

# Healthy KidsConnect Managed Care Plan B – Benefit Summaries for children of families over 300 percent FPL

This Healthy KidsConnect Benefit Summaries briefly outline the benefits we cover and your cost sharing requirements. **Eligible American Indian / Alaskan Native children above the 300% FPL are not eligible for HKC subsidy and are responsible for coinsurance, copayments, and premium.** This is not a contract, and does not fully describe the benefit coverage. Please refer to the benefit handbook for exact terms, conditions, provisions, exclusions, and limitations.

POLICY INFORMATION	
Policy Number:	G0017282
Plan Type:	Managed Care Plan B: Over 300 Plan
Medical Network:	PacificSource – <i>Prime PSN (primary care practitioner required)</i>
Pharmacy Retail Network:	CVS Caremark – <i>Value Drug List (VDL)</i>
Pharmacy Mail Order Network	CVS Caremark Mail or Wellpartner
Dental Network:	Advantage Dental

MEDICAL BENEFIT SUMMARY	
Lifetime Maximum Benefit	None
Pre-existing Waiting Period, including Pregnancy	None
Calendar Year Medical Deductible	\$1,000
Calendar Year Maximum Individual Medical Out-of-Pocket (OOP)*	
❖ Per Person	\$6,000
*This is the maximum amount you will pay for covered medical services per calendar year, before your plan will begin paying 100% for covered services. Once the out-of-pocket limit has been met, this plan will pay 100% of covered charges for participating and network not available providers for the rest of that calendar year. Benefits paid in full, transplants, and disallowed charges do not accumulate to the out-of-pocket limit.	
Benefit – Participating Providers	Member Pays
Preventive Care and Services	
❖ Women’s Health Care Services and Men’s Health Care Services	\$0
❖ Routine Immunizations	\$0
❖ Well-Baby Care (0-36 months) and Well-Child Care (3-18 years)	\$0
❖ Outpatient Diabetic Instruction	\$0
❖ Prostate Cancer Screening	\$0
Professional Office Visits	20%, after deductible
Hospital Inpatient Care	20%, after deductible
Outpatient Surgery	20%, after deductible
Skilled Nursing Facility – <i>limited to 60 days</i>	20%, after deductible
Home Health Care – <i>limited to 60 visits</i>	20%, after deductible
Emergency Room – <i>waived if admitted</i>	20%, after deductible
Ambulance, Ground – <i>to nearest facility able to treat condition, 300 mile annual max</i>	20%, after deductible
Ambulance, Air – <i>if ground is medically/physically inappropriate, \$6,000 annual max</i>	20%, after deductible

<b>Benefit – Participating Providers</b>	<b>Member Pays</b>
Maternity Care, Normal Pregnancy <ul style="list-style-type: none"> <li>❖ Pre and postnatal visits –<i>global copay covers all routine professional visits</i></li> <li>❖ Labor and delivery hospital stay –<i>facility</i></li> <li>❖ <i>NOTE: Complications of pregnancy covered as any other illness</i></li> </ul>	20%, after deductible 20%, after deductible
Diagnostic X-Ray, Imaging, Lab, and Special Diagnostic Procedures	20%, after deductible
Transplants	20%, after deductible
Hospice Care	20%, after deductible
Rehabilitation – <i>physical, occupational, and speech therapy combined limit</i> <ul style="list-style-type: none"> <li>❖ Inpatient –<i>limited to 60 days per year</i></li> <li>❖ Outpatient –<i>limited to 60 visits per year</i></li> </ul>	20%, after deductible 20%, after deductible
Durable Medical Equipment and Supplies	20%, after deductible
Mental Health and Chemical Dependency <ul style="list-style-type: none"> <li>❖ Inpatient Psychiatric Care</li> <li>❖ Residential/Day Treatment –<i>up to 45 days per year</i></li> <li>❖ Outpatient Treatment</li> </ul>	20%, after deductible 20%, after deductible 20%, after deductible
Acupuncture, Chiropractic, and Naturopathic ( <i>subject to referral by primary care practitioner</i> )	20%, after deductible
Hearing Aid Services	20%, after deductible
<b>Benefit – Non-participating Providers</b>	<b>Member Pays</b>
Non-participating providers <i>**Services are covered only when obtained from participating providers except in emergencies or when PacificSource provides an out-of-network preauthorization. In these limited circumstances, normal copay or coinsurance would apply.</i>	100% –Not covered**
<b>Benefit – Providers Outside Oregon</b>	<b>Member Pays</b>
Providers outside Oregon <i>*** Providers must be based in Oregon. Except for emergencies, services must be provided by an Oregon-based provider within the PacificSource provider network.</i>	100% –Not covered***

