer Polaris Standard, a comprehensive health insurance plan that includes chronic condition management. By taking advantage of the chronic

condition management services available through Polaris Standard, you can work closely with your health care provider to develop a plan of care that's tailored to your individual needs. With chronic condition management, you can ensure that your condition is being managed effectively, so that you can stay as healthy as possible.

EXCLUSIONS

EXCLUSIONS

The Polaris Standard plan does not cover certain medical services and treatments. These services and treatments are known as exclusions. It is important for employees to be aware of the exclusions in this plan, so they can make informed decisions about their healthcare.

Emergency Services: The Polaris Standard plan does not cover emergency services. This includes ambulance services and treatments that require immediate care. If you require emergency services, you will be responsible for the full cost of those services.

Mental Health and Substance Abuse Coverage: The Polaris Standard plan does not cover any mental health and substance abuse coverage. This includes counselling, psychotherapy, and other treatments related to mental health and substance abuse.

Out-of-Network Services: The Polaris Standard plan does not cover any services that are provided by a provider that is not part of the Polaris Health network. This includes doctors, hospitals, and other healthcare providers who are not part of the Polaris Health network.

Tips

When selecting a healthcare plan, it is important to be aware of the exclusions in the plan. Here are some tips to help you understand the exclusions in the Polaris Standard plan:

1. Understand the types of services that are not covered by the Polaris Standard plan. Be sure to familiarize yourself with the list of exclusions and make sure that any services you might require are covered.

2. If you require emergency services, be sure to check with your provider to see if they are part of the Polaris Health network. If they are not, you will be responsible for the full cost of those services.

3. If you require mental health or substance abuse treatments, be sure to check with your provider to see if they are part of the Polaris Health network. These services are not covered by the Polaris Standard plan.

4. If you require services from a provider that is not part of the Polaris Health network, you will be responsible for the full cost of those services.

By understanding the exclusions in the Polaris Standard plan, you can make informed decisions about your healthcare. Be sure to read the plan document carefully to make sure that the plan meets your healthcare needs.

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

It may be possible to coordinate benefits with other health care plans if you have other coverage. Coordinating benefits allows you to receive payments from each health plan towards covered services, as long as the total amount of payments does not exceed the total charges for the service.

If you have other coverage, such as Medicare or an employer-sponsored health plan, the Polaris Standard plan may be able to coordinate benefits with those plans. This can help reduce your out-of-pocket costs for health care services.

How Do I Coordinate Benefits with Other Plans?

If you have other health care coverage, you should contact the other health care plan(s) to determine how to coordinate benefits. Depending on the plans you have, you may be able to coordinate benefits by filing a claim with both plans.

You will need to provide the other plan with a copy of the Explanation of Benefits (EOB) from the Polaris Health plan. The EOB is a summary of the services you received and how much the Polaris Health plan paid for those services.

When filing a claim with the other health care plan, you may also need to provide a copy of your bill or invoice. The other plan may require additional information as part of the claim process.

You should keep copies of all documentation that you submit to the other plan. This can help you track your claim and follow up with the other plan if there are any delays in processing.

Exceptions

Coordination of benefits with other plans is not available for all types of services. For example, coordination of benefits will not be available for services related to emergency care, mental health and substance abuse treatment, or services received from out-ofnetwork providers.

Tips for Coordinating Benefits

- Contact your other health care plan to determine whether you can coordinate benefits and what documentation you need to provide.
- Keep copies of all documentation you submit to the other plan, including bills and invoices.
- Follow up with the other plan if there are any delays in processing the claim.

• Be sure to read all of the plan documents and understand your coverage options.

• If you have any questions, contact the Polaris Health customer service team for assistance.

COB Definitions

WHAT IF I HAVE OTHER COVERAGE?

At Contoso, we want our employees to understand the concept of COB (Coordination of Benefits) so they can make the best decisions when it comes to their health care coverage. COB is a system used to determine which health plan pays first when an employee has more than one health plan.

When an employee has multiple health plans, the health plan that pays first is determined by the order of benefit determination. Generally, the employee's primary health plan pays first, followed by the secondary health plan. However, if one of the health plans is a Medicare or Medicaid plan, that plan pays first.

Under the Polaris Standard Plan, if you have other coverage, you may be able to use the network providers and services that are covered by Polaris Standard at a lower cost. However, the cost of services obtained from providers that are not in the Polaris Standard network will not be covered by the plan.

When you receive health care services, it's important to identify all of your coverage to the provider to ensure that they bill each health plan appropriately. This helps to ensure that you receive the full benefits offered by each plan. If you do not identify all of your health coverage, it may result in a delay of payment or denial of coverage.

When you submit a claim to Polaris Standard, you'll need to include information about the other coverage you have. If the claim is sent to Polaris Standard before any other plan, the claim will be processed based on the Polaris Standard plan benefits.

It's important to remember that Polaris Standard does not coordinate benefits with other coverage. This means that Polaris Standard will not adjust the amount of payment made to a provider to take into account payments from other coverage. If a provider has been paid by another plan, you are still responsible for the balance due after Polaris Standard pays its portion of the claim.

If you have other coverage, it's important to review the benefits of each plan to make sure you are taking full advantage of your coverage. If you need help understanding your plan benefits or have any questions about the coordination of benefits, please contact the Polaris Standard Plan Customer Service team. We're here to help!

Primary And Secondary Rules

WHAT IF I HAVE OTHER COVERAGE?

If you have other health coverage, such as coverage through a spouse’s plan, Polaris Standard may become your secondary coverage. This means that Polaris Standard will pay for eligible expenses after the other coverage pays.

The primary and secondary rules that apply to Polaris Standard are important to understand. When you have two types of health coverage, the primary plan pays first and the secondary plan pays second. The primary plan is the plan that is responsible for paying the largest portion of your healthcare costs.

For example, if you have a spouse's health plan and Polaris Standard, your spouse's plan would be the primary plan and Polaris Standard would be the secondary plan. This means that your spouse's plan would pay for the majority of your healthcare costs and Polaris Standard would pay for any remaining costs.

It's important to note that Polaris Standard will only pay for expenses that are not covered by the primary plan. Additionally, Polaris Standard will not pay any expenses that exceed the limits of the primary plan. For example, if the primary plan has a $1,000 deductible and Polaris Standard has a $500 deductible, only the $500 deductible from the primary plan will be paid.

There are some exceptions to the primary and secondary rules. For instance, if you have Medicare coverage, it will be the primary coverage for medical expenses and Polaris Standard will be the secondary coverage. However, if you have Medicare Part D for prescription drugs, Polaris Standard will be the primary coverage and Medicare Part D will be the secondary coverage.

It's also important to keep in mind that if you have other health coverage, you may need to provide evidence of that coverage to your health plan. This is known as "creditable coverage," and it helps to ensure that Polaris Standard will pay any eligible expenses once the primary plan has paid.

When it comes to understanding primary and secondary rules, it's important to remember that each health plan is different. Be sure to review your plan documents to understand the specific rules and restrictions that apply to your coverage.

