

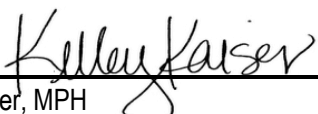
The enrollee to whom the policy is issued shall be permitted to return the policy within ten (10) days of its delivery to such person and have a refund of the premium paid if after examination of the policy the purchaser is not satisfied with it for any reason.

Any change in premiums is subject to prior approval by the Oregon Department of Consumer and Business Services



**Samaritan Healthy KidsConnect
Contract**

**An OREGON HMO
Group Health Benefit Plan
Below 300% of the Federal Poverty Level (FPL)/American Indian | Native Alaskan
Above 300% of the Federal Poverty Level (FPL)**



Kelley Kaiser, MPH
Chief Executive Officer



Healthy KidsConnect
Office of Private Health Partnerships (OPHP)
250 Church Street SE, Suite 200
Salem, OR 97301
Salem (503) 373-1656
Toll Free 1-800-542-3104



State of Oregon
Samaritan Healthy KidsConnect Health Plan
Medical, Pharmacy, Comprehensive Care Management,
Vision and Dental Benefits; above and below 300% of the Federal Poverty Level (FPL)
Effective February 1, 2010

This document describes the Medical, Pharmacy, Comprehensive Care Management, Vision and Dental benefits for eligible participants of Healthy KidsConnect Program. This document serves as your Member Handbook and Benefit Plan Description designed to explain your plan as of January 1, 2012. We guarantee coverage based on eligibility and provisions of this document, not based on health status, race, creed, or disability in accordance with ORS 743.757.

Every effort has been made to make these explanations as accurate as possible in accordance with the Life and Health Insurance Policy Language Simplification Act, Patient Protection and Affordable Care Act (PPACA) of 2009 and Oregon Revised Statute (ORS) 743.106. For more information, contact Samaritan Healthy KidsConnect Health Plan at (541)768-4550; toll free 1-800-832-4580 or TTY 1-800-735-2900; Monday through Friday 8 a.m. to 5:00 p.m.

Or Visit...

Samaritan Healthy KidsConnect Health Plan

Samaritan Health Plans
815 NW Ninth Street
Corvallis, OR 97339

(541) 768-4550
1-800-832-4580
TTY 1-800-735-2900

Alternate format information

If you need this handbook or other informational materials in another form, such as:

- Other languages
- Large print
- Braille
- Audio tape
- Computer disk
- Oral presentation

Please call Samaritan Healthy KidsConnect Health Plan Customer Service Department at (541) 786-4550; 1-800-832-4580 or TTY 1-800-735-2900 to request the format you need.

Translations

(English)

If you need this booklet in another language, large print, Braille, on tape, or another format, call (541) 786-4550; 1-800-832-4580 or TTY 1-800-735-2900.

(Spanish)

Si necesita este folleto en otro idioma, letra más grande, Braille, cinta de audio, o en otro tipo de formato, llame al 1-800-832-4580 o al 1-800-735-2900 (TTY).

(Russian)

Если Вам нужна эта брошюра на другом языке, напечатанная большими буквами, шрифтом Брайля, на кассете или в каком-нибудь другом формате, пожалуйста, позвоните по телефону (541) 786-4550; 1-800-832-4580 или телетайпу 1-800-735-2900.

To the member

Dear Member:

The benefits described on the pages of the attached Samaritan Healthy KidsConnect member handbook is meant to provide the comprehensive health care under the new Healthy KidsConnect private market insurance program. Samaritan Health Plans is one of the insurance carriers selected by the Office of Private Health Partnerships (OPHP) to offer health care to eligible children in Linn, Benton, Lincoln and Tillamook counties.

Healthy KidsConnect was authorized by the 2009 Oregon Legislature through the passage of House Bill 2116. OPHP, the state agency leading this new program, is part of the new Oregon Health Authority. Official rules of the Department of Consumer and Business Services (DCBS) Insurance Division require that you be notified of the following:

- OPHP is the policyholder for Healthy KidsConnect insurance.
- OPHP can make changes to this group policy including, but not limited to, eligibility, premium, out-of-pocket expenses, and benefits.
- OPHP will give timely notification of changes to the participants.
- The consent of the participant is not required for OPHP as the policyholder to make changes.

Here are contact numbers if you have questions or need more information:

- For questions about the medical benefits described in this booklet, please contact Samaritan Health Plans toll free at 1-800-832-4580
- For questions about your subsidy or premium payments call OPHP toll free at (888) 260-4555.
- For questions about your eligibility determination, call Oregon Department of Human Services toll free at (877) 314-5678.

Thank you for choosing Samaritan Health Plans, and we look forward to serving you.

Sincerely,



Kelley Kaiser, MPH
Chief Executive Officer

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Definitions

Throughout this document you will find underlined terms. These underlined terms and words are defined in this section, **Definitions**. If you have questions about a this document, please call Samaritan Healthy KidsConnect at (541) 768-4550, toll free 1-800-832-4580 or TTY 1-800-735-2900.

Brand-name medication means prescription medication that has a patent and is marketed and sold by only one source or is listed in widely accepted references as a brand-name medication based on manufacturer and price.

Claim means a request for payment under the terms of this plan.

Co-insurance means the percentage of charges that you must pay on a claim, i.e., the portion of the claim that you pay after we pay the maximum amount for that benefit. Co-insurance and co-pay descriptions can be found in your Summary of Benefits. **American Indian/Native Alaskan members on the Zero Cost Share Plan do NOT have cost sharing for covered in-network services**

Compound medication means two or more medications that a pharmacist mixes together. In order to be covered, compound medications must contain, in therapeutic amount, either one federal legend medication or one state restricted medication. Co-payment amounts are assessed on each covered prescription medication claim.

Contracted agency means any of the following with whom we have contracted to provide services and supplies under this contract: Home health care agency, home infusion therapy agency, or hospice care plan.

Contracting durable medical equipment supplier means a supplier of durable medical equipment that has contracted to provide services and supplies to you under this plan.

Co-payment means a fixed amount that you pay for covered medical services. Co-pays are due at the time of service. Co-insurance and co-pay descriptions

can be found in your Summary of Benefits. **American Indian/Native Alaskan members on the Zero Cost Share Plan do NOT have cost sharing for covered in-network services**

Cosmetic means services and supplies that are applied to normal structures of the body primarily for the purposes of improving or changing appearance or enhancing self-esteem.

Covered expenses means the amounts that this plan pays for covered services.

Creditable coverage Health coverage of an individual under a group health plan, (including while on COBRA continuation coverage), individual health insurance coverage, Medicare, Medicaid, a state health benefits risk pool, a public health plan, and certain other health programs that meet specified requirements and benchmarks of coverage.

Deductible is the portion of covered benefit costs each member is obligated to pay before Samaritan Healthy KidsConnect will provide payment for benefits. Deductibles do not apply to preventive benefits and to those members who have been determined to be **below** 300% of the Federal Poverty Level (FPL)

Durable medical equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of illness and/or injury, and is appropriate for use in your home. Examples include oxygen equipment and wheelchairs.

Eligibility means the requirements that you must meet in order to qualify for and remain in the Healthy KidsConnect Program and is not based on Medicaid. **See “When Coverage Begins” and “When Coverage Ends” sections.**

Emergency medical condition or medical emergency means a medical condition with symptoms of sufficient severity for which a sensible person, who possesses an average knowledge of health and medicine, would reasonably

expect that failure to receive immediate medical attention would place your health, or the health of your fetus in the case of a pregnant woman, in serious jeopardy.

Emergency medical screening exam means the medical history, examination, ancillary tests, and medical determinations required to ascertain the nature and extent of an emergency medical condition.

Emergency services means those health care items and services furnished in an emergency department and all ancillary services routinely available to an emergency department to the extent they are required to stabilize your condition.

Exclusions means specified conditions or circumstances, listed in this plan, for which we pay no benefits. Exclusions may apply to services that are medically necessary.

Generic medication means a prescription medication that is an equivalent medication to the brand-name medication, is marketed and sold by more than one source, and is listed in widely accepted references as a generic medication based on manufacturer and price. Equivalent medication means the Food and Drug Administration (FDA) ensures that the generic has the same effectiveness as the brand-name medication.

Grievance means a verbal or written complaint submitted by or on behalf of an enrollee regarding

- Availability, delivery or quality of health care services, including a complaint regarding an adverse determination based on the decision of the plan through a prior authorization
- Claims payment, handling or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between an member and the plan

Health Benefit Plan means any hospital cost, medical cost or hospital or medical cost policy or certificate, health care service contractor or health maintenance organization subscriber contract, any plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended

Healthy KidsConnect Program means the Healthy Kids Program of the Office of Private Health Partnerships (OPHP), 250 Church Street SE, Suite 200, Salem, OR 97301. Telephone Salem (503) 373-1656, Toll Free 1-800-542-3104.

Home health-care means services and supplies that a licensed home health agency provides to a homebound patient.

Hospice means a program designed to provide comfort and supportive services to terminally ill patients and their families.

Hospital means a facility that provides diagnostic and treatment services for inpatient surgical and medical care of persons who are injured or ill. It must be licensed under applicable laws as a general hospital. Its services must be under the supervision of a staff of physicians and must include 24-hour-a-day nursing service by registered nurses. Facilities that are primarily for rest, the aged or convalescence homes are not considered hospitals and neither are facilities operated by the state or federal government.

Illness means a physical illness or mental illness. Physical illness is a disease or bodily disorder. Mental illness is an Axis 1 diagnosis listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, except those specifically excluded in the **“General Exclusions” subsection in the “Benefit Exclusions” section.**

Injury means a personal bodily injury to you caused directly and independently of all other causes by external, violent, and accidental means.

In-network means only the covered services that you receive from participating providers, also known as contracted providers.

Late enrollee is a member who enrolls in the group after the initial enrollment period during which the individual was eligible for coverage.

Maximum out-of-pocket means the maximum amount you will incur in a calendar year before the plan begins paying at 100% for eligible medical cost. The deductible amount for those above 300% FPL **does** apply to the out-of-pocket maximum.

Medical emergency means a sudden and unexpected illness or injury, which requires immediate attention.

Medically necessary or medical necessity means health care services or supplies that a health care provider, exercising prudent clinical judgment, would provide to you for the purpose of preventing, evaluating, diagnosing, or treating an illness, or injury, disease, or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury, or disease;
- not primarily for the convenience of you, your physician, or other health care provider; and
- not more costly than an alternative service or sequence of services, or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury, or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, the views of health care providers practicing in relevant clinical areas, and any other relevant factors.

Samaritan Healthy KidsConnect Health Plan reserves the right to review or otherwise deny services that are found to not be medically appropriate.

Member means the eligible enrollee or dependant covered under Samaritan Healthy KidsConnect Health Plan

Obesity means a condition in which a person has a body mass index of at least 30.0 kg/m² but less than 40.0 kg/m².

Out-of-network means covered services that you receive from providers that have **NO** contract with us to serve Samaritan Healthy KidsConnect members. These providers may or may not be in our service area. Please contact the Health Plan for confirmation of provider participation

Participating pharmacy means a pharmacy that has a contract with us to submit claims electronically and discount all prescription medications.

Participating provider means a provider that has a contract with us to serve Samaritan Healthy KidsConnect members.

Patient Protection and Affordable Care Act (PPACA) is a federal statute that was signed into law in the United States by President Barack Obama on March 23, 2010. Along with the Health Care and Education Reconciliation Act of 2010. The Act is the product of the health care reform agenda and includes numerous health-related requirements that a health plan is required to adhere to.

Pharmacist means an individual licensed to dispense prescription medication and counsel a patient about how the medication works and its possible adverse effects.

Pharmacy means any licensed outlet in which prescription medications are regularly compounded and dispensed.

Plan means our Samaritan Healthy KidsConnect **Medical Benefits Plan, Pharmacy Benefits Plan, Dental Benefits Plan, Vision Benefits Plan**, and administrative procedures (such as procedures for claims submission, grievances, appeals, external review, coordination of benefits, and third party liability), all as described in this member handbook.

Pre-authorization and prior authorization mean a determination by us prior to provision of services that we will provide reimbursement for the services. Pre-authorization does not include referral approval for evaluation and management services between providers. See **Prior Authorization List** on **page 28**

Pre-existing condition means a health benefit plan provision applicable to an enrollee or late enrollee that excludes coverage for services (this is an exclusion period), charges or cost incurred during a specified period immediately following enrollment for a condition for which medical advice, diagnosis, care or treatment was recommended or received during a specified period immediately preceding enrollment. Samaritan Healthy KidsConnect does not have an exclusion period or a pre-existing conditions clause.

Prescription medication means medications and biologicals that relate directly to the treatment of an illness or injury and that can legally be dispensed only with a prescription order. By law, they must bear the legend: “Caution – federal law

prohibits dispensing without prescription.” For purposes of the outpatient prescription medication benefit, prescription medications also include covered insulin and supplies used for the administration of insulin, Self injectable medications, and compound medications. We require a prescription order for insulin and diabetic supplies.

Prescription order means a written prescription or oral request for prescription medications issued by a professional provider who is licensed to prescribe medications.

Professional provider means any of the following, for medically necessary services, which are within the scope of the professional provider’s state license or registry:

- A **physician** (doctor of medicine or osteopathy);
- **podiatrist**;
- **dentist** (doctor of medical dentistry, doctor of dental surgery, or denturist);
- **pharmacist**;
- **psychologist**;
- **optometrist**
- **Oregon-registered clinical social worker and counselors**;
- **certified nurse practitioner**;
- **registered nurse or licensed practical nurse**, but only for services rendered upon the written referral of a doctor of medicine or osteopathy, and only for those services for which nurses customarily bill a patient;
- **physician assistant** (to be paid as if submitted by the supervising physician); or
- **Registered physical, occupational, speech, or Audiological therapist**.
- **Women’s health care provider or pediatrician**

The term “**professional provider**” does not include any other class of provider not named previously, and no medical benefit of the plan will be paid for their services. For certain providers, coverage may exist under the **Dental Benefits** or **Vision Benefits** of the plan.

Provider or health care provider means a professional provider, or a facility, agency, supplier, or program that provides health care services or supplies to our members.

Reconstructive means services, procedures, and surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

Residential/partial hospitalization/day care means care in a residential facility, hospital or other facility which provides an organized full-day or part-day program of treatment and is licensed or approved for the particular level of care for which reimbursement is being sought by the Oregon Office of Alcohol and Drug Abuse Programs or by the Oregon Mental Health Division (or the equivalent agencies, if the services are provided outside Oregon).