<b>PRESCRIPTION DRUG BENEFIT SUMMARY (subject to the VDL value drug list)</b>	
Calendar Year Prescription Drug Deductible	None
Calendar Year Maximum Prescription Drug Out-of-Pocket	None
<b>Benefit – Participating Retail Pharmacies, 34-day supply</b>	<b>Member Pays</b>
Generic Drug	\$5
Certain Preventive Care Drugs (see below)	\$0
<ul style="list-style-type: none"> <li>Folic Acid for women. Single entity only.</li> <li>Fluoride: Through age 6 years only. Single entity only.</li> <li>Iron: Through age 1 year only. Single entity only.</li> <li>Nicotine Replacement for age 15 years or older: If enrolled in Quit for Life, they will send you an 8-week supply of nicotine patches or gum, or you can get a 12-week supply of bupropion (generic of Zyban) or Chantix at participating pharmacy when prescribed by your doctor.</li> <li>Seasonal Flu Vaccines: Once per calendar year at participating flu shot pharmacy clinics.</li> </ul>	
Preferred Brand (VDL)	\$50 or 50%, whichever is less
Nonpreferred Brand	Not covered, except as described below*
*Nonpreferred prescription drugs are not covered. Exceptions to this are only considered when all equivalent generic and preferred brand drugs have been tried unsuccessfully and certain criteria is met, as determined by PacificSource. In such limited cases, the drug will be covered at the Preferred Brand copay level.	
<b>Benefit – Participating Mail Order Pharmacies, 34-day supply</b>	<b>Member Pays</b>
Generic Drug	\$5
Certain Preventive Care Drugs (see above)	\$0
Preferred Brand (VDL)	\$50 or 50%, whichever is less
Nonpreferred Brand	Not covered, except as described below*
*Nonpreferred prescription drugs are not covered. Exceptions to this are only considered when all equivalent generic and preferred brand drugs have been tried unsuccessfully and certain criteria is met, as determined by PacificSource. In such limited cases, the drug will be covered at the Preferred Brand copay level.	
<b>Benefit – Specialty Drugs, 30-day supply</b>	<b>Member Pays</b>
Specialty Drugs**	\$50 or 50%, whichever is less
**Caremark® Specialty Pharmacy Services is your provider for specialty and biotech drugs often used to treat chronic or genetic disorders. The program is designed to help PacificSource members with the following health conditions maximize the value of their health plan benefits.	
Asthma	Growth hormone deficiency
Crohn's disease	Immune disorders
Enzyme replacement	Multiple sclerosis
Gaucher's disease	Oncology
	Psoriasis
	Pulmonary arterial hypertension
	Pulmonary disease
	RSV prevention
	Rheumatoid arthritis
NOTE: Some specialty drugs that are not self-administered are not covered under this pharmacy benefit, but are covered under the medical plan's office supply benefit.	
<b>Benefit – Non-participating Pharmacies</b>	<b>Member Pays</b>
Non-participating providers	100% - Not covered in most cases**
**Drugs are covered only when obtained from participating pharmacies except in emergencies. In these limited circumstances, normal copays would apply.	
<b>Benefit – Drugs Excluded</b>	<b>Member Pays</b>
Excluded Drugs	100% - Not covered