Finally, if you have any questions or concerns about your coverage, be sure to reach out to Polaris Health. Their knowledgeable customer service representatives are always available to answer your questions and provide guidance on how best to use your coverage.

COB's Effect On Benefits

WHAT IF I HAVE OTHER COVERAGE?

When you have other health insurance coverage, coordination of benefits (COB) can affect how your benefits are paid. COB is a process where your insurance companies coordinate who pays first when you have multiple health insurance plans that cover the same medical expenses. The insurance company that pays first is called the primary payer, and the company that pays second is called the secondary payer.

Coordination of Benefits Exceptions

There are a few exceptions to COB rules that may apply to you. If you are covered by Medicare, Medicaid, or a veterans' health plan, Polaris Standard may pay first, even if the other plan is usually the primary payer. Additionally, if you are enrolled in a plan that is required by law to coordinate benefits, such as an employer-sponsored plan, Polaris Standard may pay first.

Understanding How COB Affects Your Benefits

When COB applies, the primary and secondary payers will each pay a portion of the eligible expenses and combined payments cannot exceed the total cost. Depending on the type of service, the primary payer may pay all of the eligible expenses. When this happens, the secondary payer may pay nothing.

For example, if you receive a medical bill for $1,000 and the primary payer pays $800, the secondary payer will pay the remaining balance of $200. However, if the primary payer pays the full $1,000, the secondary payer will not pay anything.

Tips for Working with COB

When you have multiple health insurance plans, it's important to understand how COB works and how it can affect your benefits. Here are a few tips to help you manage your benefits:

- Make sure that each insurance company has all of the necessary information about your other coverage, including plan numbers and policy dates.
- Confirm that your primary and secondary payers have updated information about each other.
- Ask your health care providers to submit claims to both insurance companies.
- Understand any limitations or exclusions that may apply to your benefits.
- If you have questions, contact each insurance company for clarification.

Overall, it's important to understand how COB works and how it affects your benefits. By being aware of the rules and exceptions, you can ensure that you are getting the full coverage you need from both insurance companies.

Subrogation And Reimbursement

Subrogation And Reimbursement

When you have other health coverage, such as Medicare or another employer's health plan, Polaris Standard may still provide coverage in certain circumstances. This is called "subrogation and reimbursement." Subrogation and reimbursement works when another health plan pays for a service that is covered by Polaris Standard. In this case, Polaris Standard will pay for the same service, assuming that it was medically necessary and you received it from an in-network provider.

If Polaris Standard pays for a service that is already covered by your other health plan, you may be responsible for reimbursing Polaris Standard. This can happen if you do not provide Polaris Standard with proof of your other coverage.

There are certain exceptions to subrogation and reimbursement. If you are a Medicare beneficiary, Polaris Standard will not seek reimbursement from Medicare. In addition, Polaris Standard will not seek reimbursement from any other health plan if the service you received is not covered by the other health plan.

When filing claims, it is important to keep in mind that you need to provide Polaris Standard with proof of your other coverage. This can include a copy of your other plan's Explanation of Benefits (EOB) or a letter from the other health plan stating that the service is not covered.

When providing proof of other coverage, it is important to remember to include the following information:

• Your name, address, and policy number

• The name of the other health plan

• The date of service for the claim

• The amount paid by the other health plan

• Any additional information required by Polaris Standard

If you are unsure of what information to provide, you can always contact Polaris Standard for assistance.

It is also important to remember that if you are filing claims with both Polaris Standard and another health plan, you must submit a claim to Polaris Standard first. This will allow Polaris Standard to determine if the service is covered and if you are eligible for subrogation or reimbursement.

Finally, if you have any questions or need assistance with filing claims, Polaris Standard offers a customer service team that can help. You can contact them at any time, and they can provide you with the information you need to understand your coverage and benefits.

By understanding subrogation and reimbursement and the exceptions to it, you can ensure that you are taking advantage of all of your benefits and coverage. Polaris Standard is committed to providing you with the coverage you need and helping you understand your benefits.

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

Uninsured and Underinsured Motorist/Personal Injury Protection Coverage

When you sign up for Polaris Standard, you may be eligible for Uninsured and Underinsured Motorist/Personal Injury Protection Coverage (UM/UIM/PIP). This coverage is designed to protect you in the event that you are injured in an accident with an uninsured or underinsured driver. It also provides you with coverage for medical bills and other related costs that you may incur due to the accident.

Under this coverage, Polaris Health will pay for medical bills, lost wages, and other related expenses that are the result of an injury you sustain in an automobile accident. It will also cover you in the event that you are hit by an uninsured or underinsured motorist. Generally, this coverage is limited to the amount of your policy limits.

In some states, you may also be eligible for Personal Injury Protection (PIP) coverage. This coverage is designed to provide you with coverage for medical bills and other related costs that you may incur due to an automobile accident. Generally, PIP coverage is limited to the amount of your policy limits.

However, it's important to note that not all states offer UM/UIM/PIP coverage. It's important to check with Polaris Health to see what type of coverage is available in your state. Additionally, there may be certain exceptions or exclusions to the coverage that you should be aware of.

When it comes to UM/UIM/PIP coverage, there are a few tips that you should keep in mind. First, make sure you have the right amount of coverage for your particular situation. Second, if you are ever in an accident, make sure to get all the necessary information from the other party so that you can file a claim with Polaris Health. Third, if you are ever injured in an accident, make sure to seek medical attention as soon as possible.

Finally, make sure to keep your policy up to date. As life changes, so do your needs, and it's important to make sure that your coverage is enough to protect you in the event of an accident. By taking the time to review your policy and make sure that you have the right coverage, you can be sure that you have the protection you need.

HOW DO I FILE A CLAIM?

Timely Filing

HOW DO I FILE A CLAIM?

Timely Filing

At Polaris Health, timely filing is important to ensure that your claims are processed correctly and in a timely manner. All claims must be filed within twelve months of the date of service, otherwise the claims may be denied. Claims submitted after the twelve month window may be reviewed for consideration of payment, however, no guarantee is made that the claims will be accepted.

If you are a Polaris Standard member, you may be able to file a claim directly through the Polaris website or app. If you're filing a claim on behalf of a family member, make sure that you have their authorization to do so.

It's important to also keep in mind that some services are subject to pre-approval from Polaris Health, and your provider may need to submit a request prior to the service being performed. This includes services such as MRI/CT scans, physical therapy, and other specialty services. If you are unsure whether your provider requires pre-approval for a service, you should contact Polaris Health prior to the service being performed.

There are a few exceptions to the twelve month timely filing limit. These include claims submitted for newborns, claims submitted for a deceased member, and claims submitted for services that were provided out-of-country. In these situations, claims may be submitted up to 24 months after the date of service.

It's also important to remember that when filing a claim, you should make sure to include all necessary documentation. This includes itemized bills, a completed claim form, and any other documentation that is requested by Polaris Health. If any of these items are missing, your claim may be delayed or denied.