Samaritan Healthy KidsConnect Health Plan means the Healthy KidsConnect Managed Health Organization (HMO) Plan administered by Samaritan Health Plans.

Self injectable medications mean outpatient injectable prescription medications intended for self-administration and approved by us for self-injection.

Services means health care diagnosis, treatments, procedures, equipment, medications, or devices. Services include supplies to support a service.

Service area for Samaritan Healthy KidsConnect Health Plan is defined as Linn, Benton, Lincoln and Tillamook counties.

Skilled nursing facility means a facility licensed under applicable laws to provide inpatient care under the supervision of a medical staff or a medical director. It must provide continuous 24-hour-a day nursing service supervised by registered nurses.

Spell of illness means the duration of a particular illness that lasts for a period of consecutive days beginning with the first day not part of a previous illness on which you are admitted to a hospital, and ending at the close of the first 60-day period thereafter during which you have neither been a hospital inpatient nor been confined in any other type of facility.

Supplies mean consumable goods to support health care services.

Transplant means a procedure or a series of procedures by which an organ or tissue is either: removed from the body of one person (called a donor) and implanted in the body of another person (called a recipient), or removed from and replaced in the same person's body (called a self-donor). In treatment of cancer, the term transplant includes any chemotherapy and related course of treatment, which the transplant supports.

Usual and customary or reasonable charge means:

- Usual — not more than the provider's, dispenser's or vendor's usual charge for a given service or supply; and
- Customary — an amount which falls within the range of usual charges for the service or supply billed by most professional providers, dispensers or vendors of the same or similar service or supply in the service area; or
- Reasonable — an amount, determined by us, according to our proprietary database on health care billings; or use of pharmacy or Medicare data, which is usual (not more than the provider's normal charge) and customary (falls within the range of average charges for a service or supply billed by most providers or vendors for the same or similar service or supply in the service area).

We, us, or our, refers to your Samaritan Healthy KidsConnect Health Plan insurance company.

When coverage begins means:

- The first of the month after we have received your completed enrollment materials from the Healthy KidsConnect Program.
- From birth or placement for adoption, in the case of a newborn or adoptee enrolled in accordance with the requirements of the Healthy KidsConnect Program.

When coverage ends is when you have:

- Become age 19 (except as provided under portability).
- Become eligible or entitled to Medicare.
- Become eligible for Medicaid/Oregon Health Plan (OHP).
- Not paid your premiums.
- Moved out of state.
- Moved out of our service area.
- Otherwise fail to satisfy the eligibility requirements of the Healthy KidsConnect Program.

You or your means the person enrolled in Samaritan Healthy KidsConnect Health Plan.

Medical deductible and out-of-pocket maximums

Questions regarding benefits and coverage This plan contains information about the benefits specific to the Samaritan Healthy KidsConnect Health Plan. Please be sure to read carefully the terms, conditions, provisions, limitations, and exclusions of this plan.

Medical deductible Plan option BELOW 300% FPL—does **not** have an **annual medical deductible**. Plan option ABOVE 300% FPL—**does have an annual medical deductible of \$1,000**. This deductible does not apply to preventive benefits. This deductible does apply to your maximum out-of-pocket cost. Plan option American Indian/Native Alaskan members on the Zero Cost Share Plan **do NOT have cost sharing for covered in-network services**

Your maximum out-of-pocket cost Your maximum out-of-pocket cost amount is **\$900** per year for you, **\$1,800** for you and your covered family for those **below** 300% of the Federal Poverty Level (FPL) or **\$6,000** for those **above** 300% of the FPL, each calendar year for in-network covered medical expenses. The maximum out-of-pocket cost is the maximum set amount that you will incur in a calendar year, beginning in January, before we begin paying 100% for in-network covered medical expenses

There is **no** maximum out-of-pocket for your out-of-network services. Out-of-network charges do not count towards your maximum out-of-pocket total. **See “Summary of Maximum Out-of-Pocket Expenses”**.

You are responsible for the co-insurance or co-payment amount for each covered medical service listed in the following **Your Benefits** section until your medical out-of-pocket covered expenses reach your maximum out-of-pocket cost amount. The maximum out-of-pocket medical amount accumulates based your own covered expenses.

Non covered charges do not accumulate towards the maximum out-of-pocket cost

- There is no annual deductible amount that needs to be met for the Medical benefit plan for those **below** 300% of the Federal Poverty Level (FPL). The **\$1,000** deductible will apply to the **\$6,000** maximum out-of-pocket cost limit for those **above** 300% of the FPL.
- **Annual out-of-pocket limit \$900** per year for you, **\$1,800** for you and your covered family for those **below** 300% of the Federal Poverty Level (FPL) or **\$6,000** for those **above** 300% of the FPL. Once the applicable out-of-pocket limit has been met, this plan will pay 100% of covered charges for services at the applicable in-network or out-of-network benefit level for the rest of that calendar year.

Non covered charges do not accumulate towards the maximum out-of-pocket cost. Other services which **do not** accumulate toward the maximum out-of-pocket or have cost sharing:

- Women’s preventive services
- Men’s preventive services
- Routine physical examinations
- Colorectal cancer screenings and exams
- Immunizations
- One PKU test
- Well-baby/well-child care
- Outpatient diabetic instruction
- Transplant facilities that are participating providers

Summary of out-of-pocket maximums

Annual out-of-pocket MEDICAL limit*-Individual; below 300% FPL	Annual out-of-pocket MEDICAL limit*-Multi-child; below 300% FPL	Annual out-of-pocket MEDICAL limit* Above 300% FPL
\$900	\$1,800	\$6,000
Annual out-of-pocket PRESCRIPTION limit*-Individual	Annual out-of-pocket PRESCRIPTION limit*-Multi-child	Annual out-of-pocket PRESCRIPTION limit*-Above 300% FPL
\$100	\$200	None
Annual out-of-pocket DENTAL limit* Individual	Annual out-of-pocket DENTAL limit*-Multi-child	Annual out-of-pocket DENTAL limit* Above 300% FPL
\$200	\$400	\$200

*This is only a brief summary of benefits. Please refer to the additional information provided in following sections of this [Member Handbook](#) for a further explanation of benefits including limitations and [exclusions](#).

Summary of maximum out-of-pocket expenses Your maximum out-of-pocket cost amount is \$900 per year for you, \$1,800 for you and your covered family for those below 300% of the Federal Poverty Level (FPL) or \$6,000 for those above 300% of the FPL, when you use in-network providers. The maximum out-of-pocket cost amount is not applicable when you use out-of-network providers.

Non covered charges do not accumulate towards the maximum out-of-pocket cost.

Services are covered only when obtained from in-network providers except in emergencies or when we provide an out-of-network pre authorization. In these circumstances, normal cost-sharing would apply

This [plan](#) has no maximum lifetime medical benefit

American Indian/Native Alaskan members on the Zero Cost Share Plan do NOT have cost sharing for covered in-network services

Service area

The Samaritan Healthy KidsConnect Health Plan service area is defined as Linn, Benton, Lincoln, and Tillamook counties. **PLEASE NOTE:** all out-of-area, non-urgent or non-emergent services shall be considered out-of-network provider services if provided through a non-contracted provider or if services have not been authorized.

Urgent and emergent services are always covered at the in-network provider level, as are services provided by in-area contracted providers and those out-of-network services that have been prior authorized.

Not all providers in our service area are considered to be a preferred provider. Please call our Customer Service Department or visit www.SamaritanHealthPlans.com to verify the network status of your provider before getting services. Contact us t (541) 768-4550; toll free1-800-832-4580 or TTY 1-800-735-2900.

Out-of-network providers

Non covered services Samaritan Healthy KidsConnect does not cover out-of-network or services provided by a non-contracted provider unless it has been prior authorized. The Samaritan Healthy KidsConnect Health Plan service area is defined as Linn, Benton, Lincoln, and Tillamook counties. PLEASE NOTE: all out-of-area and in-area, non-urgent or non-emergent services shall be considered non-preferred provider services if provided through a non-contracted provider or if services have not authorized.

Your list of contracted providers You can visit our website or call our Customer Service Department to view and print a list of contracted Primary Care Providers (PCP), specialists, and facilities for your health care needs

You can visit:

www.samaritanhealthplans.com/healthykidsconnect

Your Customer Service Department

Samaritan Healthy KidsConnect Health Plan

Samaritan Health Plans

815 NW Ninth Street

Corvallis, OR 97339

(541) 768-4550

1-800-832-4580

TTY 1-800-735-2900

Becoming a Healthy KidsConnect Health Plan member

When you become a member of Samaritan Healthy KidsConnect Health Plan, you receive a New Member Packet. The following information and materials are found in your packet. This packet will include a summary of your benefit coverage and important information about your appeal rights.

Enrollment period Please refer to Office of Private Health Partnerships for enrollment periods and dates.

Please keep these materials for future reference:

- Welcome letter
- Choosing a PCP card
- PCP Provider Directory
- Health Information Form
- Notice of Privacy Practices pamphlet
- Summary of benefits
- How to get your Member Handbook
- Educational materials

In addition to your new member packet, you will receive a member identification card to use for getting services. If you have misplaced, changed personal information or changed your PCP, please call our Customer Service Department to order a new one.

If you are missing any of these materials please call the **Customer Service Department at (541) 768-4550; toll free 1-800-832-4580 or TTY 1-800-735-2900.**

Choosing your Primary Care Provider (PCP)

As a Samaritan Healthy KidsConnect Health Plan member, you must choose a Primary Care Provider (PCP) for yourself and each family member covered under the plan. Your PCP will oversee your medical care and treatment and make sure that you see specialists when needed. This plan permits a female enrollee to designate a women's healthcare provider as her PCP or a pediatrician for a child's PCP. Please see the Primary Care Provider (PCP) directory for a complete list of providers to choose from. To choose a PCP, complete the "Choosing a PCP" card included in your packet, and mail it to us. If we do not hear from you within one (1) week after your enrollment, Samaritan Healthy KidsConnect Health Plan will assign you a PCP. We will then send you an identification card with the name of your PCP written on it. If you need help choosing a PCP, you may call our **Customer Service Department at (541) 768-4550; toll free 1-800-832-4580 or TTY 1-800-735-2900 for assistance.**

If you are already seeing a PCP, and you want to continue services with that PCP, make sure that he/she is listed in the PCP directory. If your PCP is not listed or you do not want to continue seeing that PCP, choose a new one listed in the PCP directory. Once you have made your decision, complete the "Choosing a PCP" card, and mail it to Samaritan Healthy KidsConnect Health Plan.

Once enrolled in Samaritan Healthy KidsConnect Health Plan, you are allowed to change your PCP three times within a 12-month period. If you still want a new PCP after your third change, you must write a letter explaining your reasons. Samaritan Healthy KidsConnect Health Plan will then decide whether or not you can change PCPs based on the reasons listed in your letter. If you change your PCP, you may not see your new PCP until the first day of the following month. For example, if you choose a new PCP on October 15th, you must wait until November 1st to see that provider. In order to change your PCP, you need to call Samaritan Healthy KidsConnect Health Plan or write to the following address:

Samaritan Healthy KidsConnect Health Plan

815 NW Ninth Street

Corvallis, OR 97330

Your Samaritan Healthy KidsConnect Health Plan member identification (ID) card

You will receive a Samaritan Healthy KidsConnect Health Plan member identification (ID) card once you have chosen a PCP. You must present this card when you receive services. It lists information about you, the name of your PCP and the PCP's phone number. If you lose your Samaritan Healthy KidsConnect Health Plan member ID card, please call us and we will send you a new one. You will also receive a new card any time you change your PCP.

Interpreter services

If you need a foreign language interpreter at your medical appointments, please contact Samaritan Healthy KidsConnect Health Plan's Customer Service

Department to make those arrangements. To make sure that an interpreter will be at your appointment, please have this information ready when you call:

- The name of the person or persons the appointment is for
- The member's ID number
- A home phone number
- The date and the time of the appointment
- The name of the health care provider
- The full address of the appointment
- The phone number of the provider's office
- The reason for the appointment

Please call the **Samaritan Healthy KidsConnect Health Plan Customer Service Department** at **(541) 768-4550; toll free 1-800-832-4580 or TTY 1-800-735-2900** with all of the necessary information at least 72 hours before your appointment.

Your benefits

To receive benefits, you must be enrolled with us. Listed below are your medical benefits, exclusions that apply to specific benefits. Your co-insurance and/or co-payment amounts and out-of-pocket expenses are listed in your Summary of Benefits document sent to you upon enrollment. Not all benefits are described in this document. Please call our Customer Service Department for questions on services and coverage:

The interpretation and validity of this contract will be governed by the laws of the State of Oregon without regard to its conflict of law rules. If there is conflict between the provisions of this plan and Oregon State or Federal Laws, Oregon State or Federal Laws will take precedence over the provisions of this plan.

American Indian/Native Alaskan members on the Zero Cost Share Plan do NOT have cost sharing for covered in-network services

Alternative services (acupuncture, chiropractic, and naturopathic care)
Please obtain an authorization for Naturopathic care These services may be done with a professional provider or by an acupuncturist, chiropractor, or naturopathic provider.

Ambulance services We cover medically necessary ambulance services, including local ground transportation by a state-certified ambulance for transportation to the nearest hospital that has the facilities to give the necessary services. Certified air ambulance transportation will be covered if it is medically necessary. Coverage and payments are made directly to the billing provider or jointly to the member if the member has paid for services out-of-pocket.

Biofeedback therapy Covered expenses for biofeedback therapy services are limited to treatment of tension or migraine headaches.

Case management services Samaritan Healthy KidsConnect Health Plan also has nurses who help members who have chronic medical conditions (such as diabetes, asthma or heart disease). These nurses work with the PCP, the

member and other health care providers as needed. The goal is to help the member understand their chronic medical conditions.

If you have questions or want to know more about case management services, please call our **Customer Service Department at (541) 768-4550; toll free 1-800-832-4580 or TTY 1-800-735-2900.**

Chemotherapy Chemotherapy services are paid by the provisions of this plan.

Developmental and learning disabilities We will cover services for developmental and/or learning disabilities in the absence of an illness or when it is medically necessary. Services for the treatment and diagnosis of these conditions may be covered under your **Medical benefits**.