<b>DENTAL BENEFIT SUMMARY</b>	
Calendar Year Maximum Benefit	\$1,000
Calendar Year Dental Deductible	None
Calendar Year Maximum Dental Out-of-Pocket	
❖ Per Person	\$200
❖ Per Family	\$400
<i>*This is the maximum amount you will pay for covered dental benefits per calendar year, before your plan will begin paying 100% for covered services.</i>	
<b>Benefit – Participating Dental Providers</b>	<b>Member Pays</b>
<b>Diagnostic and Preventive</b>	
❖ Examinations – <i>two per calendar year; separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered</i>	\$0
❖ X-rays – <i>one complete mouth series in any three year period; up to four bite-wing films in a six-month period</i>	\$0
❖ Prophylaxis Cleanings – <i>combined total of three prophylaxis cleanings or periodontal maintenance procedures (see Periodontics) per calendar year</i>	\$0
❖ Fluoride Treatment – <i>two per calendar year through age 18</i>	\$0
❖ Sealants on permanent molars and bicuspids – <i>one application in a five-year period for individuals through age 18</i>	\$0
<b>Restorative, Oral Surgery, and Endodontics – copays are per tooth</b>	
❖ Amalgams or Composite Resin – <i>composite filling in a posterior tooth is limited to the amount that would be paid for a corresponding amalgam restoration; fillings on a tooth surface are limited to once per calendar year</i>	\$10
❖ Extractions and certain other minor surgical procedures – <i>include general anesthesia when administered by dentist in office; a separate charge for alveolectomy performed in conjunction with removal of teeth is not covered</i>	\$10
❖ Root Canal Therapy – <i>one in a three-year period per tooth</i>	\$10
❖ Crowns – <i>restoration of any one tooth in a five-year period covered when teeth cannot be restored with other materials; if can be restored with a material such as amalgam or composite resin, covered charges are limited to the cost of amalgam or non-laboratory composite resin restoration even if another type of restoration is selected by the patient and/or dentist</i>	\$30
<b>Periodontics</b>	
❖ Space maintainers – <i>through age 13</i>	\$10
❖ Periodontal Maintenance – <i>combined total of three periodontal maintenance procedures or prophylaxis cleanings (see Cleanings) per calendar year; separate charge for periodontal charting not covered; periodontal maintenance not covered within three months of periodontal scaling, root planning, or curettage.</i>	\$10
❖ Periodontal scaling and root planing and/or curettage – <i>one procedure per quadrant in any three-year period; treatment of tissue supporting the teeth</i>	\$10
<b>Prostodontics (Removable)</b>	
❖ Complete or Partial Dentures – <i>construction, repair, or reline; replacement of existing device that is unserviceable, cannot be made serviceable, and has been in place for at least five years; construction of fixed bridges</i>	\$30

<b>Benefit – Participating Dental Providers – Continued</b>		<b>Member Pays</b>
❖ Repairs to Complete and Partial Dentures <i>–to make serviceable</i>		\$15
❖ Denture Rebase and Reline Procedures <i>–once every 12 months</i>		\$15
Orthodontics		
❖ Covered if have a diagnosis of cleft palate with cleft lip and preauthorized		\$30
<b>Benefit – Non-participating Dental Providers</b>		<b>Member Pays</b>
Non-participating providers		100% -Not covered**
<i>**Covered only when obtained from participating providers except in emergencies or when PacificSource provides an out-of-network preauthorization. Normal Advantage Dental maximum allowances would apply.</i>		

<b>VISION BENEFIT SUMMARY</b>	
<b>Benefit – Participating Providers</b>	<b>Member Pays</b>
Routine Vision Examinations <i>–one per calendar year</i>	\$0
Vision Therapy Services <i>–six sessions per calendar year</i>	\$0
Radiological Services <i>–by Optometrists or Ophthalmologist</i>	\$0
<b>Benefit – Participating Providers</b>	<b>Maximum Allowance</b>
Prescription Lenses	
❖ One Pair Per Calendar Year <i>–you pay any amount over the maximum allowance.</i>	
○ Single Vision Lenses	\$96
○ Bifocal Lenses	\$134
○ Trifocal Lenses	\$180
○ Contact Lenses (in place of lenses and frames)	\$192
Frames	
❖ One Frame Every Calendar Year <i>–you pay any amount over maximum allowance</i>	\$96
<b>Benefit – Non-participating Providers</b>	<b>Member Pays</b>
Non-participating providers	100% - Not covered

<b>OTHER VISION RELATED BENEFITS</b>	
<b>Covered Under Medical</b>	
The following vision related services are covered under your medical benefit when pre-authorized by PacificSource for medically necessary surgery or treatment.	
❖ Prescription Contact Lenses <i>–one contact lens for each eye undergoing cataract surgery</i>	
❖ Ocular Prosthetics, Artificial Eye <i>–documentation required</i>	
❖ Postsurgical Care, Optometrists Post <i>–operative Care</i>	