To ensure timely filing, it's important to keep track of the dates of service for all services you receive. You should also keep copies of all documentation related to your services, and if you're unsure of the filing requirements, you should contact Polaris Health for clarification.

Overall, timely filing is an important part of the claim filing process. By following the guidelines for timely filing and including all necessary documentation with your claims, you can help ensure that your claims are processed quickly and accurately.

COMPLAINTS AND APPEALS

What You Can Appeal

COMPLAINTS AND APPEALS

What You Can Appeal

When you have Polaris Standard coverage, you have the right to appeal any denial of services or payment of benefits. This includes if you disagree with the amount of the payment or if you feel that your claim was denied incorrectly. You also have the right to appeal if you feel that an authorization was not provided for a service, or if you believe that a service should be covered by your plan but was not.

If you believe that your claim was wrongly denied or that you have a dispute over a service that is covered or not covered, you have the right to file a formal appeal. It is important to note that the appeals process is different than filing a complaint. A complaint is an informal way of expressing your dissatisfaction with a service or policy, and does not include a formal review of your claim.

You can file an appeal by submitting a letter or appeal form to Polaris Health. The letter or form should include the reason for your appeal, supporting documentation, and any other information that you believe will be relevant to your case. It is important to note that you must file your appeal within 60 days of the date of the denial, or within 180 days if the denial is related to a service that was preauthorized by your insurance provider.

When you file your appeal, Polaris Health will review it and provide you with a written decision. This decision will include an explanation of why your claim was denied or why a service was not covered. It is important to note that all appeals will be reviewed according to the terms of your plan and in relation to any applicable state or federal laws.

If you are not satisfied with the outcome of your appeal, you may be able to pursue a second level of appeal. You may also be able to file a complaint with your state insurance department if you believe that your rights have been violated.

It is important to remember that Polaris Health must provide you with the specific reason for your denial in writing, and must provide you with appeal rights in writing. The appeal process may require you to submit additional information, so it is important to make sure that you provide all relevant information. Additionally, you may also want to consider consulting an attorney or other qualified professional if you believe that your rights have been violated.

When filing an appeal, it is important to keep accurate records of all communication and correspondence. This includes any letters or forms that you submit, as well as any responses that you receive from Polaris Health. Additionally, you should consider keeping copies of any medical records, documents, or other information that may be relevant to your appeal. This will help to ensure that your appeal is handled properly and that you receive a fair and timely response.

Overall, it is important to remember that you have the right to appeal any denied services or payments under your Polaris Standard plan. This process can be complex, so it is important to make sure that you understand your rights and the appeals process. Additionally, if you are not satisfied with the outcome of your appeal, you may be able to pursue a second level of appeal or file a complaint with your state insurance department.

Appeal Levels

COMPLAINTS AND APPEALS

At Contoso, we understand that there may be times when you are not satisfied with the service provided by Polaris Health. When this happens, Contoso wants to ensure that you have the opportunity to voice your concerns and appeal a decision. Polaris Health has a three-level appeals process that allows you to dispute coverage decisions and claim denials.

Level 1: Initial Appeal

If you disagree with a coverage decision or claim denial from Polaris Health, you can submit a written appeal within 60 days of receiving the decision. This first appeal must be

submitted directly to Polaris Health. The appeal must include a detailed explanation of why you believe the claim should be covered and any supporting documentation.

If you need assistance with your appeal, you can contact Contoso's Human Resources department for guidance.

Level 2: External Review

If your initial appeal is denied, you can request an external review from the North Carolina Department of Insurance. This review is conducted by an independent, third-party

reviewer. You must submit your request within four months of receiving the decision from Polaris Health.

To submit an external review request, you must provide a written explanation of why you disagree with Polaris Health's decision. You must also include any supporting documentation.

Level 3: Civil Action

If your external review is denied, you have the right to file a civil action in North Carolina state court. You must file this action within one year of receiving the external review decision.

Tips for Appealing a Decision

When appealing a decision from Polaris Health, it's important to provide as much detail as possible. This includes an explanation of why you believe the claim should be covered and any supporting documentation. It's also important to remember the deadlines for each level of appeal.

Be sure to keep copies of all documents and records related to your appeal. This includes any correspondence from Polaris Health, your appeal letter, and any supporting documentation. This will help ensure that your appeal is processed efficiently.

Finally, if you need assistance with your appeal, you can contact Contoso's Human Resources department for guidance. We are here to help you navigate the appeals process and ensure that your concerns are heard.

How To Submit An Appeal

COMPLAINTS AND APPEALS

How To Submit An Appeal

At Polaris Health, we understand that you may not agree with every decision made about your coverage or care. If you disagree with a decision made by your plan, you have the right to submit an appeal. Appealing a decision can help ensure that you get the care you need.

What Is An Appeal?

An appeal is a written request for your plan to reconsider a decision. This could include decisions about coverage for a service, the amount paid for a service, or a denial of a service. You can also appeal if you feel that your plan hasn't provided the services that it agreed to provide.

When Can I Submit An Appeal?

You can submit an appeal if you have received a written denial of coverage or payment. You should receive a written notice from your plan that explains the denial and provides you with instructions on how to file an appeal. If you do not receive a notice, contact your plan for more information.

What Is The Deadline For Submitting An Appeal?

You must submit an appeal within 180 days of the date of your notice of denial. If you don't submit the appeal within this time frame, your appeal may be denied.

How Do I Submit An Appeal?

You can submit an appeal by mail, fax, or email. You should include the following

information in your appeal: • Your name and address

• Your plan ID number

• The date of the denial notice

• A copy of the denial notice

• A detailed explanation of why you disagree with the decision

• Any additional information to support your appeal

• Your signature

Exceptions

If you need an expedited appeal, you can contact your plan to discuss this option. If you need an expedited appeal due to an urgent medical condition, your plan must respond within 24 hours.

Tips

• Make sure to include all of the necessary information in your appeal.

• Keep a copy of your appeal for your records.

• Don't hesitate to contact your plan if you need assistance with the appeal process.

• Follow up with your plan if you don't receive a response to your appeal within a reasonable amount of time.

• Consider hiring a lawyer if you need help with your appeal.

Once The IRO Decides

Once The IRO Decides

The Independent Review Organization (IRO) is a third-party organization that reviews appeals and complaints about healthcare services that have been denied coverage under the Polaris Standard plan. If an employee is not satisfied with the decision made by Polaris Health, they can submit a written complaint or request an appeal by filing a formal grievance.

What Happens After The IRO Decides?

Once the IRO has completed its review, it will issue a formal decision either upholding the original decision or reversing it. The decision made by the IRO is considered final and binding.

Exceptions

There are some exceptions to the IRO decision that could be applicable to your case. If the IRO determines that the decision was the result of a misapplication of plan provisions or incorrect information, the decision can be reversed. Additionally, if the IRO finds that the decision was not made in accordance with the terms of the plan, the decision can be reversed.

Tips For Employees

If you are not satisfied with the decision made by Polaris Health, there are some tips that can help you in the appeals process.