Coverage for Developmental and learning disabilities are defined by ORS 743A.190 and House Bill 2918. We will cover, for members who have been diagnosed with a pervasive developmental disorder, all medical services, including rehabilitation services, which are medically necessary and are otherwise covered under the plan. These services may have limitations and exclusions based on the provisions of the plan and this document

Pervasive developmental disorder means a neurological condition that includes Asperger's syndrome, autism, developmental delay, developmental disability, or mental retardation

Disease management services Samaritan Healthy KidsConnect Health Plan provides disease management programs. Those eligible for disease management are identified using a combination of methods, and referral, or you may self-enroll. Please contact our Customer Service Department for more information

Durable medical equipment, supplies, and appliances We cover the following medically necessary supplies and appliances when required by

standard treatment practices for the treatment of an illness or injury or to restore or maintain activities of daily living:

- Casts, trusses, limb or back braces, and crutches
- Ostomy supplies
- Mastectomy supplies
- Diabetic supplies (strips, lancets, insulin pumps)
- Medically necessary PKU formulas
- Nonprescription elemental enteral formula for home use when ordered by your authorized physician as long as:
 - The formula is medically necessary for the treatment of severe intestinal mal-absorption, inborn errors of metabolism that involve amino acids, carbohydrates and fat metabolisms
 - The formula comprises the sole or an essential source of your nutrition.
- Nutritional supplies and medical assessment equipment necessary to diagnose, monitor and control disorders of inborn metabolic disorders
- One contact lens or one pair of glasses for each eye after undergoing cataract surgery
- Prosthetics, artificial limbs, artificial eyes and orthotic devices
- Maxillofacial prosthetic devices that are medically necessary for the restoration and management of head and facial structures that cannot be replaced by living tissue, are defective due to disease, trauma, or developmental deformity to control or eliminate infection and pain and restore facial configuration and function
- Rental (not to exceed the reasonable purchase price if the item can be purchased) of a wheelchair, hospital-type bed, oxygen, or other durable medical equipment unique to medical care or treatment

Covered durable medical equipment must be medically necessary and may not serve solely as a comfort or convenience item. The following items are *not* durable medical equipment and, therefore, are not covered: deluxe equipment with mechanical or electrical features such as motor-driven wheelchairs and chair lifts; environmental controls or environmental enhancements such as air

conditioners, air filters, and portable whirlpool pumps. **Durable medical equipment requires prior authorization if purchase price is more than \$1,000 or rental is for more than 3 months.** Diabetic supplies, incontinent, and CPAP supplies do not require prior authorization.

Emergency room services If you receive services for an emergency medical condition, you are responsible for the emergency room co-payment. If you are admitted as an inpatient to the hospital while seeking emergency room services the co-payment may be waived. **Emergency services do not require authorization.**

We will cover emergency services from an out-of-network provider if a prudent layperson possessing an average knowledge of health and medicine, would reasonably believe that the time required to go to an in-network provider would place your health; or the health of your fetus, in the case of a pregnant woman, in serious jeopardy.

When should you go to the emergency room? Emergency room care is very expensive. **Do not go to the emergency room for care that should take place in your PCP's office.** Routine care for things like sore throats, colds, flu, back pain or tension headaches is not considered an emergency. If you do not know whether or not your condition is an emergency, call your PCP. Call your dental plan for dental questions. **You may call your PCP any time, day or night. Someone is always available to give you advice 24 hours a day, seven days a week.** Speak to the provider on call, even if he/she is not your usual PCP. Many times they can see you in the office or send you to an urgent care clinic instead of going to the emergency room.

In a true medical emergency, emergency care is covered at the In-network Provider Benefit shown on the Member Benefit Summary even if you are treated at a out-of-network hospital. When feasible, emergency care should be obtained at a SHS facility.

An emergency is a serious threat to your health or your unborn baby's health if you are pregnant. If you do have a serious health crisis, illness or accident, call 911 or go to your closest emergency room. Tell them that you are a member of Samaritan Healthy KidsConnect Health Plan. Then ask them to call your PCP.

Some examples of possible medical emergency situations are:

- Chest pain
- Trouble breathing
- Bleeding that does not stop
- Broken bones
- Loss of consciousness or blacking out
- Rape or assault
- Drug or other poisoning
- Severe burns
- Onset of delivery

Emergency care when you are away from home The same emergency room guidelines apply if you are traveling and away from home. You will still need to call your PCP. This includes urgent and emergent services out of state and emergent services out of country.

Emergency room co-payments are (per admission)

Hearing services and hearing aids Services and payment to an audiologist or hearing aid dealer for a hearing aid will be considered only after examination for ear pathology and written prescription for a hearing aid by an ear, nose, and throat specialist (ENT) or general practitioner who has training to examine the ear and performs within the scope of his/her practice, i.e. primary care physician (not appropriate is an orthopedic specialist, chiropractor, gynecologist, etc.). Cochlear and bilateral implants are covered.

Home or office visits A visit means that a professional provider actually examined you. Covered expenses include physician consultations in addition to second opinion surgery consultations.

Home health care A visit must be for intermittent care of no more than two hours in duration. A physician must order the home health care services. Providers who deliver home health care must be registered or licensed practical nurses;

physical, occupational, speech, or respiratory therapists; or licensed social workers.

This home health care benefit excludes home care services provided as part of a hospice treatment plan.

- **Maximum visits.** There is a two-visit maximum allowed in any one day for the services of a registered or licensed practical nurse. The maximum visits allowed for each other classification of home health care provider is one visit per day.
- **Pre-authorization.** If a provider other than a contracted provider provides the home health care, contact the Customer Service Department before receiving such care.

Covered expenses for home health care exclude:

- More than one visit of any one kind of rehabilitation on any one day;
- rehabilitative care provided in your home and covered under the inpatient or outpatient rehabilitation care benefit;
- recreational or educational therapy;
- self-help or training; or
- Treatment of psychotic or psychoneurotic conditions.

Home infusion therapy We cover home infusion therapy services and supplies as described in this section that a physician orders and determines to be medically necessary, that an accredited home infusion therapy provider provides and that the therapy regimen requires.

Limited services. Home infusion therapy is limited to the following:

- Aerosolized pentamidine;
- blood product administration;
- enteral nutrition (under certain circumstances);
- hydration therapy;
- intravenous medication therapy;
- intravenous/subcutaneous pain management;

- SynchroMed pump management therapy;
- terbutaline infusion therapy; or
- Total parenteral nutrition.

Covered expenses include only the following medically necessary services and supplies:

- Ancillary medical supplies;
- collection, analysis, and reporting of the results of laboratory testing services required to monitor response to therapy;
- durable medical equipment;
- nursing services associated with:
 - administrative therapy;
 - emergency care;
 - patient and/or alternative care giver training;
 - visits necessary to monitor intravenous therapy regimen.
- pharmacy compounding and dispensing services; and
- solutions, medications, and pharmaceutical additives.

If a provider other than a contracted provider provides the home infusion therapy, ask your physician to contact our case management department before receiving such care.

Hospice care benefits and definitions The following definitions apply only to this hospice care section:

- Approved hospice is a private or public hospice agency or organization approved by Medicare or accredited by the Joint Commission on Accreditation of Hospitals.
- Homebound means that your condition is such that there exists a normal inability to leave home. If you do leave home, the absences must be infrequent, or short duration and mainly for the reason of receiving medical services.

- Home health aide is an employee of an approved hospice who provides intermittent care under the supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist.
- Hospice treatment plan is a written plan of care established and periodically reviewed by your attending physician. The physician must certify in the plan that you are terminally ill. The plan must describe the services and supplies for medically necessary or palliative care to be provided by the approved hospice.
- Palliative care is care primarily for the relief or control of distressing symptoms, not cure.
- Terminally ill means your condition has reached a point where recovery can no longer be expected and you are facing imminent death.

Palliative hospice care We cover palliative hospice care as described in this section when provided by a Medicare or state-certified hospice care provider. A hospice care program is a coordinated program for home and inpatient care, available 24 hours a day. It uses an interdisciplinary team of personnel to provide palliative and supportive services to a patient-family unit experiencing a life threatening disease with a limited prognosis. The services include acute, respite, and home care to meet the physical, psychological, and special needs of a patient-family unit during the final stages of illness and dying.

Palliative hospice care means medical services provided by a hospice care program that alleviates symptoms or affords temporary relief of pain but are not intended to affect a cure. If you elect palliative hospice care, then you are not eligible for any other benefits for active treatment of the terminal illness.

In order to qualify for palliative hospice care, your physician must certify that you are terminally ill with a life expectancy of six months or less if the illness runs its normal course.

Palliative hospice care benefits are limited to the following levels of care:

- Routine home care;
- continuous home care;
- inpatient respite care; and
- inpatient hospice care.

Additionally, covered expenses for palliative hospice care include the following when provided under any of the levels of care listed on the previous section:

- Durable medical equipment;
- medications, including infusion therapy;
- care by any enrollee of the hospice interdisciplinary team; and
- any other supplies required for the palliative hospice care.

If you elect to discontinue palliative hospice care before this benefit has been exhausted, you will forfeit any remaining hospice benefit and we will not be obligated to pay for any additional palliative hospice care for you.

Palliative hospice care pre-authorization If a provider other than a contracted provider provides palliative hospice care, you must contact our case management department before receiving such care, when appropriate. If palliative hospice care is provided by a provider that has not contracted with us, we strongly urge you to ask your provider to contact our Pre-authorization Department before receiving such care to avoid a denial or reduction of benefits due to lack of medical necessity.

Hospital care We pay for services provided in a hospital. **A physician must authorize hospitalization** and it must be medically necessary for acute care and services for illness or injury. All clinical decisions regarding length of stay in a health care facility, transfer between levels of care and follow-up care are the decision of the treating physician in consultation with you and subject to medical necessity as defined by us. The benefits are explained on the following page.

Covered expenses consist of the following:

- The charge for a semiprivate room or billed charges, whichever is less, up to the hospital's most common rate for a room with two beds.
- Isolation care when medically necessary to protect other patients from contamination or to protect you from contracting the illnesses of others.
- Use of an intensive care or coronary care unit. We establish our definition of an intensive care or coronary care unit by using the criteria of the Joint Commission on Accreditation of Hospitals as a guide, but

we reserve the right to decide whether the unit in a particular hospital is qualified for coverage.

- The use of the facility for surgery performed in a hospital outpatient department.
- Other hospital services and supplies that are necessary for diagnosis and treatment, and that the hospital ordinarily furnishes. These include, but are not limited to, operating and recovery rooms, traction equipment, and special diets.
- Covered services provided in a participating hospital.
- Inpatient mental health and chemical dependency services

Number of inpatient hospital days covered We will provide benefits for unlimited days of hospital inpatient care for most conditions. Inpatient services for some conditions may be limited to a lesser number of days. If benefits under this plan change while you are in the hospital, we will determine what the covered expenses are according to the benefits in effect when the stay began. The same rule applies to stays in other kinds of medical facilities. **Inpatient stays at a hospital require a prior authorization, with the exception of maternity delivery services.**

Pre-admission testing We cover expenses for necessary pre-admission testing.

Hospital inpatient care We cover hospital inpatient care, including intensive care, coronary care, and inpatient care for mental illness or chemical dependency

Hospital outpatient care We pay for medically necessary hospital outpatient care, including, but not limited to:

- Outpatient surgery
- Outpatient rehabilitative hospital care (maximum of 60 days per calendar year)
- Emergency room

Injury and accidental injury We cover services for the purpose of injury and or accidental injury and will be paid by the provisions of this plan based on the services rendered. Medically necessary therapy and services for the treatment

of traumatic brain injury will be paid by the provisions of this plan. Services and treatment for injuries resulting from alcohol and controlled substances will also be paid by the provisions of the plan.

Imaging and invasive diagnostic services We cover imaging services such as MRI and CT scans, and diagnostic procedures that require entry into the body cavity, such as angiograms and endoscopy when they are medically necessary.

- X-ray/radium therapy, chemotherapy
- Diagnostic X-ray and laboratory for accident, illness, and pre-admission testing
- **Some imaging and invasive diagnostic require Prior Authorization (see Prior Authorization list page 28)**

Inpatient rehabilitation hospital care These benefits are available only as long as you require the full rehabilitative team approach and services on an inpatient basis. This plan covers rehabilitative services that a professional provider delivers to you when not confined in a hospital. Rehabilitative services are physical, occupational, speech, or Audiological therapy, necessary to restore or improve lost function caused by illness or injury. In order for this plan to cover expenses for these types of services and therapies, it must be medically necessary

In order to be a covered cost, inpatient rehabilitative care must be pre-authorized and be part of a licensed physician's formal written program to improve and restore lost function following illness or injury, and it must be consistent with the condition that is under treatment.

Maternity care Pregnancy care, childbirth, termination of pregnancy, and related conditions are covered for you. We will not limit benefits for the mother and her newborn's length of inpatient stay to less than 48 hours for a normal delivery and 96 hours for a cesarean section as defined by the Mother's and Newborn's Act. However, the attending physician in consultation with the mother may decide on an early discharge. Such discharges do not need to be pre-authorized.

This plan does not discriminate between married and unmarried women or between children of married or unmarried women

Maxillofacial prosthetic services We will cover services considered necessary for adjunctive treatment for restoration and management of head and facial structures and that cannot be replaced with living tissue and that are defective because of disease, trauma or birth, and developmental deformities when such restoration and management are performed for the purpose of: **Prosthetic services require prior authorization**

- controlling or eliminating infection;
- controlling or eliminating pain; or
- resorting facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures rendered to improve on the normal range of conditions.

Mental health and chemical dependency care We will cover mental health and chemical dependency services under the plan the same as illness and injury resulting due to or in part by the use of alcohol or controlled substances. We cover mental health and chemical dependency services that are residential care (care in a licensed residential facility, hospital, or other facility which provides an organized full-day or part-day program of treatment). **Inpatient and residential mental health and chemical dependency require prior authorization**

Definitions The following definitions apply to treatment of mental health conditions and chemical dependency conditions:

Chemical dependency conditions are substance-related disorders included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Chemical dependency is an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with your social, psychological, or physical adjustment to common problems. Chemical dependency does not include addiction to or dependency on tobacco, tobacco products, or foods.

Mental health conditions are mental disorders defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association except as otherwise excluded under this plan. Mental disorders that accompany an excluded diagnosis are covered.

Mental health and chemical dependency services are medically necessary outpatient, residential, partial hospital, or inpatient services provided by an approved licensed facility or licensed professionals who meet our credentialing requirements. Our mental health and chemical dependency benefit does not cover skilled nursing facility services (unless the services are provided by a licensed behavioral health provider for a covered diagnosis), home health care services, or court ordered services (unless the services are determined by us to be medically necessary). Mental health and chemical dependency services do not include:

- Educational programs for drinking drivers;
- voluntary mutual support groups, such as Alcoholics Anonymous; and
- family education or support groups.