- Familiarize yourself with the Polaris Standard plan provisions and the process for filing an appeal.
- Gather all relevant information, including medical records, reports, and documents related to the decision that you are appealing.
- Ensure that all relevant information is included in the appeal.
- Submit the appeal within the timeframe specified in the plan.
- Keep a copy of your appeal and all supporting documentation.
- Contact Polaris Health or the IRO if you have any questions or need additional help.
- If the IRO upholds the original decision, you may have other options available to you, such as an external review or an appeal to the state insurance commission.

Conclusion

The Independent Review Organization (IRO) is the final step in the appeals process for Polaris Standard plan members. While the decision made by the IRO is considered final and binding, there are some exceptions that could apply to your case. Familiarizing yourself with the plan provisions and the process for filing an appeal, gathering all relevant information, and submitting the appeal within the timeframe specified in the plan are all important steps in the appeals process.

Additional Information About Your Coverage COMPLAINTS AND APPEALS

If you feel that you have not received the health care services or benefits that you are entitled to, or you are not satisfied with the quality of care you have received, you have the right to appeal or file a grievance. Below is additional information about filing a complaint or an appeal.

Understanding Your Right to Appeal or File a Grievance

If you are enrolled in the Polaris Standard plan, you have the right to file an appeal or a grievance if you believe that Polaris Health has not provided a service or benefit to which you are entitled. The law requires Polaris Health to provide a timely response to your appeal or grievance.

You can file an appeal if you disagree with a decision made by Polaris Health, such as a denial of a claim or a denial of prior authorization for a service. You can file a grievance when you have an issue with the quality of care you have received or with the way you have been treated by Polaris Health or its providers.

Filing an Appeal or Grievance

When filing an appeal or grievance, you must provide the following information:

-Your name and address

-Your Polaris Health ID number

-The date that you received the services

-A detailed explanation of the services received or requested

-The reason for the appeal or grievance

You can file an appeal or grievance through one of the following methods:

-By mail:

Polaris Health

Attn: Appeals and Grievance Department

123 Main Street

Anytown, USA 12345

-By fax: 123-456-

7890 -By phone:

1-800-123-4567

-By email:

appeals@Polarishealth.com

Processing Your Appeal or Grievance

Once your appeal or grievance is received, Polaris Health will begin the review process. You will receive written confirmation that your appeal or grievance has been received. Your appeal or grievance will be assigned to a case manager, who will contact you if additional information or clarification is needed.

Polaris Health will make a decision regarding your appeal or grievance within 30 days. You will be notified of the decision in writing. If the appeal or grievance was approved, you will receive a detailed explanation of the decision. If the appeal or grievance was denied, you will receive a detailed explanation of the decision, including the right to review the decision and submit additional information.

Additional Information

If you need assistance filing an appeal or grievance, you can contact Polaris Health's Member Services department at 1-800-123-4567.

It is important to note that Polaris Health is not responsible for any services or benefits provided to you by any other health care provider or plan. For example, if you received a service or benefit from a non-network provider, Polaris Health will not be responsible for any costs associated with that service or benefit.

In some cases, you may have the right to an external review of your appeal or grievance. If you have exhausted the appeals process within Polaris Health and you believe that your appeal or grievance was not adequately addressed, you can contact your state's insurance department or the federal Department of Health and Human Services for more information about the external review process.

OTHER INFORMATION ABOUT THIS PLAN

Conformity With The Law

OTHER INFORMATION ABOUT THIS PLAN: Conformity With The Law

Contoso and Polaris Health understand the importance of following the law when it comes to employee benefits and strive to ensure that the Polaris Standard plan is in compliance with all applicable laws.

ERISA Requirements

The Employee Retirement Income Security Act of 1974 (ERISA) sets minimum standards for pension and health plans in private industry. Polaris Standard meets the requirements established by ERISA, including providing employees with a Summary Plan Description and an annual report.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives employees and their families the right to continue their health coverage after a job loss or other qualifying event. Polaris Standard meets the requirements established by COBRA, including providing employees with information about their right to continue coverage and the cost of such coverage.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) sets standards for health insurance plans to protect employees from discrimination and to protect the privacy of their health information. Polaris Standard meets the requirements established by HIPAA, including the provision of special enrollment rights to employees who have experienced a qualifying event.

Affordable Care Act

The Affordable Care Act (ACA) requires employers to offer minimum essential coverage to their employees or face a penalty. Polaris Standard meets the requirements established by the ACA and provides minimum essential coverage to all eligible employees.

Tips For Employees

Employees should make sure they understand their rights and responsibilities under the law when it comes to their employer-provided health insurance plan. Here are a few tips employees should keep in mind:

- Be aware of the terms of your health plan: it's important to understand how your plan works and what it covers.

- Keep track of any changes to the plan: employers are required to provide employees with notice of any material changes to the plan.

- Know your rights under COBRA: if you lose your job or otherwise qualify for COBRA, you may be able to continue your coverage for a certain period of time.

- Understand your rights under HIPAA: you have the right to access your health information and correct any inaccurate information.

- Make sure you understand the requirements of the ACA: if you're eligible, your employer must offer you minimum essential coverage or face a penalty.

Following the law is an important part of employee benefits, and Contoso and Polaris Health strive to ensure that the Polaris Standard plan is in compliance with all applicable laws. Employees should make sure they understand their rights and responsibilities under the law when it comes to their employer-provided health insurance plan. With Polaris Standard, you can be sure that you're getting the coverage you need and that you're in compliance with the law.

Entire Contract

OTHER INFORMATION ABOUT THIS PLAN: Entire Contract

The Polaris Standard plan is a contract between the employee and Polaris Health. By enrolling in the plan, the employee agrees to all of the terms and conditions included in the plan documents. It is important to understand that the plan documents are the ultimate authority for any questions about benefits, coverage, and exclusions.

The plan documents state that the Polaris Standard plan provides coverage for medical, vision, and dental services. This coverage includes preventive care services and prescription drug coverage. The plan does not provide coverage for emergency services, mental health and substance abuse coverage, or out-of-network services.

The plan documents also include information on how to access care, including a list of innetwork providers such as primary care physicians, specialists, hospitals, and pharmacies. Additionally, the plan documents outline the plan's coordination of benefits and any limitations or exclusions.

It is important to remember that the plan documents are the ultimate authority for any questions about benefits, coverage, and exclusions. If there is ever a discrepancy between what is stated in the plan documents and what is stated in any other sources, such as Polaris Health's website or a customer service representative, the plan documents take precedence.

Tips for Employees

When it comes to understanding Polaris Standard, the plan documents are everything. Here are a few tips to help employees get the most out of their plan:

- Read the plan documents thoroughly and keep them in a safe place.

- Make sure to understand what is and what is not covered by the plan.

- Familiarize yourself with the list of in-network providers.

- Be aware of any coordination of benefits that are listed in the plan documents.

- Understand any limitations and exclusions that are listed in the plan documents.
- Remember that the plan documents take precedence over any other sources of information.

By following these tips, employees will be better equipped to make informed decisions about their health care and get the most out of their Polaris Standard plan.

Evidence Of Medical Necessity

OTHER INFORMATION ABOUT THIS PLAN

Evidence Of Medical Necessity

When you use Polaris Standard, you must provide evidence of medical necessity for certain services. This evidence is usually provided by your healthcare provider, and is required in order to receive coverage under the plan.

Examples of services that require evidence of medical necessity include, but are not limited to, hospital stays, surgery, diagnostic tests, and specialized treatments. This evidence must be provided to Polaris Health in order for the service to be covered.

Examples of the types of medical evidence that may be requested include:

- Medical records
- Physician's notes
- Diagnostic test results
- Treatment plans

It is important to note that Polaris Health reserves the right to deny any services or treatments that it believes are not medically necessary.

Exceptions

In some cases, Polaris Health may waive the requirement for evidence of medical necessity. For example, if the service or treatment is deemed to be medically necessary and urgent, Polaris Health may choose to provide coverage without requiring additional evidence.

Tips for Employees

If you are receiving services or treatments that require evidence of medical necessity, there are a few steps you can take to ensure that your claim is processed quickly and accurately:

- Ask your healthcare provider to provide you with a detailed explanation of the services and treatments you are receiving, as well as the medical necessity for them.
- Make sure that all documentation is complete, including all required forms, test results, and physician's notes.

- Send the documentation to Polaris Health as soon as possible.
- Follow up with Polaris Health to ensure that your claim has been received and is being processed.

By following these steps and providing any necessary evidence of medical necessity, you can help to ensure that your claim is processed quickly and accurately.

The Group And You

OTHER INFORMATION ABOUT THIS PLAN

The Group and You

The Polaris Standard plan is a group plan, meaning that it is offered to a group of people and not to individuals. The group includes all eligible employees of Contoso and their spouses or dependents. It is important to understand that the plan may not cover all or part of the cost of services received by those who are not considered eligible members of the group.

Exceptions

There are a few exceptions to the group coverage provided by the Polaris Standard plan. For example, the plan does not cover services provided by any health care provider who is not contracted with Polaris Health. In addition, the plan does not cover services that are not medically necessary, such as cosmetic surgery.

Tips for Employees

When you enroll in Polaris Standard, it is important to familiarize yourself with the plan and its coverage options. You should also make sure that you understand any restrictions that may apply to the services you receive. Be sure to check with your provider to make sure that they accept the Polaris Standard plan. Also, it is a good idea to familiarize yourself with the cost of the services you receive, so that you know what you may be responsible for paying out of pocket. Finally, keep in mind that the Polaris Standard plan does not cover any services received outside of the network of in-network providers.

Healthcare Providers - Independent Contractors

OTHER INFORMATION ABOUT THIS PLAN

Healthcare Providers - Independent Contractors

The Polaris Standard plan includes independent contractors in its network of healthcare providers. These independent contractors provide services that are covered under the plan, such as primary care physician visits, specialty care services, and other healthcare services. Depending on the plan, these independent contractors may also provide services such as mental health and substance abuse counseling, physical therapy, and home health services.

It is important for employees to understand that Polaris Standard does not provide coverage for care received from independent contractors. Employees must pay for these services out-

of-pocket, and any claims for services provided by independent contractors must be submitted directly to the provider.

When seeking care from an independent contractor, it is important for employees to make sure they are aware of any additional fees or restrictions that may apply. For example, some providers may require a fee for services such as mental health counseling, or may only accept certain types of insurance. It is also important for employees to understand that the provider may not be able to provide care if the employee does not have the required documentation or is unable to pay the required fee.

In addition, it is important for employees to understand that independent contractors may not be subject to the same regulations as other healthcare providers. For example, the provider may not be required to adhere to the same quality standards as other healthcare providers, and may not be required to be licensed in the state where the services are provided.

When selecting a provider, it is important for employees to make sure they are familiar with the provider's policies and procedures. Employees should also make sure they understand any additional costs that may be associated with the services provided by the independent contractor.

Finally, when selecting a provider, it is important for employees to research the provider's background and credentials. Employees should make sure the provider is properly licensed and certified, and has a good reputation in the healthcare community. Additionally, employees should make sure the provider is up-to-date on the latest advances in healthcare technology and treatments, so they can be sure they are receiving the best possible care.

Overall, when selecting a healthcare provider, it is important for employees to do their research and make sure they understand the provider's policies and procedures, as well as any additional costs that may be associated with the services they provide. Additionally, it is important for employees to make sure the provider is properly licensed and certified, and has a good reputation in the healthcare community. By doing their research and understanding the provider's qualifications and policies, employees can be sure they are receiving the best possible care.

Intentionally False Or Misleading Statements OTHER INFORMATION ABOUT THIS PLAN Intentionally False Or Misleading Statements:

When it comes to health insurance, there are unfortunately many companies who make intentionally false or misleading statements about their plans. Polaris Health is no exception. It is important for employees to be aware of any potential inaccuracies or false information that Polaris Health may use when discussing their plans.

First and foremost, it is important to remember that Polaris Standard does not offer coverage for emergency services, mental health and substance abuse coverage, or out-ofnetwork services. The Polaris Standard plan provides coverage for medical, vision, and

dental services, but does not cover any of the services mentioned. While Polaris Health may advertise that their plan covers these services, it is important to be aware that they do not.

Polaris Health may also make claims that their plan covers any type of preventive care services. While Polaris Standard does cover some preventive care services, it is important to remember that they may not cover all preventive care services. It is important to read the plan details in order to determine which preventive care services are covered.

It is also important to be aware that Polaris Health may make claims that their network of in-network providers is comprehensive. While Polaris Standard does offer a variety of in-network providers, it is important to remember that the network of in-network providers may not be as comprehensive as Polaris Health claims. It is important to research the providers and services offered in the Polaris Standard plan in order to determine if the providers and services offered are sufficient for the employee's needs.

In addition, Polaris Health may make claims that their plan offers low or no cost prescription drugs. While Polaris Standard does offer a prescription drug coverage, it is important to remember that the plan does not necessarily offer low or no cost prescription drugs. It is important to read the plan details to determine which prescription drugs are covered and what the associated costs are.

Finally, Polaris Health may make claims that their plan is the best plan available. While Polaris Standard may be a good plan, it is important to remember that there may be other plans that are better suited to the employee's needs. It is important to research other plans and compare them to Polaris Standard in order to determine which plan is the best option.

Tips for Avoiding Intentionally False Or Misleading Statements:

When it comes to understanding a health plan, it is important to be aware of any intentionally false or misleading statements that the plan provider may make. To avoid being misled, employees should follow the following tips:

1. Read the plan details carefully. It is important to understand the details of the health plan in order to make sure that the plan fits the employee's needs.

2. Ask questions. If the employee is unsure about any part of the plan, it is important to ask questions in order to make sure that the plan is suitable for their needs.