Pre-authorization The pre-authorization procedures described in this document should be followed for treatment of chemical dependency conditions and/or mental health conditions. **The prior authorization list is on page 28 of this document.**

Miscellaneous services Benefit amounts for medically necessary services not previously specified or is not described in or as another benefit category, should be discussed with our Customer Service Department. Please call our Customer Services Department for more information.

Newborn nursery care We cover routine nursery care of an enrolled newborn infant while the mother is confined in the hospital and receiving maternity benefits under this plan. However, we cover professional services for well-baby care under the well-baby care benefit. This plan does not provide coverage for pediatric standby charges for vaginal delivery. **PLEASE NOTE:** Newborns whose mother is covered under the plan, the delivery services will be paid under the mom. All other services after the delivery (routine nursery care at the time of delivery) will be paid under the child and will be at 100%. **Please call Office of Private Health Partnerships for questions regarding your enrollment.** Any other services are subject to regular cost shares under the plan.

Outpatient diabetic self-management This plan covers services and supplies used in outpatient diabetic self-management programs when they are provided by a health care professional or by a credentialed or accredited diabetic

education program for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes. For the purposes of this benefit, a health care professional means a licensed physician, registered nurse, nurse practitioner, certified diabetes educator, or licensed dietician with demonstrated expertise in diabetes.

We will pay for one outpatient diabetic self-management program of assessment and training after diagnosis, including up to three hours per year of assessment and training when there is a material change of condition. Diabetic medication and supplies that are not included in the charge for the outpatient diabetic self-management program are covered under the prescription medication benefit under this plan. Diabetic insulin and supplies used for the administration of insulin are covered under the prescription medication benefit. Diabetic syringes, insulin pumps, and lancets are covered under your durable medical equipment benefit.

Outpatient rehabilitation This plan covers outpatient rehabilitative services that a professional provider delivers to a patient who is not confined in a hospital. Rehabilitative services are physical, occupational, speech, or audiological therapy services necessary to restore or improve lost function caused by illness or injury. **Outpatient rehabilitative services require prior authorization, with the exception of Audiological services.**

In order for us to cover the therapy, it must be part of a written plan of treatment that a physician prescribes. Covered expenses exclude the following: more than one session of any one kind of rehabilitation on any one day; rehabilitative care provided in your home are covered under the home health care benefit; recreational or educational therapy; self-help or training; or treatment of psychotic or psychoneurotic conditions.

Outpatient services This plan covers outpatient services that a professional provider delivers to a patient who is not confined in a hospital. Outpatient services include infusion services, dialysis services, chemotherapy services, outpatient surgeries. These services are paid by the provisions of the plan.

Preventive care services

Preventive Care services do not require co-pays or other cost sharing. Prior authorizations are not required for preventive services, as listed below, and are covered as your provider deems medically appropriate. The limits and schedule of recommended visits and screenings are only **RECOMMENDATIONS**. If your provider believes that you need more services than what is described in this section, we will pay for those services if they are preventive and described in the preventive care services section of this document. Preventive care services recommended and supported for adults, adolescents, infants by the US Preventive Services Task Force, Advisory Committee on Immunizations Practices of the Center of Disease Control Services, and Health Resources and Services Administration as required by reform are covered without cost sharing.

Adult routine physical examinations We cover one of the following physical examinations and related laboratory tests and X-ray examinations (as long as a third party is not liable for these charges) for adults age 18: Routine periodic health appraisals, routine physical examinations, and physical examinations required for school and/or to participate in athletics. Handling fees are not covered.

- Age 18 – Once

Colorectal screenings We cover the following services for colorectal cancer screening for any individual at high risk:

- One fecal occult blood test each calendar year;
- one flexible sigmoidoscopy every five years;
- one colonoscopy every ten years; or
- one double contrast barium enema every five years.

Those that are at high risk for colorectal cancer for the purpose of this plan are:

- Individuals who have a family history of colorectal cancer; or

- a prior occurrence of cancer or precursor neoplastic; polyps; or a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, chronic disease, or ulcerative colitis.

Immunizations We cover immunizations recommended by the Center of Disease Control and Prevention for you up through age 18. Covered expenses do not include immunizations for the sole purpose of travel, occupation, or residence in a foreign country. Human papilloma virus (HPV) vaccine for female beneficiaries of this plan is covered as medically appropriate as determined by their physician.

Men's preventive services We will provide coverage for prostate cancer screening examinations including a digital rectal examination and a prostate-specific antigen test (PSA) for males who are at high risk for prostate cancer as determined by the treating physician.

PKU testing We cover PKU testing to detect the presence of Phenylketonuria (PKU).

If the test detects the presence of PKU, we cover the formulas determined to be medically necessary for the treatment of PKU. **We cover necessary formulas for treatment under the supplies, appliances, and durable medical equipment section of this plan.**

Well-baby care Well-baby care covers physical examinations provided by a professional provider, including the standard in-hospital examination at birth, diagnostic X-rays, and laboratory services for an enrolled baby up to age 24 months.

Well-child care We cover routine periodic health appraisals, routing physical examinations, and physical examinations required for school and/or to participate in athletics. Handling fees are not covered.

We cover physical examinations and any related laboratory tests and X-ray examinations up to the following amounts:

- Age 2-6, one examination every calendar year.
- Age 7-17, one examination every two calendar years.

Women's preventive services We cover women's breast, pelvic, and Pap smear examinations once every calendar year. However, we cover more frequent examinations if they are medically necessary and the woman's health care provider recommends them. By breast examination, we mean a complete and thorough exam of the breast for women age 18, including but not limited to a clinical breast examination, performed by a health care provider to check for lumps and other changes for the purpose of early detection and prevention of breast cancer. Mammograms will be paid as medically necessary, determined by their provider

Any medically necessary follow up exams will be covered according to the general medical benefits of this plan and subject to any cost-sharing. We cover any covered expenses for laboratory, X-ray procedures, or mammography that accompany the examination according to the diagnostic X-rays and laboratory services. This plan permits a female enrollee to designate a women's healthcare provider as her PCP.

Professional provider services Care received from certain professional providers must meet specific criteria as described below.

- **Dentist** (doctor of medical dentistry or doctor of dental surgery). This medical benefit covers treatment of accidental injury to natural teeth or fractured jaw rendered within 12 months after the injury, or for surgery that does not involve repair, removal or replacement of teeth, gums or supporting tissue. The injury must be one that occurred while you were enrolled under this plan. You have additional dental coverage under the **Dental Benefits** portion of this plan. Medical dental services require prior authorization please see the **Medical Dental** section for more information.
- **Oregon-registered Clinical Social Worker**. This plan covers services rendered upon the written referral of a physician, a physician's assistant, or psychologist.
- **RN or LPN**. This plan covers services rendered upon the written referral of a physician if nurses customarily bill those services to patients.
- **Therapists**. This plan covers services of registered physical, occupational, speech, or Audiological therapists for rehabilitative services. We require that a physician write a referral for all but the

physical therapist. Any medically necessary follow up exams will be covered according to the general medical benefits of this plan and subject to any co-payment.

Professional provider visits in the hospital Covered expenses include professional provider visits to you during a covered hospital or skilled nursing facility stay. We do not cover separately, visits relating to surgery performed during a hospital stay because these visits are ordinarily included in the surgeon's fee.

Covered expenses also include physician consultations with written reports during each hospital stay. We do not cover staff consultations required by hospital rules. These benefits apply only if you are eligible for hospital or skilled nursing facility benefits. For hospital inpatient treatment of mental health/chemical dependency, covered expenses are limited to durational visit limit. (See "Benefit Limitations" section).

Skilled nursing facility care We cover care in a skilled nursing facility up to 60 days per spell of illness per calendar year. Your attending physician must give us proof of medical necessity, that we find acceptable, showing that you would require hospitalization if care in a skilled nursing facility were not possible.

Skilled nursing facility care requires prior authorization.

Covered expenses exclude routine nursing care, non-medical self-help or training, personal hygiene or custodial care. Covered expenses exclude an admission to a skilled nursing facility that began before you enrolled in Samaritan Healthy KidsConnect or for a stay where care is provided principally for:

- Mental deficiency or retardation; or
- mental illness.
- Number of days..... Up to 60 days per spell of illness per calendar year
Semiprivate room plus medically necessary ancillary services

Smoking cessation Samaritan Healthy KidsConnect also offers other ways to help you stop using tobacco, including a telephone-based program, "Free and Clear" as well as various classes offered through Samaritan Health services. For

more information about this and other options, contact **Samaritan Healthy KidsConnect at 1-800-832-4580 or TTY 1-800-735-2900.**

Quitting for life Quitting tobacco classes are a covered benefit for Samaritan Healthy KidsConnect members. Samaritan Healthy KidsConnect will pay the enrollment fee for quitting tobacco. Quitting tobacco classes are offered in your local area:

Quitting Tobacco for Life
Albany, Corvallis, Lebanon and Tillamook County
1-877-768-7867

If your doctor feels that you need a prescription to help you quit tobacco, Samaritan Healthy KidsConnect will pay for Nicotine Replacement Therapy (NRT).

Medical dental care We cover the treatment of accidental injury to natural teeth or a fractured jaw after you have paid any cost-sharing. To qualify for coverage, you must receive the treatment from a physician or dentist while you are enrolled under this plan, and within 12 months after the injury except when completion is delayed due to healing time following medically necessary surgery. **Medical dental care services require prior authorization.**

For purposes of this special dental care benefit, injury does not include accidents that occur during eating, biting, or chewing. You have additional dental coverage described under the **Dental benefits** section of this document.

Special facility care This plan includes care provided in a special facility. A special facility is an ambulatory surgical facility, surgical center, dialysis center, infusion center or birthing center. Covered expenses include use of the procedure room, professional services and other services and supplies that are medically necessary for treatment.

Speech-language pathology This plan includes speech-pathology, audiology and hearing aid services. The provision of speech therapy services must be supported by a written order and a therapy treatment plan signed by the prescribing practitioner.

A written order is required for the initial evaluation, for therapy and must specify the ICD-9-CM diagnosis code, service, amount, and duration required. **Written orders must be submitted with the pre-authorization request** and a copy must be on file in the provider's therapy record.

Surgery This plan covers surgery (operative and cutting procedures), including treatment of fractures, dislocations and burns, and includes the services of the primary surgeon, assistant surgeon, the anesthesiologist or certified anesthesiologist. It also covers surgical supplies such as sutures and sterile setups when surgery is performed in the physician's office. **Some elective and planned procedures require a prior authorization**

Temporomandibular joint services Temporomandibular joint disorders are covered under the plan the same as for other injuries or musculoskeletal disorders. **All diagnostic, surgical and those services intended to treat TMJ services require pre-authorization.**

Therapeutic injections We cover therapeutic injections, such as allergy shots, when given in a professional provider's office, except when comparable results can be obtained safely with home self-care or thorough oral use of a prescription medication. Therapeutic injection benefits apply only to administrative charges. Medicine charges for serum, vaccine, or mixture in connection with the therapeutic injection are not part of this benefit, but may be paid under the provisions of the plan, subject to any co-insurance. Vitamin and mineral injections are not covered unless medically necessary for treatment of a specific medical condition.

Transplants Benefits for services and supplies (including medications) rendered in connection with a transplant, including pre-transplant procedures such as ventricular assist devices (VADs), organ or tissue harvesting (donor expenses), postoperative care (including anti-rejection medication treatment) and transplant-related chemotherapy for cancer are limited as described here.

We will cover expenses for certain medically necessary and non-experimental transplantation procedures. **Eligible transplants must be pre-authorized through a case manager.**

Urgent care services Urgent care is needed to prevent serious harm to your health from an unforeseen illness or an injury. **You can call your PCP's office 24 hours a day, seven days a week. Even if the office is closed, there is still someone available to help you.** Your PCP can decide if you need to go to an urgent care or pediatric clinic. Urgent care and pediatric clinics are located in Linn, Lincoln, Benton and Tillamook counties. For current telephone numbers, hours and locations, please call our Customer Service Department.

Medically appropriate x-rays and laboratory tests Medically necessary diagnostic X-rays and laboratory tests are covered when a professional provider orders them. The X-rays for tests must be related to diagnosis or treatment of an illness or injury. **Some imaging services will require a prior authorization; see the prior authorization list on page 28 of this document. Some services may have professional fees.**

Prescription benefits

Generic; below 300% FPL	Preferred; below 300% FPL	Non-Preferred*; below 300% FPL
\$0	\$10	Not covered*
Generic; above 300% FPL	Preferred; above 300% FPL	Non-Preferred*; above 300% FPL
\$5	\$50 or 50%, whichever is the lesser	\$50 or 50%, whichever is the lesser
Annual out-of-pocket PRESCRIPTION limit*- Individual; below 300% FPL	Annual out-of-pocket PRESCRIPTION limit*- Multi-child; below 300% FPL	Annual out-of-pocket PRESCRIPTION limit*- Above 300% FPL
\$100	\$200	None

*non preferred prescription drugs are covered only when an exception process has been followed and approved with Samaritan Healthy KidsConnect Health Plan and in such cases would be covered at the preferred brand co-pay level. FPL is defined as Federal Poverty Level

Services are covered only when obtained from in-network providers except in emergencies or when we provide an out-of-network pre authorization. In these circumstances, normal cost-sharing would apply.

American Indian/Native Alaskan members on the Zero Cost Share Plan do NOT have cost sharing for covered in-network services

Generic medications A generic drug has been approved by the FDA and has the same active ingredient as the brand name. Generally, when a generic version of a drug is available SKC will require that the generic be used by members unless it is medically necessary for a member to use the brand version of a drug.

Preferred medications Are covered brand medications.

Non-Preferred medications These are medications that are not covered without an approved Medication Exception through our Pharmacy Department.

Maximum quantities. The largest allowable quantity at one time for outpatient prescription medications purchased from a pharmacy, is a 34-day supply. Your co-payment is always based on each dispensing.

Refills This plan allows refills from a pharmacy after 75 percent of the supply from the previous prescription order is used. You are responsible for the full cost of any prescription medications that are denied at the participating pharmacy because you have refilled them “too soon.”

Mail order option. This plan offers our members a mail order option. Mail order prescriptions may be ordered up to a 90-day supply. Please call the Customer

Service Department or visit our website for more information and appropriate forms.

Samaritan Healthy KidsConnect Health Plan

Customer Service Department

Member Number

(541) 768-4550

Provider Number

(541) 768-5207

Toll Free 1-888-435-2396

Monday through Friday

8:00 a.m. to 5:00 p.m.