3. Research other plans. It is important to research other plans and compare them to Polaris Standard in order to determine which plan is the best option.

4. Verify the information. If the employee is unsure about the accuracy of any information that Polaris Health provides, it is important to verify the information with a trusted source.

By following these tips, employees can make sure that they are not misled by Polaris Health's intentionally false or misleading statements. It is important for employees to be

aware of any potential inaccuracies or false information that Polaris Health may use when discussing their plans in order to make the most informed decision possible.

Member Cooperation

MEMBER COOPERATION

At Polaris Health, we understand that people are more likely to get the care they need when they are informed and empowered with the knowledge they need. That is why we have included the following information in our Polaris Standard plan to help inform and empower our members.

When you sign up for the Polaris Standard plan, you are agreeing to certain responsibilities as a member of the plan. This includes being aware of the plan's benefits and limitations, as well as your obligations under the plan.

Covering Your Expenses

When you are enrolled in Polaris Standard, your plan will cover a portion of your medical and vision expenses. However, you may be responsible for certain co-payments or co-insurance amounts. It is important to be aware of the terms of your plan and to know what you will be responsible for so that you can plan for these expenses.

Seeking Pre-Approval for Care

In some cases, you may need to seek pre-approval or authorization before receiving certain medical services. This is especially true for certain types of specialty care, such as mental health and substance abuse treatment. If you are unsure if pre-approval is required, contact Polaris Health to verify.

Staying Informed

It is important that you stay informed about the benefits, limitations, and requirements of your plan. Polaris Health provides several ways for you to stay informed, including:

- Our website – which provides information about the plan, including benefits, exclusions and limitations, and member responsibilities.
- Our customer service representatives – who are available to answer your questions about the plan and provide guidance.
- Our plan documents – which provide detailed information about the plan and your rights and responsibilities.
- Our newsletters – which provide updates about the plan and new features.
- Our provider directories – which list all of the in-network providers and facilities that are available under the plan.

Getting the Most Out of Your Plan

To get the most out of your Polaris Standard plan, here are some tips to keep in mind:

- Be sure to use in-network providers as much as possible, as this will help you maximize your benefits and minimize your out-of-pocket expenses.
- If you need to use out-of-network providers, be sure to contact Polaris Health first to verify coverage.
- Be sure to inform your providers of any pre-existing conditions or special circumstances that could affect your care.
- Be sure to stay informed about the plan and your rights and responsibilities as a member of the plan.
- Follow up with your provider after receiving care to ensure that all procedures were properly billed to the plan.
- Remember to use any preventive care benefits that your plan offers. These services can help you stay healthy and ensure that any issues are caught early.
- Remember to contact Polaris Health with any questions you may have about the plan.

By understanding your rights and responsibilities under the plan, as well as the benefits and limitations of the plan, you can feel confident that you are getting the most out of your Polaris Standard plan.

Exceptions

It is important to note that while Polaris Standard covers a variety of services, there are some exceptions. These include emergency services, mental health and substance abuse coverage, and out-of-network services. If you need any of these services, be sure to contact Polaris Health to verify coverage.

We hope that this information has been helpful in understanding the plan and your rights and responsibilities as a member of Polaris Standard. For more information, contact Polaris Health or visit our website.

Notice Of Information Use And Disclosure

Notice Of Information Use And Disclosure

At Polaris Health, we understand how important it is to protect your personal information. As part of that commitment, we abide by the rules of the Health Insurance Portability and Accountability Act (HIPAA), which regulates the use and disclosure of protected health information. This includes your medical records, payment records, and other information related to your health care.

Under the HIPAA Privacy Rule, Polaris Health may use and disclose your protected health information for treatment, payment, and health care operations. These activities include

providing you with care, billing you for services, analyzing the performance of our health care services, and improving the services we provide.

However, we may also use and disclose your protected health information for other purposes if we have obtained your written authorization. This includes any use or disclosure that is not for treatment, payment, or health care operations. Examples of nonhealth care uses and disclosures include marketing, fundraising, and research activities.

We may also use and disclose your protected health information without your authorization to comply with state or federal laws, such as reporting information to the Department of Health and Human Services or other government agencies, or in response to a court order or subpoena. In addition, we may use and disclose your protected health information for public health activities, to report certain types of illnesses, injuries, and medical conditions, or to report suspected abuse, neglect, or domestic violence.

In certain circumstances, we may also disclose your protected health information to friends or family members involved in your care or payment for care. For example, if you are incapacitated, we may discuss your care with a family member to ensure you are getting the best possible care.

It is important to remember that any use or disclosure of your protected health information is subject to the terms of Polaris Standard. Polaris Health will not use or disclose any of your protected health information without your consent, unless it falls into one of the categories described above.

One of the best ways to protect your health information is to be aware of how it is used and disclosed. This includes understanding how Polaris Health may use and disclose your information. We encourage you to read our Notice of Information Use and Disclosure carefully and ask questions if you have any concerns about your privacy.

Notice Of Other Coverage

OTHER INFORMATION ABOUT THIS PLAN

Notice Of Other Coverage

When you enroll in the Polaris Standard plan, you may be eligible to continue coverage under other health plans. This could include coverage from your spouse's or a parent's employer, or from a government-sponsored program such as Medicare or Medicaid.

If you and your spouse have coverage under different plans, you must determine which plan is the primary plan and which is secondary. This is important, as the primary plan will pay first; the secondary plan will pay what the primary plan does not.

If you have other coverage, you must notify Polaris Health of any changes in your coverage status or any changes in any of your other coverage. If you fail to do so, you may be responsible for any charges that Polaris Health would have paid if you had notified them of the other coverage.

In certain circumstances, you may be able to keep your other coverage and still be eligible for coverage under the Polaris Standard plan. However, if the other coverage is primary, you will be responsible for any charges that would have been paid by the Polaris Standard plan.

It is also important to note that if you have coverage through a government-sponsored program such as Medicare or Medicaid, you may be subject to certain restrictions. For example, you may be required to obtain certain services through the governmentsponsored plan.

Tips for Employees

To ensure you get the most out of your Polaris Standard coverage, here are some tips:

- Make sure you understand the terms and conditions of your other coverage and any restrictions associated with it.
- Know which plan is primary and which is secondary.
- Notify Polaris Health of any changes in your coverage status or any changes in any of your other coverage.
- Understand any restrictions associated with any government-sponsored programs you may be enrolled in.
- Your Polaris Standard plan does not cover certain services, such as emergency care, mental health and substance abuse coverage, or out-of-network services. Be sure to explore alternative coverage options if you need coverage for these services.
- Take advantage of preventive care services and prescription drug coverage available through your Polaris Standard plan.
- Make sure you understand your plan's coverage limits and any out-of-pocket expenses you may be responsible for.

By understanding your coverage and taking advantage of all the benefits available through the Polaris Standard plan, you can make sure that you are getting the most out of your health insurance coverage.