To obtain prescriptions medications, you must display your Samaritan Healthy KidsConnect Health Plan ID card at any network pharmacy. Prescription medications must be medically necessary and must be the result of a prescription order. Any balances over the maximum amount available under this prescription medication benefit are not eligible for payment under any other provision of the plan. Prescription medication expenses **DO NOT** accumulate toward the maximum out-of-pocket medical cost.

Samaritan Healthy KidsConnect Health Plan uses a “formulary,” that lists the covered prescription medications. Some covered medications may have additional requirements or limits on coverage. These requirements may include:

Prior authorization: Samaritan Healthy KidsConnect Health Plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Samaritan Healthy KidsConnect Health Plan before you fill your prescriptions. We will make a decision within Pharmacy authorization will be processed within 14 days of complete submission

Quantity limits: For certain drugs, Samaritan Healthy KidsConnect Health Plan limits the amount of the drug that is covered

Step therapy: In some cases, Samaritan Healthy KidsConnect Health Plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

You can find out more about additional requirements or limits on covered medication by contacting our Customer Service Department or your physician.

Our formulary list shows the brand-name medications we cover. We will not exclude coverage of a prescription medication for a particular indication solely on the grounds that the indication has not been approved by the United States Food and Drug Administration, if the Oregon Health Resources Commission determines that the medication is recognized as effective for the treatment of that indication.

Diabetic supplies that are covered at the pharmacy include insulin, syringes and other supplies that are used for the administration of insulin.

The chart below outlines your co-payment expenses for your prescription drug plan:

Medication co-payments for all plans:

Generics.....	\$0
Preferred brands	\$10
Non-preferred brand.....	Not covered*

* Non-preferred prescription drugs are covered only through a medication exception process and in such cases would be covered at the preferred brand co-payment level.

For a copy of Samaritan Healthy KidsConnect Health Plan Formulary go to www.SamaritanHealthPlans.com

Or visit

Samaritan Healthy KidsConnect Health Plan

815 NW Ninth St, Suite 101

P.O. Box 1310

Corvallis, OR 97339

Benefit limitations

There are limitations on the benefits available under this plan of certain conditions and services. These limitations are explained in the following paragraphs. **American Indian/Native Alaskan members on the Zero Cost Share Plan do NOT have cost sharing for covered in-network services**

Breast reconstruction Limited to surgery following a mastectomy that was necessary due to illness or injury. Please review the Women's Health and Cancer Rights Act (WHCRA) notification below.

WHCRA The Women's Health and Cancer Rights Act of 1998 requires Samaritan Health Plans to notify you, as a participant or beneficiary of the Samaritan Healthy KidsConnect Health Plan, of your rights related to benefits provided through the plan in connection with a mastectomy. You as a participant or beneficiary have rights to coverage to be provided in a manner determined in consultation with your attending physician for:

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

These benefits are subject to the plan's regular deductible and co-pays/ co-insurance. See your Summary of Benefits for details.

Keep this notice for your records and call Samaritan Healthy KidsConnect Health Plan, for more information.

Home health care

- **Maximum visits.** There is a two-visit maximum allowed in any one day for the services of a registered or licensed practical nurse. The

maximum visits allowed for each other classification of home health care provider is one visit per day.

- **Rehabilitative care.** Rehabilitative services are physical, occupational, speech, or respiratory therapy services necessary to restore or improve lost function caused by illness or injury. In order for us to cover the therapy, it must be part of a written plan of treatment that a physician prescribes. Home health care provided by a licensed social worker is paid according to the home health care benefit. This plan covers services rendered by an Oregon-registered clinical social worker upon the written referral of a physician or psychologist.

Home health care benefits exclude:

- More than one visit of any one kind of rehabilitation on one day;
- rehabilitative care provided in your home and covered under the home health care benefit;
- recreational or educational therapy;
- self-help or training; or
- treatment of psychotic or psychoneurotic conditions.

Outpatient prescription limitations

- **Maximum quantities.** The largest allowable quantity at one time for outpatient prescription medications purchased from a pharmacy, or mail order, is a 34-day supply. Your co-payment is always based on each dispensing.
- **Refills.** This plan allows refills from a pharmacy after 75 percent of the supply from the previous prescription order is used. You are responsible for the full cost of any prescription medications that are denied at the participating pharmacy because you have refilled them "too soon."

- **Medication dispensing limits.** There are certain prescription medications that have medication dispensing limits. Medication dispensing limits (MDL) means the quantity or dispensing frequency of a prescription medication that we determine is medically necessary before it is dispensed. MDL apply to prescription medications that are used to treat a limited number of conditions or that have limited durations of therapy. Any prescription medications with MDL that are purchased without MDL authorization are not covered under this prescription medication plan, even if purchased from a participating pharmacy. Participating providers, including participating pharmacies, are notified which prescription medications have MDL. Only providers prescribing medications or pharmacies filling medications can request MDL authorization. The participating pharmacy will let you know if MDL authorization is necessary for the medication.

Telemedicine We cover certain telemedicine services. We cover telemedical services via two-way video communication (face to face). Coverage of telemedical health services such as hospital, rural health clinic, doctor's office, community mental health, etc equal to covered provisions of this plan.

Transplants (See "Transplant Exclusions" subsection in the "Benefit Exclusions" section) Benefits for services, supplies, and medications rendered in connection with a transplant, including pre-transplant procedures such as organ or tissue harvesting are limited as indicated on the following pages: **Transplant require review and prior authorization**

Definitions for the transplant benefit

- A **contracting transplant facility** means a health care facility with which we have contracted or arranged to provide facility transplant services for you.
- **Contracted amount** means the amount that the contracting transplant facility has agreed to accept as payment in full for facility transplant services for a specific type of transplant.
- **Covered transplant** means medically appropriate transplant of one of the following organs or tissues only when determined by us to be medically necessary, and no others:

- Allogenic or syngeneic hematopoietic stem cells whether harvested from bone marrow or peripheral blood, or from any other source;
- autologous hematopoietic stem cells whether harvested from bone marrow or peripheral blood, or from any other source;
- heart;
- heart/lung;
- lung;
- kidney;
- corneal (does not require prior authorization);
- pancreas;
- liver;
- pediatric small bowel; or
- small bowel/liver/multi-visceral.

Covered transplant does not include transplant of blood, blood derivatives (except peripheral stem cells), cornea, or any other organ or tissue not specifically listed.

- **Donor expenses** mean all expenses, direct and indirect (including program administration expenses), incurred in connection with: medical services required to remove the organ or tissue from either the donor's or self-donor's body; preserving it; and transporting it to the site where the transplant is performed; and related and unrelated donor search cost.
- **Facility transplant services** means all medically necessary services and supplies provided by a health care facility in connection with a covered transplant except donor expenses and anti-rejection medications.
- **Medically appropriate for purposes of this transplant limitation** means the recipient or self-donor meets our medical necessity criteria for a transplant.
- **Professional provider transplant services** means all medically necessary services and supplies provided by a professional provider in

connection with a covered transplant except donor expenses and anti-rejection medications.

Facility benefits We will pay for facility transplant services according to the benefits described under “**Your Benefits**” **section** of this plan.

NOTE: Transplant services do not accumulate toward the maximum out-of-pocket amount under the plan.

Professional provider benefits We will pay for professional provider transplant services according to the benefit under “**Professional provider services**” **subsection in the “Your Benefits” section** of this plan.

Donor cost benefits We will pay donor expenses incurred in connection with a covered transplant if the recipient is covered under this plan. We will not pay toward donor expenses if the donor is covered under this plan and the recipient is not. Complications and unforeseen effects of the donation will be covered as any other illness under the terms of the plan only if the donor or self-donor is enrolled under the plan.

Anti-rejection medication benefits We will pay according to the prescription medication benefit under the plan for anti-rejection medications following the covered transplant.

Transplant pre-authorization requirement All transplant procedures must be pre-authorized for type of transplant and must be medically appropriate according to our established criteria. Failure to pre-authorize as described will result in a denial of benefits. Please ask your provider to contact the case management nurse who will work with you and your physician in selecting a transplant facility and negotiating for services.

The pre-authorization requirement is a part of the benefit administration of the plan and is not a treatment recommendation. The actual course of medical treatment you choose remains strictly a matter between you and your physician.

Transplant pre-authorization procedure To pre-authorize, your physician must contact our case management before the transplant admission. Pre-authorization should be obtained as soon as possible after you have been identified as a possible transplant candidate.

Only our written approval of a proposed transplant will constitute pre-authorization. If time is a factor, pre-authorization will be made by telephone followed by written confirmation. Pre-authorization can be obtained by writing to our transplant coordinator.

Prior authorization list

Coverage of certain medical services and surgical procedures requires Samaritan Healthy KidsConnect written authorization before the services are performed. All coverage is subject to reviewed for medical appropriateness

Prior authorization by Samaritan Healthy KidsConnect is required for the following medical services and surgical procedures:

- Clinical trials
- Durable Medical Equipment (DME) including insulin pumps, prosthesis, orthotics, oxygen and oxygen supplies, with line items with prices over \$1,000 in rental or purchase fees or rentals over (3) months. (This does not include diabetic, incontinence, and CPAP supplies.)
- Elective Procedures or Services (for the following):
 - Genetic testing except standard prenatal testing
 - Medical dental services
 - Services provided by a Naturopath
 - Non contracted provider (all services)*
 - Outpatient therapy (physical, occupational, speech)
 - Services (including diagnostic) and treatment for Temporomandibular Joint Dysfunction (TMJ)
- Inpatient stay, including
 - Mental health
 - Chemical dependency/ Substance Abuse
 - Exception of maternity delivery services *
- Potentially cosmetic and experimental procedures and services
- Residential services for mental health and substance abuse.
- Radiological Services (for the following):
 - Computer Axial Tomography (CAT) scans
 - Positron Emission Tomography (PET) scans
 - Magnetic Resonance Imaging (MRI)
 - Virtual Colonoscopy

- Skilled nursing facility (SNF) services
- Transplants, except corneal (including evaluation)

*Inpatient hospitalization admissions for the purpose of childbirth do not require a prior authorization in accordance with the Newborns' Mothers' Protections (Newborns' Act). Services do not require a prior authorization unless the hospital stay exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section.

Samaritan Healthy KidsConnect Health Plan reserves the right to review or otherwise deny payment for services that are not found to be medically necessary. All services provided by a non-contracted provider require prior authorization.

Medically appropriate services and medical supplies that are required for prevention, diagnosis or treatment of a health condition which encompasses physical or mental conditions, or injuries, and which are:

(a) Consistent with the symptoms of a health condition or treatment of a health condition;

(b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community, evidence-based medicine and professional standards of care as effective;

(c) Not solely for the convenience of member or a provider of the service or medical supplies; and

(d) The most cost effective of the alternative levels of medical services or medical supplies which can be safely provided to member in the PCP's judgment.

"Prior authorization" means a decision made by an insurer before services are obtained that the insurer will provide payment for the services.

Benefit exclusions

This plan does not cover the following:

Cosmetic/reconstructive surgery We do not cover services and supplies for cosmetic or reconstructive purposes, including complications resulting from cosmetic or reconstructive surgery. However, we do provide coverage if the surgery is performed:

- To correct a functional disorder;
- to correct a disorder that results from accidental injury that occurs while a person is covered by this plan;
- to correct congenital anomalies; or
- for the reconstruction of the involved breast following a mastectomy necessary because of illness or injury and for all stages of reconstructive breast reduction on the non-diseased breast to make it equal in size with the diseased breast after final reconstructive surgery on the diseased breast has been performed, or for prostheses and physical complications from all stages of mastectomy, including lymphoedemas.

Experimental or investigational services We do not cover services, which are, in our judgment, experimental or investigational for your specific illness or injury. Services, which support or are performed in connection with the experimental or investigational services, are also excluded. Services may be reviewed or otherwise denied if we believe them to be not medically necessary, experimental, or investigational.

For purposes of this exclusion, experimental or investigational services include, but are not limited to, any services, which at the time they are rendered and for the purpose and in the manner they are being used:

- Have not yet received final Food and Drug Administration approval for other than experimental, investigational, or non-qualifying clinical trials; or;

- are provided under a written protocol or are the same services provided to other patients under a written protocol for the diagnoses; or
- are determined by us, in consultation with medical advisors, to be in a research status prior to general use in the medical community in Oregon. We will consider a service to be in a research status prior to general use in the medical community in Oregon, if two or more of the following indicators apply to a service at the time of pre-authorization request or claim review:
 - The service is not performed in Oregon; or
 - the service is the subject of a non-qualified Phase I, II or III trial; or
 - the service has not been the subject of a study published in peer reviewed medical literature. Peer reviewed medical literature means a U.S. scientific publication which requires that manuscripts be submitted to acknowledged experts inside or outside the editorial office for their considered opinions or recommendations regarding publication of the manuscript. Additionally, in order to qualify as peer reviewed medical literature, the manuscript must actually have been reviewed by acknowledged experts before publication; or
 - studies published in peer reviewed medical literature indicate the need for further investigation on dosage, means of administration, long term effects or other factors important to efficacy and patient safety; or
 - no federal government agency or national professional medical society or organization, which has done a formal evaluation, has declared the service to be appropriate medical practice.

Experimental or investigational dental or vision services are excluded under the same standards. An experimental or investigational service is not made eligible

for coverage even if your doctor considers that other services will be ineffective or not as effective as the service or that the service is the one most likely to prolong life.

General exclusions

We will NOT cover:

- Appliances or equipment primarily for comfort, convenience, cosmetics, environmental control or education, such as air conditioners, air filters, whirlpools, heat lamps or tanning lights.
- Custodial care including routine nursing care and rest cures, and hospitalization for environmental change.
- Dental services, except as specifically provided in the **“Medical dental care” subsection in the “Your benefits” section and in our Dental benefits plan.** The dental services excluded from the medical benefit plan are services to prevent, diagnose or treat disease of the teeth, gingiva, the periodontal tissue and the alveolus, including services to repair defects, which have developed because of tooth loss, and/or to restore the ability to chew. Medical dental service due to injury or accident may be covered under your Medical benefits.
- Educational programs for which drivers are referred by the judicial system, or for volunteer mutual support groups.
- Eye examinations and routine eye exercises, except as specifically provided in the **Vision benefits plan.**
- Infertility services and treatment (except sterilization), artificial insemination, in-vitro fertilization, or to surgically to correct voluntary sterilization.
- Fitting, provision, or replacement of hearing aids, including implantable hearing aids and the surgical procedure to implant them except as specifically covered in plan.
- Inpatient services after your termination from this plan. The only exception occurs if you are in the hospital on the day the coverage ends. This plan will continue to provide benefits for that hospitalization until your discharge from the hospital.
- Instruction or training programs, except as covered under the disease management benefit. Examples of instruction or training programs excluded from coverage are:
 - Instruction to learn to self-administer medications or nutrition, except as provided in the outpatient diabetic instruction benefit;
 - self-management education courses;
 - training to control weight or provide general fitness, except under our disease management program;
 - programs that teach you how to use durable medical equipment, except for prosthetics or orthotics; or
 - training how to care for your family.
- Massage or massage therapy.
- Treatment of sexual dysfunction or inadequacy or services and supplies related to sex change procedures.
- Off the shelf orthopedic shoes and orthopedic inserts.
- Orthognathic surgery, which includes services and supplies to change the position of a bone of the upper or lower jaw.
- Personal items, such as telephones, televisions and guest meals, in a hospital or skilled nursing facility.
- Physical exercise programs, even though they may be prescribed for a specific condition.
- Private nursing service for hospital or skilled nursing facility inpatients.
- Routine tests and screening procedures not specified by this plan, except that routine preadmission testing is covered.
- Services and supplies you received while in the custody of any law enforcement authority; while in jail or prison or as a result of criminal activity.
- Services or supplies that are not medically necessary for the diagnosis or treatment of an illness or injury.
- Services and supplies provided by your immediate family.
- Skilled nursing care for mental illness, mental deficiency, or retardation.

- Surgical procedures, which alter the refractive character of the eye, except as, covered under our **Vision benefits plan**. Examples of surgical procedures excluded from medical benefits are:
 - radial keratotomy, myopic keratomileusis and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia or astigmatism
 - reversals or revisions of surgical procedures, which alter the refractive character of the eye and complications of all of these procedures.
- Missed appointments, completion of claim forms or completion of reports requested by us in order to process claims.
- The fitting, provision, or replacement of eyeglasses, except as specifically provided in the **Vision benefits plan**.
- Services for corns, calluses, removal of nails (except complete removal), and other routine foot care. Except for when diagnosed with diabetes, peripheral vascular disease, or recurring infections.
- Services for weight control or obesity may not be covered services or treatments that have not been medically or scientifically proven to treat a disorder are not covered. However, disease management programs for overweight or obesity are covered and services may be reviewed on a case by case basis as medically appropriate.
- Surgery that is intended for weight loss, such as bariatric or lap-band surgery and related services are not covered.
- Treatment of any condition caused by or arising out of service in the armed forces of any country or from war or insurrection.
- Services you received before the effective date of your enrollment in this plan or after the date of your termination from this plan
 - more than one visit of any one kind of rehabilitation on any one day;
 - deluxe equipment with mechanical or electrical features such as motor-driven wheelchairs and chair lifts;
 - environmental controls or environmental enhancements such as air conditioners, air filters and portable whirlpool pumps;
 - food services, such as Meals on Wheels;
 - homemaker or housekeeping services, except those that home health aids provide as ordered in the hospice treatment plan;
 - legal and financial counseling services;
 - normal necessities of living, including but not limited to food, clothing, and household supplies;
 - pastoral and spiritual counseling;
 - recreational or educational therapy; self-help or training;
 - rehabilitative care provided in your home and covered under the home health care benefit;
 - Separate charges for reports, records or transportation;
 - Services provided to other than the terminally ill patient, including bereavement counseling;
 - Services that your family or volunteer workers provide;
 - Services in excess of the benefit limitations;
 - Services not included in the hospice treatment plan or not specifically set forth in a hospice benefit;
 - Services provided more than six months after the initial date of covered hospice care, unless specifically approved by us;
 - supportive environmental materials, including but not limited to hand rails, ramps, air conditioners and telephones; or
 - treatment of psychotic or psychoneurotic conditions.

Hospice care exclusions and limitations

In addition to other exclusions listed in the “**Benefit exclusions**” section, we will not pay for the following hospice services and supplies:

- Care that is not palliative;

Mental health and chemical dependency exclusions

We will not cover the following when administering benefits under the plan for treatment of mental health conditions and chemical dependency conditions:

Counseling or treatment in the absence of illness

Services in the absence of illness are excluded. For example, we will not cover:

- Educational, social, image, behavioral or recreational therapy;
- sensory movement groups;
- marathon group therapy;
- sensitivity training;
- employee assistance plan services;
- wilderness programs;
- premarital or marital counseling; or
- family counseling (however family counseling will be covered when you have a covered diagnosis and the family counseling is part of the individual's treatment).

Mental health services for certain conditions We will not cover services for Paraphilias no matter your age. Additionally, **we will not cover any "V Code" diagnoses except** the following when medically necessary for a child five years of age or younger:

- Parent-child relational problems;
- neglect or abuse; or
- bereavement.

By "V Code", we mean diagnosis codes as described in the most recent edition of the Diagnostic Statistical Manual of Mental Disorders (DSM-IV TR) that describe relational problems, problems related to abuse or neglect or other issues that may be the focus of assessment or treatment, such as occupational or academic problems.

Other services and or treatment NOT covered under the mental health benefit:

- Treatment that has not been medically or scientifically proven to treat a disorder.
- Treatment of dementia, including any organic psychotic manifestations
- Marital, career or personal growth counseling
- Voluntary mutual support groups like alcoholics anonymous
- Psychological testing that is not medically necessary
- Any mental health services unrelated to the treatment or diagnosis of a mental disorder.

Sexual dysfunction Services and supplies for sexual dysfunction regardless of cause, except for counseling services provided by covered, licensed mental health practitioners are not covered.

Sexual reassignment Treatment, surgery, or counseling services for sexual reassignment are not covered.

Outpatient prescription exclusions

We will not cover:

- Administration or injection of prescription or non-prescription medications.
- Any medication not specifically described as a benefit under the prescription medication benefit.
- Devices or appliances of any type, even if they may require a prescription order. Some devices and appliances maybe covered under the other provisions of this plan.
- Fertility medications.
- Immunization agents, biological sera, blood or blood plasma. These may be covered elsewhere in your Medical benefits
- Newly approved prescription medications. This plan may exclude, for up to 18 months from the federal Food and Drug Administration (FDA) approval date, prescription medications that the FDA newly approves.

The list of newly approved prescription medications currently excluded is provided to participating pharmacies and is available on our Web site and in paper form.

- Non-prescription medications, which are medications that by law do not require a prescription order and which are not, included in the outpatient prescription medications that this plan covers.
- Medications dispensed in a facility to you while a patient in a hospital, skilled nursing facility, nursing home or other health care facility.
- Prescription medications for cosmetic purposes, including but not limited to: Tretinoin (i.e. Retin-A); Renova; topical Minoxidil or other medications used to treat baldness; and medications used to treat nail fungus, such as Sporanox and Lamisil.
- Over the counter contraceptives are not covered.

- Pharmacy consultations are not covered
- Prescription medications for weight loss or treatment of obesity.
- Prescription medications for which claims are submitted 12 months or more after the date of purchase.
- Prescription medications that are not medically necessary.
- Prescription medications with no proven therapeutic indication.
- Refills needed for stolen, lost, spilled or destroyed prescription medications.
- Vitamins and fluoride, except those that by law require a prescription order.
- Insulin and diabetic supplies without a prescription order.

Your Vision benefits

Services are covered only when obtained from in-network providers except in emergencies or when out-of-network services have been prior authorized. In these circumstances, normal cost-sharing would apply. American Indian/Native Alaskan members on the Zero Cost Share Plan do NOT have cost sharing for covered in-network services

There is **no deductible** for covered vision services or supplies and the benefits are paid at 100% of the allowed charge, up to the limits listed above, for services at participating vision providers. Allowed charge means the charge for covered services up to the maximum plan allowance. These vision care benefits are provided as shown below every 12 months. This time period begins January 1st and every benefit year following; this is a per calendar year benefit.

This Plan pays for vision exams, and corrective lenses and frames when prescribed by a licensed ophthalmologist or licensed optometrist, for you. The Plan allows you to choose any licensed ophthalmologist, optician, or optometrist.

Covered benefits

Eye examinations: One complete eye exam, annually, is paid at 100%.

Lenses and frames: Covered when eyeglasses are first acquired or when required by a change in prescription. Prescription contact lenses are paid when approved for Medical appropriateness. Maximum amount payable for Lenses or contacts annually is defined by the following:

Lenses, frames and contacts are paid up to \$200.00, combined, per benefit year

Limitations and exclusions

The vision care benefit will only pay for one pair of non-disposable contact lenses or one pair of glasses per insured individual up to the allowable amount annually.

Exclusions

The following are not covered benefits under this Plan. Any of the following services and supplies:

- Visual field charting;
- Fitting charges;
- Orthoptics
- Lenticular lenses;
- Contact lenses, except as shown in the vision benefit plan provisions
- Subnormal vision aids;
- Aniseikonic lenses;
- Tinted lenses, except no. 1 and no. 2 pink;
- Nonprescription lenses; or
- More than the allowance for a standard prescription when multi-focal hard resin lenses, coated lenses or no-line bifocals (blended type) are chosen;
- Extra charges for fashion eyewear features such as blended, coated, flintglass, oversize lenses or extra charges for special frames
- Medical or surgical treatment of the eyes; this may be covered under the medical provisions of the plan;
- Services and supplies that are payable under a workers' compensation or occupational disease law;
- Any cost which results from an act of declared or undeclared war or armed aggression;

- Any cost which is in excess of the maximum plan allowance;
- Replacement of lost, stolen, or broken lenses;
- Duplication or spare eyeglasses, lenses or frames;
- Any eye examination required as a condition of employment; and
- Any cost paid in whole or in part by any other provision of the Group Health Insurance Plan provided by the Policyholder.

Experimental or investigational vision services are excluded under the same standards as the medical benefits described under the **Experimental and investigational** section. An experimental or investigational service is not made eligible for coverage even if your doctor considers that other services will be ineffective or not as effective as the service or that the service is the one most likely to prolong life.



Your Dental benefits

Annual out-of-pocket DENTAL limit* Individual	Annual out-of-pocket DENTAL limit* Multi-child
\$200	\$400

*This is the maximum amount you will have to pay out-of-pocket before the plan begins to pick up 100% of covered services.

ANNUAL MAXIMUM BENEFIT Below 300%	ANNUAL DEDUCTIBLE Below 300%	OUT-OF-POCKET MAXIMUM* Below 300%
\$1,750	None	\$200

ANNUAL MAXIMUM BENEFIT Above 300%	ANNUAL DEDUCTIBLE Above 300%	OUT-OF-POCKET MAXIMUM* Above 300%
\$1,000	None	\$200

Services are covered only when obtained from in-network providers except in emergencies or when out-of-network services have been prior authorized. In these circumstances, normal cost-sharing would apply. American Indian/Native Alaskan members on the Zero Cost Share Plan do NOT have cost sharing for covered in-network services

Dental services are provided by Willamette Dental Group

Extensive coverage

- Low out-of-pocket expenses for most dental treatment
- Predictable co-pays for services
- Orthodontia Coverage

- Emergency dental care

High quality care

- More than 30 years of providing quality dental care
- Clinical professionals who maintain one of the highest credentialing standards in the dental industry
- Evidence-based dental care treatment philosophy
- Most offices are open Monday through Friday, 7 AM to 6 PM and limited Saturdays

Appointments or emergencies

Toll Free (800) 461-8994

Portland Metro Area (503) 952-2100

Appointment center hours

Monday - Thursday 7:00 AM - 8:00 PM - PST
Friday 7:00 AM - 6:00 PM - PST
Saturday 7:00 AM - 4:00 PM - PST

Appointments

Willamette Dental strives to keep dental expenses affordable for its patients. To achieve this, facilities are usually operating at their fullest capacity. Schedules fill up quickly and last-minute appointments are rare. **It is very important to schedule appointments in advance.** New patients are generally able to obtain their initial appointment within 30 days of their call to the Willamette Dental Appointment Center. Hygiene appointments generally have a wait-time of 45 days. Restorative treatment appointments generally have a wait-time of 60 days. These wait-times are averages. The wait-time for an appointment may vary based on your choice of provider, dental office location and your desired day or time of appointment.

Emergencies

In the event of a dental emergency, call the Willamette Dental Appointment Center at (800) 359-6019. Generally, members can be seen by a Willamette Dental dentist for a dental emergency within approximately 24 hours.

To change an appointment Please call the Willamette Dental Appointment Center as soon as your plans change to reschedule your dental appointment. If you cancel with less than 24 hours notice, then you will be charged a missed-appointment fee. By giving us advance notice, we can schedule another patient for that time.

Patient relations (customer service) Willamette Dental has a full staff of patient relations representatives who will answer any question that you may have about your dental plan or service.

Please reach us:

Monday - Friday 8 AM to 5 PM - PST
Toll Free (800) 460-7644
Portland Metro Area (503) 952-2000
E-mail relations@willamettedental.com
Internet www.WillametteDental.com

A healthier approach to dental care Willamette Dental has been providing quality dental care to members in the Pacific Northwest for over 30 years. Each provider upholds our mission to deliver superior patient care through a partnership with our patients.

Clinically, we strive to stop the dental disease/repair cycle by implementing evidence-based methods of prevention and treatment. To do so, each of our more than 660 dental professionals have adopted today's latest approaches to dental care that are supported by credible scientific findings.

In our practice, we use the best available scientific evidence combined with clinical experience and patient circumstances to direct treatment. Because of this evidence-based approach, our dentists have moved away from the role of repair technician and assumed a broader role of healer. Dental care providers assess risks and develop appropriate treatment plans for each patient.

A key to this philosophy is our emphasis on preserving the patient's natural tooth-structure and preventing dental disease. By using proven techniques, including non-surgical methods of treatment, our practitioners can help to prevent or even reverse dental disease. As a body of dental care professionals, our practice emphasizes providing only the appropriate treatment that will lead to the optimum oral health of our patients.

Higher standard providers Each clinical professional at Willamette Dental has to meet and maintain one of the highest credentialing standards in the dental industry. The Willamette Dental Provider Credentialing Policy ensures that providers have the professional qualifications, licenses, endorsements, certifications and permits required by law, as well as those that meet our own schedule of standards. All providers are routinely evaluated to be sure their

credentials are current, and that they are working within their appropriate scope of practice.

So that quality of care is the same throughout our dental offices, every clinical professional is a member of the Willamette Dental Quality Assurance Program. This is how dentists, hygienists and dental assistants regularly receive updates on new products and technological advances. In this program, dentists receive regular peer reviews that monitor their treatment planning and the documentation of patient treatment. Knowing that the quality of their treatment can be reviewed by their colleagues is one of the most powerful motivators for our dentists to continuously practice our standard of quality dental care. More so, these activities promote professional development and enhance the capabilities of all Willamette Dental providers.