Notices

OTHER INFORMATION ABOUT THIS PLAN: Notices

It is important to be aware of any notices related to Polaris Standard. The notices provide important information about the plan and its coverage. Below, you will find a list of the notices you should be aware of as an employee of Contoso.

Notice of Privacy Practices:

This notice provides information about how Polaris Health collects, uses, and discloses protected health information. It is important to read this notice and make sure you understand how Polaris Health may use your information.

Notice of Benefit and Payment Parameters:

This notice provides important information about the plan and its benefits, including what kind of coverage is provided, what types of services are covered, and what out-of-pocket costs you may be responsible for.

Notice of Pre-Existing Condition Exclusions:

This notice provides information about any pre-existing condition exclusions that may apply to your coverage. It is important to read this notice carefully to make sure you understand when pre-existing condition exclusions may apply and how they could affect your coverage.

Notice of Continuation Coverage Rights:

This notice provides information about your rights to continue coverage if you lose your job or if you experience a qualifying event. It is important to read this notice carefully to make sure you understand your rights to continue coverage.

Notice of Availability of Plan Documents:

This notice provides information about where you can find the plan documents for Polaris Standard. It is important to read this notice so you know how to access the plan documents if you need them.

Notice of Creditable Coverage:

This notice provides information about your rights to creditable coverage. This notice explains what creditable coverage is and how it may affect your coverage under Polaris Standard.

Notice of Right to Change Coverage:

This notice provides information about your rights to change your coverage. It is important to read this notice so you understand how and when you can change your coverage under Polaris Standard.

Notice of Addition or Deletion of Benefits:

This notice provides information about any additions or deletions to the benefits provided under Polaris Standard. It is important to read this notice carefully so you know what changes have been made to your coverage.

Tips for Understanding Notices

When reading the notices provided by Polaris Health, it is important to take the time to read them carefully and understand what they mean. Here are a few tips to help you:

- Read all of the notices thoroughly, even if some of the information does not apply to your situation.
- Ask questions if you are unsure of what the notices mean or how they might affect your coverage.
- Make sure you understand the terms and conditions of each notice, including any exclusions or limitations that may apply.
- Keep a copy of all notices in a safe place so you can refer back to them if needed.
- Contact Polaris Health if you have any questions or need additional information.

By taking the time to read and understand the notices provided by Polaris Health, you can make sure you are aware of all the important information related to Polaris Standard, including any changes that have been made to the plan and what coverage is provided. This can help you make informed decisions about your coverage and ensure you are getting the best possible coverage.

Right Of Recovery

OTHER INFORMATION ABOUT THIS PLAN

Right of Recovery

Polaris Standard plan offers a right of recovery for any services that were already paid for by the insured. This is a great feature for employees to be aware of, as it can help to save time and money.

This right of recovery means that if the insured has already paid for a service that is covered under the Polaris Standard plan, they can submit a claim to the insurance company and be reimbursed for the amount they paid. This is a great option for employees who may have already paid for a service that is covered under the plan and are unaware that they can be reimbursed.

However, there are certain conditions that must be met in order for the right of recovery to be available. In order to be eligible, the service must have been provided and paid for during the plan's effective date, before the employee was enrolled in the Polaris Standard plan. Additionally, the service must be one that is covered under the plan. If the service is not covered, then the employee will not be eligible for the right of recovery.

It is important for employees to keep in mind that the right of recovery must be requested within two years of the service being provided in order for the employee to be eligible for reimbursement. Any claims submitted after this period will not be considered.

In addition, there are some services that are not eligible for the right of recovery. These include services related to mental health and substance abuse, emergency services, inpatient services, and any services that are not covered under the Polaris Standard plan.

It is also important to note that the right of recovery is only applicable to services that were paid for by the insured, and not by any other third party. This includes family members, friends, employers, or other insurance plans.

Employees should keep in mind that the right of recovery is subject to the terms and conditions of the Polaris Standard plan. Therefore, it is important to read the plan documents in detail to understand any additional exclusions or limitations of the right of recovery.

To take advantage of the right of recovery, employees should submit a claim to the insurance company with all of the relevant details and documentation. This should include a copy of the bill for the service, proof of payment, and any other documentation that may be required.

The Polaris Standard plan's right of recovery is a great feature that can help employees save time and money. It is important to be aware of the conditions and exceptions associated with this right, as well as any additional documentation that may be required. By understanding the right of recovery and following the steps outlined above, employees can take advantage of this great feature and be reimbursed for services that were already paid for.

Right To And Payment Of Benefits

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

The Polaris Standard plan is a comprehensive health plan that provides coverage for medical, vision, and dental services. It also includes preventive care services and prescription drug coverage. Polaris Standard offers a variety of in-network providers, including primary care physicians, specialists, hospitals, and pharmacies.

Under this plan, Polaris Health will cover the cost of eligible services you receive, as long as you follow certain rules. Some services may require pre-authorization or be subject to an annual deductible or coinsurance. Polaris Health is also responsible for processing and paying claims correctly.

Right to Benefits

You have the right to receive the benefits available under the Polaris Standard plan. This includes the right to receive services from any in-network provider, subject to certain rules and regulations. You also have the right to be informed about the types of services that are covered and the costs associated with them.

Payment of Benefits

Polaris Health is responsible for paying claims correctly. They will do this by determining your eligibility, obtaining pre-authorization for services when required, and paying for eligible services based on the terms of the plan. Polaris Health will also provide you with an explanation of benefits (EOB) after they process a claim. The EOB will outline the services that were provided, the amount of the claim, and the amount that was paid by Polaris Health.

Exceptions

Polaris Standard does not cover emergency services, mental health and substance abuse services, or out-of-network services.

Tips

Before receiving any services, make sure to check with Polaris Health to determine if the service is covered and if pre-authorization is required. Additionally, Polaris Health will provide you with an EOB after they process a claim. Make sure to review the EOB to ensure that the services and amounts are correct.

If you have any questions about your coverage or about the payment of your benefits, contact Polaris Health for assistance. Their customer service team is available to answer any questions you may have.

Venue

OTHER INFORMATION ABOUT THIS PLAN

Venue

When filing a claim, it is important to understand the state and county in which the claim is being filed, as the venue may affect the outcome of the claim. Generally, the venue for a claim is the place where the injury or illness occurred, or the place where the services were rendered.

In cases where the injury or illness occurs in multiple states or counties, the venue will typically be the state or county where the majority of the services were rendered. Claims for services rendered outside of the United States should be filed in the state or country in which the services were rendered.

When filing a claim with Polaris Health, it is important to note that any disputes concerning the claim must be resolved in the state where the claim was filed, according to the state's laws. The claim cannot be resolved in any other state or country.

Tips

Here are a few tips to keep in mind when filing a claim with Polaris Health:

• Always keep the location of the service in mind when filing a claim.

• Make sure to include the appropriate state or country on the claim form.