Personal dental care plan Members of the Willamette Dental Plan are encouraged to follow the personal dental care plan that is developed with them during their first visit with their dentist. This program helps members to achieve and maintain good dental health. We have found that most patients with good home health care habits can maintain their natural tooth structure for a lifetime, ensuring healthy gums and teeth.

Caries management therapy In the past, dentists believed that the only effective treatment for dental decay, also known as caries, was to remove the diseased portion of the tooth and replace it with a filling.

However, scientific studies have shown that dental decay is an infectious disease caused by a specific type of oral bacteria called *mutans streptococci* and that early areas of decay can be reversed. Studies also show that inappropriate or unnecessary removal of tooth structure weakens teeth, which makes them more susceptible to fracture. These findings form the basis of Willamette Dental's modern treatment philosophy.

Willamette Dental practices Caries (cavities) Management Therapy. This involves identifying patients at risk or potential risk of tooth decay and providing appropriate therapeutic treatment. The goal is to prevent decay and conserve natural tooth structure through an extensive evaluation and treatment regimen.

As part of their Personal Dental Care Plan, every new Willamette Dental member receives a thorough risk assessment to determine susceptibility to dental decay. Decayed tooth surfaces are diagnosed and coded based upon the level of decay penetration. Willamette Dental dentists then make appropriate treatment decisions from this examination.

In most cases, advanced areas of dental decay will be restored using traditional filling materials. Early areas of decay may be reversed and re-mineralized utilizing antibacterial medications and highly concentrated fluoride solutions. This approach may require more frequent recall appointments to treat the affected areas.

Questions & answers

Can I sign up for the Willamette Dental Plan and still go to my own dentist?

Your dental care will only be covered when it is provided by a dentist or specialist at a Willamette Dental office. Your coverage also extends if you are referred to an outside dentist or specialist by your Willamette Dental dentist. If referred to an outside dentist or specialist, your co-payments for services within the scope of the Willamette Dental dentist's referral will remain the same as shown in your Certificate of Coverage.

How do I schedule an appointment? To schedule an appointment, please call our Appointment Center:

Toll free (800) 461-8994
Portland Metro Area (503) 952-2100

Appointment center hours:

Monday - Thursday 7 AM to 8 PM - PST
Friday 7 AM to 6 PM - PST
Saturday 7 AM to 4 PM - PST

How long does it generally take to get an appointment? Willamette Dental's scheduling goals are as follows:

First appointment: 30 Days

Regular hygiene (cleanings): 45 Days

Operative: 60 Days

Emergencies: Within approximately 24 hours

With the exception of emergencies, the number of days shown above are averages. The length of wait-time for an appointment may vary based on your choice of provider, dental office location and your desired day or time of appointment.

What can I expect at my first visit? At your first visit to our office, you will receive a thorough dental examination that includes X-rays and comprehensive risk assessments. Then, your dentist will develop a Personal Dental Care Plan based on your immediate needs, current dental health and long term oral health goals. This individual plan will include recommendations for cleanings, restorations and preventive treatments.

Will I receive two cleanings per year? Your Willamette Dental dentist will make a recommendation for your teeth cleaning and examination frequency that fits your risk factors and oral health condition. It could involve more than two or less than two appointments per year. Your Personal Dental Care Plan will outline the frequency and duration of your treatments and examinations throughout the year.

For example, a member with periodontal disease could need four or five therapeutic cleanings in a year, whereas a member with healthy teeth and gums may only need to have a cleaning once every 12 months.

What happens if I change offices? Willamette Dental members have the freedom to receive dental care at most any Willamette Dental location. To change offices and/or dentists, call our Appointment Center toll free at (800) 461-8994. Please be aware that changing your dentist may result in a treatment delay.

What if I have a dental emergency? Willamette Dental provides emergency dental care during regular office hours. If you have a dental emergency, then you should call the Appointment Center toll free at (800) 461-8994. If necessary, you will be able to see a Willamette Dental dentist within approximately 24 hours. You will pay an emergency office visit co-payment for this service. After-hours, a dentist is available for dental emergency consultation over the telephone, at no cost.

What if I have a dental emergency while I'm out of town? In Washington, Oregon or Idaho If you are traveling in our service area, then call the Appointment Center at (800) 461-8994 to make an appointment at a Willamette Dental office.

Outside our service area If you are traveling outside of a 50 mile radius of our service area, then you may go to any licensed dentist to obtain emergency treatment. Emergency dental treatment may be eligible for reimbursement as stated amount in your Certificate of Coverage. Upon arriving home, contact our Patient Relations Department for reimbursement. You will need to schedule your follow-up care with your Willamette Dental primary care dentist.

Can I choose one primary care dentist to coordinate my care? Yes, we encourage you to establish a long-term relationship with a primary Willamette Dental dentist. Once you select your dentist, you may schedule all future appointments with them. You are also free to change Willamette Dental dentists or locations at anytime.

How do I change an appointment? If you need to reschedule or cancel an appointment, please call our Appointment Center at (800) 461-8994 as soon as possible. A missed appointment fee is applied to your account for any appointment that you miss without a minimum of 24 hours notice.

Can I get major work done right away? Our practice philosophy is to first diagnose and treat urgent conditions that pose an immediate threat to your oral health. The next priority is prevention; controlling the disease process and motivating you to be active in maintaining good oral health. This assists in preventing future deterioration of oral and dental tissues due to progressive decay or periodontal disease. Major restorative work is normally performed once you have achieved a satisfactory state of oral health where your teeth and supporting structures are stabilized, and when you have demonstrated a commitment to maintaining your oral health. This is the best way to ensure the long-term success of whatever major restorative work that you may need.

Is orthodontia available in every office? Specialty services, including orthodontia for children and adults, are generally available on a regional basis. To find out where specialty service is available in your area, simply contact our Appointment Center toll free at (800) 461-8994.

Who do I call for more information? Questions about your dental plan or service should be directed to the Willamette Dental Patient Relations Department. You can reach us:

Monday - Friday 8 AM to 5 PM - PST
Phone (800) 460-7644
E-mail relations@willamettedental.com

Exclusions

The following services are Not Covered:

(they may be covered under other benefits of this plan)

- Services to the extent that they are not necessary for treatment of a dental injury or disease or are not recommended and approved by the licensed dentist attending the member.
- Conscious sedation/general anesthesia.
- Any condition resulting from military service or declared or undeclared war.
- Any injuries sustained while practicing for or competing in a professional or semiprofessional athletic contest.
- Semiprofessional athletics is an athletic activity for gain or pay that requires an unusually high level of skill and
 - substantial time commitment from the participants, who are nevertheless not engaged in the activity as a full-time occupation.
- Bleaching of a tooth.
- Cast dowel posts.
- Endodontics, bridges, crowns or other service or prosthetic devices requiring multiple treatment dates or fittings if treatment was started or ordered prior to the member effective date under the Contract or if the item was installed
 - or delivered more than sixty (60) days after the member's coverage under the Contract has terminated. Root canal treatment will be covered if the tooth canal was opened prior to termination and treatment is completed within sixty (60) days after termination.
- Services or products by any person other than a licensed dentist, licensed dentist, or licensed hygienist.
- Services or products that would not have occurred or that the member would not have had an obligation to pay in the absence of coverage under the Contract.
- Services or products incurred to comply with Occupational Safety and Health Administration (OSHA) requirements.
- Full-mouth reconstruction.
- Orthognathic surgery. This may be covered under the Medical benefit plan
- Cosmetic dentistry or surgery (not including orthodontia).
- Habit breaking or stress-breaking appliances.
- Dental implants or implant supported prosthetics.
- Excision of a tumor; biopsy of soft or hard tissue; removal of a cyst, or exostosis. This may be covered under the Medical benefit plan Dental services started prior to the date the person became eligible for services under the Contract.
- Services or supplies provided to correct congenital or developmental malformations including; but not limited to;
 - cleft palate; maxillary and/or mandibular (upper and lower jaw) malformations; enamel hypoplasia; ectodental displasia; and fluorosis (discoloration of teeth).
- Services for temporomandibular joint disorders.
- Extraction of permanent teeth for tooth guidance procedures; procedures for tooth movement, regardless of purpose; correction of malocclusion; preventive orthodontic procedures or other orthodontic treatment, unless specifically provided in a rider under the Contract.
- Investigational services or supplies.
- Materials not approved by the American Dental Association.
- Occupational injury or disease (including any arising out of self-employment).

- Personalized restoration, precision attachments, and special techniques.
- Prescription drugs, medications, or supplies.
- Repair or replacement of lost, stolen, or broken items.
- Replacements of an existing denture, crown, or bridge less than five (5) years after the date of the most recent placement.
- Replacement of sound restorations.
- Veneers; composite surfaces on posterior teeth.
- Services or supplies that are not listed as covered under the Contract.
- To the extent that coverage is available under any federal, state, or other governmental program if application is duly made therefore, except where required by law such as cases of emergency.
- Intentionally self-inflicted injuries. The fact that a person may be under the influence of any chemical substance shall not be considered as a limitation on the ability to form intent.
- Occlusal guards.
- Services for accidental injury to natural teeth that are provided more than 12 months after the date of the accident.
- Splints, nightguards, and other appliances used to increase vertical dimension and restore bite.
- Hospital or other facility care for dental procedures, including physician services for hospital treatment. However, subject to the hospital co-pay as shown in your Certificate of Coverage, services of a Licensed Dentist will be provided in a hospital or other facility only when both the following requirements are met: A) A hospital setting must be medically necessary. B) The services must be authorized, in writing, in advance by a Participating Dentist.
- Emergency room services when used for dental care. These services may be covered under the medical benefit plan.

General Provisions

Samaritan Healthy Kids Health Plan is NOT responsible for the following administrative services:

Eligibility and enrollment

Eligibility criteria Eligibility and enrollment are determined and processed through Oregon Private Health Partnerships (OPHP) and DHS. You will need to contact OPHP to determine whether or not you meet the eligibility criteria to be enrolled on to this plan.

Generally, children in families with incomes over 200 percent Federal Poverty Level (FPL) who don't have access to a qualified employer-sponsored insurance plan will be able to enroll in the Plan. Those children in families with incomes above 300% FPL who don't have access to a qualified employer-sponsored insurance plan will also be able to enroll in our Above 300% plan option.

Office of Private Health Partnerships (OPHP) is responsible for collecting and determining your premiums. If you have questions regarding your premiums or premium payment, please contact:

Oregon Private Health Partnerships (OPHP)

Church Street SE, Suite 200

Salem, OR 97301

Telephone Salem (503) 373-1656 or Toll Free 1-800-542-3104.

Premiums will be on a sliding scale based on income — families between 200 through 300 percent FPL will pay approximately between 10 to 25 percent of the premium, while families over 300 percent FPL will pay the entire premium for that plan.

Any child will be eligible for a Plan. Children must be without insurance for two months to be eligible, though there are several exceptions to the period of uninsurance including:

- The child's private health insurance premium was reimbursed under the policy for reimbursement of cost-effect Employer Sponsored Health Insurance;
- The child's insurance premium was subsidized by FHIAP;
- A member of the filing group was a victim of domestic violence; or
- The child lost coverage due to the loss of employment of a parent.
- Children are eligible for one year, and may continue to be enrolled as long as they remain eligible for Healthy KidsConnect.
- The child has a condition that without treatment would be life-threatening or cause permanent loss of function or disability;

Samaritan Healthy KidsConnect Health Plan

Samaritan Health Plans

815 NW Ninth Street

Corvallis, OR 97339

(541) 768-4550

1-800-832-4580; TTY 1-800-735-2900

Disenrollment Oregon Private Health Partnerships (OPHP) determines enrollment and disenrollment of participants and is responsible for notifying you of your disenrollment. You may be disenrolled from Samaritan Healthy KidsConnect Health Plan for various reasons such as:

You might move outside of the service area of the health plan. If you move outside of the service area of the health plan, you must contact Oregon Private Health Partnerships.

Your personal situation may change and you may no longer be eligible for this program.

You did not pay your premium on time and are no longer eligible for the Healthy KidsConnect Program. If this is the case you have a 10 day grace period to pay your premium.

Once you have been disenrolled from Samaritan Healthy KidsConnect you will receive a notification of your rights, portability eligibility and your termination notice within 10 days of termination by Samaritan Healthy KidsConnect.

Notification of disenrollment Samaritan Healthy KidsConnect will send you a letter explaining your options of coverage when Office of Private Health

Partnerships (OPHP) has notified us of your disenrollment because of missing a premium payment or if you have become eligible for other coverage.

Samaritan Healthy KidsConnect Health Plan IS responsible for the following administrative services:

Pre-existing conditions A pre-existing condition is a condition, regardless of cause, for which medical advice, diagnosis, care, or treatment was recommended or received within a given period of time immediately before coverage began. Samaritan Healthy KidsConnect Health Plan does not have a pre-existing condition provision or clause

Your premiums

Premiums and rates are determined by us and Oregon Private Health Partnerships and agreed upon enrollment based on the sliding scale and qualifications described above in the Eligibility section. Below are the rates that are offered for Samaritan Healthy KidsConnect Health Plan.

If a Member's coverage is terminated for non payment of premium and is granted a one-time exception, Samaritan Healthy KidsConnect Health Plan shall reinstate the Member's coverage as if there was not a termination done. Member has the right to terminate insurance coverage by contacting the State to request disenrollment or by not paying their premium. Agency is responsible for terminations and enrollments.

BELOW 300% FEDERAL POVERTY LEVEL – SUBSIDIZED

Age 0-24 Months	Age 2-18 years
\$541 per month	\$217 per month

ABOVE 300% FEDERAL POVERTY LEVEL – NON SUBSIDIZED

Age 0-24 Months	Age 2-18 years
\$440 per month	\$176 per month

Member grievance and appeals process

First step—filing a grievance

Grievance means a verbal or written complaint regarding:

- Availability, delivery or quality of health care services, including a complaint regarding an adverse determination based on the decision of the plan through a prior authorization; or
- Claims payment, handling or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between the member and the plan.

The first step is filing a grievance (complaint). You or someone you name to act on your behalf (Authorized Representative) may file a grievance, verbally or in writing. Your Authorized Representative can be a relative, friend, advocate, attorney, doctor, or someone else who is already authorized under State law. (If you want someone to act on your behalf, you can request an Authorized Representative form by calling our Customer Service Department at (541) 768-4550 or toll free 1-800-832-4580 or TTY/TTD 1-800-735-2900).