- Always provide detailed information about the services that were rendered, including the date, time, and location.
- Make sure to include any relevant medical records or other documentation with the claim.
- When possible, make sure to file the claim in the same state or county where the services were rendered.
- In cases where the services were rendered in multiple states or counties, make sure to file the claim in the state or county where the majority of the services were rendered.
- Disputes concerning the claim must be resolved in the state where the claim was filed, according to the state's laws.
- If the services were rendered outside of the United States, make sure to file the claim in the state or country in which the services were rendered.

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 provides rights and protections to people receiving mastectomies, a surgery to remove all or part of the breast. Under this law, health plans, including Polaris Standard, must provide coverage for mastectomies, reconstructive surgery, and other related medical services that are required by the attending physician in connection with a mastectomy.

The WHCRA applies to all group health plans, including Polaris Standard, and health insurance issuers that offer group health plans. This law requires all group health plans, such as Polaris Standard, to provide coverage for reconstructive surgery and other related medical services when it is medically necessary to reconstruct the breast or to treat physical complications of the mastectomy.

Not all mastectomies will qualify for WHCRA coverage. For example, mastectomies that are done for cosmetic reasons or for the treatment of a non-invasive breast cancer (i.e. Ductal Carcinoma in situ) are not covered under WHCRA.

In order for the coverage to be effective, the attending physician must provide written certification that the mastectomy was medically necessary. The certification should include a description of the medical condition, the type of mastectomy performed, and the type of reconstructive surgery required. The attending physician must also certify that the mastectomy was performed for medical reasons and not for reasons of cosmetic enhancement.

When the attending physician provides the written certification, the plan must provide coverage for the mastectomy and any reconstructive surgery that is required. The coverage must include all stages of reconstruction, prostheses, and other supplies related to the reconstruction. The plan must also provide coverage for physical complications of the

mastectomy, including lymphedema, which is a condition that causes swelling due to a buildup of lymph fluid in the affected area.

In addition, the plan must provide coverage for outpatient services, such as physical therapy and counseling, that are related to the mastectomy or reconstructive surgery. The plan must also provide coverage for ancillary services that are related to the mastectomy or reconstructive surgery, such as ambulance services, durable medical equipment, and prosthetic devices.

Under the WHCRA, the coverage must be provided without imposing any additional costs or restrictions on the patient. This means that the patient should not have to pay any additional coinsurance, copayment, or deductible for the mastectomy or reconstructive surgery.

The WHCRA also provides rights for women who have already had mastectomies. If a woman has already had a mastectomy and the plan does not cover reconstructive surgery or medically related services, the plan must provide coverage for those services if the attending physician certifies that the services are medically necessary.

Finally, the WHCRA provides certain rights for women who are considering having a mastectomy. In particular, the law requires that all group health plans provide a written notice to women about the coverage that is available under the plan for mastectomies and reconstructive surgery. This notice must be provided at the time of enrollment in the plan and at least annually thereafter.

The WHCRA provides important rights and protections to women who have had, or are considering having, a mastectomy. It is important for employees to understand their rights and to make sure that their health plan is providing the coverage that is required by the law.

Workers' Compensation Insurance

OTHER INFORMATION ABOUT THIS PLAN: Workers' Compensation Insurance

At Contoso, we are committed to providing our employees with a safe and productive work environment. As such, we provide Workers' Compensation Insurance coverage through Polaris Health. This coverage provides financial protection to employees in the event of a work-related injury or illness, including medical treatment and lost wages.

In the event of a work-related injury or illness, employees are eligible to receive benefits such as:

- Medical care: This includes doctor visits, hospital care, and other treatment deemed necessary by a physician.
- Wage replacement: This includes a portion of wages lost due to the injury or illness.
- Vocational rehabilitation: This includes education, retraining, and job placement assistance.

- Death benefits: This includes a lump sum payment to the surviving spouse or dependents in the event of a work-related death.

In order to receive these benefits, employees must report the injury or illness to their supervisor as soon as possible. Employees must also submit a written claim to their employer within one year of the injury or illness.

It's important to note that Workers' Compensation Insurance does not cover injuries or illnesses that are not work-related. This includes injuries that occur during lunch breaks, on the commute to and from work, or during leisure activities.

Employees should also be aware that benefits are limited to the amount of coverage purchased by the employer. If the cost of medical treatment exceeds the amount of coverage purchased, the employee may be responsible for the remaining balance.

Finally, employees should be aware that Workers' Compensation Insurance is regulated by state and federal laws. Depending on the state, employees may have the right to receive legal representation or to appeal denied claims. In some states, employees may have the right to choose their own physician or to receive benefits for permanent disabilities.

At Contoso, we are committed to providing our employees with a safe and productive work environment, and we take the necessary steps to ensure that our Workers' Compensation Insurance coverage meets all state and federal requirements. Should you have any questions about this coverage, please contact the Human Resources Department.

DEFINITIONS

DEFINITIONS

When it comes to understanding the Polaris Standard insurance plan, it is important to understand the various terms and definitions associated with this plan. Here is a breakdown of some of the key terms and definitions associated with the Polaris Standard insurance plan.

In-Network Provider: An in-network provider is a healthcare provider that has a contract with Polaris Health and is included in the network of providers who are eligible to receive payments from Polaris Health. This includes primary care physicians, specialists, hospitals, and pharmacies.

Out-of-Network Provider: An out-of-network provider is a healthcare provider that is not included in the Polaris Health network and is not eligible to receive payments from Polaris Health. Out-of-network providers are not covered by Polaris Standard.

Preventive Care Services: Preventive care services are services that are designed to help prevent illness and promote health. These services may include immunizations, physical exams, screenings, and other preventive care services.

Emergency Services: Emergency services are services that are provided in the case of an emergency. These services may include emergency surgery, emergency room visits, or other emergency services. Polaris Standard does not provide coverage for emergency services.

Mental Health and Substance Abuse Coverage: Mental health and substance abuse coverage is coverage for services related to mental health and substance abuse. This includes services such as therapy, counseling, and other mental health and substance abuse services. Polaris Standard does not provide coverage for mental health and substance abuse services.

Prescription Drug Coverage: Prescription drug coverage is coverage for prescription medications. This includes over-the-counter medications, as well as generic and brand name medications.

Tips for Understanding the Polaris Standard Insurance Plan

1. Make sure you understand the different types of providers that are included in the network and those that are not. Knowing which providers are in-network and out-ofnetwork can help you make sure you are getting the most out of your Polaris Standard plan.

2. Understand what services are covered by Polaris Standard and which are not. Knowing what services are covered can help you plan ahead and make sure you are getting the most out of your plan.

3. Familiarize yourself with the copayments and coinsurance associated with Polaris Standard. Understanding what you are responsible for can help you budget for healthcare expenses.

4. Review your policy regularly. It is important to review your policy periodically to make sure you understand all of the details of your plan.

5. Take advantage of preventive care services. Preventive care services are designed to help prevent illness and promote health, so make sure you take advantage of these services.

By understanding the different terms, definitions, and tips associated with Polaris Standard, you can make sure you are getting the most out of your plan. If you have any questions, it is important to contact Polaris Health or your employer for more information.