Within five business days of receiving a grievance, we will send you or your Authorized Representative an acknowledgment letter. If the grievance cannot be resolved within five business days, we will notify you in writing that additional time is required. You or your Authorized Representative will then receive a written decision within 30 days from your initial call or letter.

Second step—filing a level 1 appeal

If you remain dissatisfied after the initial grievance decision, you or your Authorized Representative have the right to file a Level 1 appeal. The appeal request must be: 1) in writing, 2) be signed, 3) include the appeal reason; and 4) be received by us within 180 days of the denial or other action giving rise to the grievance. You may use an [Appeal Request Form](#) to provide this information. Within five business days of receiving the appeal, we will send you or your Authorized Representative an acknowledgment letter. You or your Authorized

Representative have the right to appear in person to talk about your appeal. The Level 1 appeal decision will be determined by an appropriate healthcare professional not previously involved in your case. You or your Authorized Representative will receive a written decision within 15 days pre-service and 30 days post-service of our receiving your appeal request.

Please Note: If you, your Authorized Representative or your treating provider believes that the request to appeal is urgent; meaning, a review decision made within the standard timeframe of 30 days could seriously jeopardize your life or health or your ability to regain maximum function, your appeal will be processed in an expedited manner (24 hours of our receiving the appeal).

For urgent appeals:

- **your treating provider may act as your Authorized Representative without a signed Authorized Representative form; and**
- **you, your Authorized Representative or your treating provider may request a simultaneous expedited External Review.**

For more information, please refer to the section labeled Expedited Appeal Process.

Third step—filing a level 2 appeal

If you remain dissatisfied after the Level 1 appeal decision, you or your Authorized Representative have the right to file a Level 2 appeal by writing to us within 180 days of the Level 1 appeal decision. Within five business days of receiving the appeal, we will send you or your Authorized Representative an acknowledgment letter. You or your Authorized Representative have the right to appear in person to talk about your appeal. The Level 2 appeal decision will be determined by an appropriate healthcare professional not previously involved in your case. You or your Authorized Representative will receive a written decision within 15 days pre-service and 30 days post-service of our receiving your Level 2

appeal. This is the final internal level of appeal; however, you may qualify for External Review which is described in the next section.

External review

External Review decisions are made by Independent Review Organizations (IRO) that are not associated with Samaritan Health Services. Your appeal will be randomly assigned to an IRO by the Oregon Insurance Division (OID).

Your appeal may qualify for an External Review (at no cost to you) if:

- the Plan does not adhere to the rules and guidelines of the process defined for the internal review;

OR

- internal appeal Levels 1 and 2 have been completed; and, the reason for the Level 2 adverse decision was:
 - based on medical necessity; or
 - for treatment determined to be experimental or investigational; or
 - for the purpose of continuity of care (no interruption of an active course of treatment under ORS 743.854)

OR

- you and the Plan have mutually agreed to waive the internal appeals requirement.

We must receive your written request for an External Review within 180 days of the Level 2 adverse decision.

Please Note: When you send a request for External Review, you or your Authorized Representative must submit a signed a waiver granting the IRO access to your medical records pertaining to the adverse decision. You can request the waiver form from the Plan.

If your request meets the definition of urgent as defined by law, you or your Authorized Representative may request an expedited External Review. For more information, please refer to the section labeled [Expedited Appeal Process](#).

To apply for an External Review you must send your written request or the Appeal Request Form to us at the following address:

**Samaritan Healthy Kids Connect- Appeals
P.O. Box 1310
Corvallis, Oregon 97330**

Once the OID has notified the Plan of the assigned IRO, we will submit your External Review request to the IRO within 5 business days. When you are notified by the IRO that your request for External Review has been received, you will have 5 business days to submit additional information about your appeal.

- The IRO will return a written decision to you or your Authorized Representative and to the Plan within the following timeframes:
- Expedited External Review - 72 hours after receipt of the request
- Standard External Review - 45 days after receipt of the request

IRO decisions are final and we are bound by their decisions. If you want more information regarding External Review, please contact our Customer Service Department at 541-768-4550; toll-free at 800-832-4580 or TTY 1-800-735-2900.

Expedited appeal process

If you believe your appeal is urgent, you, your Authorized Representative or your treating provider, may request an Expedited appeal. If the appeal request meets the definition of urgent under the law; which means, a decision made within the standard timeframe of 30 days could seriously jeopardize your life or health or your ability to regain maximum function, the appeal will be processed in an expedited manner (within 24 hours of our receiving the appeal request). If the appeal does not meet the definition of urgent, you will be notified immediately and the appeal will then be processed within the standard timeframe.

The Expedited appeal request must:

- be filed verbally or in writing within 180 days after you receive notice of the initial written pre-service denial; and
- state the reason for the appeal request; and
- state the reason an expedited decision is needed; and
- include supporting documentation necessary to make a decision.

When applicable, if you are simultaneously requesting an expedited External Review in addition to an expedited internal review, a signed waiver granting the IRO access to your medical records pertaining to the adverse decision must be included.

The internal Expedited review decision will be determined by an appropriate healthcare professional not previously involved in your case. A verbal notice of the decision will be provided to you, your Authorized Representative and your treating provider as soon as possible but no later than twenty-four (24) hours of our receiving the appeal. A written notice will be mailed within one working day following the verbal notification. If you have requested a simultaneous expedited External Review, the plan will also forward your appeal to the IRO.

To apply for an Expedited review:

Send your written request, or the [Appeal Request Form](#), to:

Samaritan Healthy Kids Connect- Appeals
P.O. Box 1310
Corvallis, Oregon 97330

Or call our Customer Service Department:

(541) 768-4550, toll free 800-832-4580 or TTY 1-800-735-2900.

Appeal timeframes

Samaritan Healthy KidsConnect Health Plan has the following timeframes for making internal review decisions on appeals:

- 72 hours for expedited pre-service appeals
- 15 days for standard pre-service appeals
- 30 days for post-service appeals

To obtain an [Appeal Request](#) form or a waiver granting IRO access to your medical records visit www.SamaritanHealthPlans.com or call our Customer Service Department Samaritan Healthy KidsConnect Health Plan at (541) 768-4550, toll free 800-832-4580 or TTY 1-800-735-2900.

Your appeal rights

You have the right to:

- file a grievance about and/or appeal any decision we make regarding availability, delivery or quality of health care services, or an adverse determination based on the decision of the Plan through a prior authorization, claims payment, handling or reimbursement for healthcare services or matters pertaining to the contractual relationship between the member and the Plan.
- appoint someone to act as your Authorized Representative when filing a grievance or appeal, such as a relative, friend, treating physician, advocate, attorney, or someone else who has been legally appointed.
- contact us when you:
 - do not understand the reason for the denial;
 - do not understand why the health care service or treatment was not fully covered;
 - do not understand why a request for coverage of a health care service or treatment was not approved;
 - cannot find the applicable provision in your Benefit Plan Document;
 - want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision.
- request within 180 days of the denial, or other action giving rise to the grievance or appeal, a 1st Level of Internal Appeal.
- request within 180 days of the 1st Level of internal appeal denial, a 2nd Level of Internal Appeal.
- a full and fair internal review of your appeal by healthcare professionals associated with us, but who were not involved in the action being appealed provide us with additional information that relates to your appeal.
- appear in person to talk about your internal levels of appeal.
- an internal review decision within 15 days for pre-service appeals, 30 days for post-service appeals and 72 hours for an expedited appeal.
- Request a copy of the information in your appeal (free of charge) regardless if it was used to make the decision.

- file an External Review (at no cost to you) within 120 days (180 days) if applicable.
- an External Review decision within 45 days of the IRO receiving your standard request and 72 hours for an expedited request.
- send additional information, in writing, directly to the IRO.
- an Expedited Review if you, your Authorized Representative or your treating provider believes that waiting the standard 15 day timeframe would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed.
- a simultaneous Expedited Internal and External Review, if applicable.
- information about our grievance and appeal processes. Contact our Customer Service Department at 541-768-4550; toll-free at 1-800-832-4580; TTY 1-800-735-2900; or you can write to the following address:

Samaritan Healthy KidsConnect Appeal Team
815 NW Ninth Street
Corvallis, OR 97339-0336

- to pursue civil action in accordance to 502(a) of the Employee Retirement Income Security Act of 1974 after you have exhausted your internal levels of appeal on an adverse benefit determination.
- Other dispute options, such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner. To seek further assistance, contact any of the following:

Department of Consumer & Business Services
 350 Winter Street NE
 PO Box 14480
 Salem, OR 97309-0405
 Or email dcbs.director@state.or.us

Claims information

When a claim is submitted for payment every attempt will be made to process it promptly and accurately. **Claims must be submitted within one year, (365 days)**, of the time the Covered Person receives the service or supply to be eligible for payment.

Within 30 days of receipt of a clean claim, the Claims Administrator will process your claim. We will report this information to you on a form called an Explanation of Benefits. The Plan may pay claims, deny them, or accumulate them toward satisfying the Deductible (if applicable). If the Claims Administrator denies all or part of a claim, the reason or reasons for the action will be stated in the Explanation of Benefits. The explanation will also contain the following items:

- Reference to the relevant Plan provisions
- A description of any additional information that is needed and why such information is needed
- A statement of whether you must provide any additional information and why that information is necessary
- A statement that you may obtain, upon request, copies of information and documents relevant to your claim

If the Covered Person receives payment for a benefit that he or she is not eligible to receive, the Plan has the right to recover the payment from the Covered Person (including by reducing future claim payments) or anyone else who benefits from it. The covered person is has the right to appeal claims decisions that they do not agree with. **Please review the Appeals and Grievances section of this document**

All claims should be submitted to Samaritan Healthy KidsConnect Health Plan at the following address:

Samaritan Healthy KidsConnect Health Plan
PO Box 1310
Corvallis, OR 97339-0336

Explanation of benefits

We will report to you the action we take on a claim on a form called a Explanation of Benefits If we deny all or part of a claim, the reason for our action will be stated on the Explanation of Benefits. The Explanation of Benefits will also include instructions to file an appeal or grievance if you disagree with the action we have taken on your or your covered dependent's claim; When benefits are available; The cost of a service is incurred on the day the service is rendered and the cost of a supply is incurred on the day the supply is delivered to the patient.

There are two exceptions to this rule. One is when you are in the hospital on the day coverage ends. In this case, we will continue to pay toward eligible charges for the hospitalization until discharge from the hospital or until your benefits have been exhausted, whichever comes first.

We have the sole right to decide whether to pay benefits to you, to the provider of services, or to you and the provider jointly. If a person entitled to receive payment under the policy has died, is a minor or is incompetent, we may pay the benefits (up to \$1,000) to a relative by blood or marriage of that person who we believe is equitably entitled to the payment. A payment made in good faith under this provision will fully discharge Samaritan Healthy KidsConnect Health Plan to the extent of the payment.

Member claim reimbursements

When the hospital bills you You may be billed for inpatient care you or a dependent receives in a non-participating hospital, and for outpatient care you receive in any hospital outside our service area that may be paid by the provisions of this plan. In order to claim your benefits for these charges, send a copy of the bill to us, and be sure it includes all of the following:

- The name of the covered person who was treated;
- Your name and your group and identification numbers;
- A description of the symptoms that were observed or a diagnosis; and
- A description of the services and the dates on which they were given.

If you have already paid for the services or supplies, please note that fact boldly on the billing and include a receipt. Reimbursement forms are available online or by calling our Customer service Department at 541-768-4550, toll-free at 1-800-832-4580; TTY 1-800-735-2900; Monday through Friday 8 a.m. to 5:00 p.m.

The same procedure should be followed with bills for hospital or physician care you received outside the United States—for Emergency services ONLY. Reimbursement will be made at the current rate of exchange at the time of service.

Physicians' charges Your physician may bill charges directly to us. If not, you may send physician bills to us yourself. Be sure the physician uses his or her billing form and includes on the bill:

- The patient's name and the group and identification number;
- The date treatment was given;
- The diagnosis; and
- An itemized description of the services given and the charges for them

If you have already paid the services and supplies, please note that fact boldly on the billing and include a receipt.

If the treatment is for an accidental injury, include a statement explaining the dates, time, place, and circumstances of the accident when you send us the physician's bill.

Physician reimbursement You are entitled to ask if Samaritan Healthy KidsConnect Health Plan has special financial arrangements with our physicians that can affect the use of referrals and other services. To get this information, call our Customer Service Department and request information about our physician payment arrangements.

Filing a lawsuit Any legal action arising out of this plan and filed against us by a covered person or any third party must be filed within three years.

Other health care charges As we explained previously in the description of benefits, your Samaritan Healthy KidsConnect Health Plan will pay for certain other health care expenses. Bills should be forwarded to us as you receive them. Or you may send them to us at regular intervals—for example, once a month. Again, if you have already paid for the services and supplies, please note that fact boldly on the billing and include a copy of your receipt.

Prescription medication rebates Samaritan Health Plans participates in arrangements with medication manufacturer's which allows us to receive rebates based on volume of certain prescription medication purchased on behalf of covered individuals

Any rebates that we receive from medication manufacturers will be used to help minimize future covered health care expenses for individual members and the health plan.

Appliances By this term, we mean things such as artificial limbs, crutches, and wheelchairs. Bills for any of these items should include a complete description of the appliance and the reason it is needed. If your doctor wrote a prescription for the appliance, this should also be included with your claim. Always include your group and identification numbers and the patient's name.

Ambulance service Bills for ambulance service must show where the patient was picked up and where he or she was taken. They should also show the date of service, the patient's name and group and member identification numbers. We will send our payment for covered expenses directly to the ambulance service provider, unless you have already paid them, in which case we will pay you directly.

Claim determinations

Within 30 days of our receipt of a clean claim, we will notify you of the action we have taken on it, adverse or not. However, this 30-day period may be extended by an additional 30 days in the following situations:

When we cannot take action on the claim due to circumstances beyond our control, we will notify you within the initial 30 day period that the extension is necessary, including an explanation of why the extension is necessary and when we expect to act on the claim.

When we cannot take action on the claim due to lack of information, we will notify you within the initial 30-day period that the extension is necessary, including a specific description of the additional information needed and an explanation of why it is needed. You must provide us with the requested information within 30 days of receiving the request for additional information. If we do not receive the requested information to process the claim within the 60 days we have allowed, we will deny the claim.

Motor vehicle coverage In addition to liability insurance, most motor vehicle insurance policies are required by law to provide primary medical payments insurance and uncovered motorist insurance. Many motor vehicle policies also provide underinsurance coverage. Benefits for health care expenses are excluded under this policy to the extent that you or your covered dependent is able to or is entitled to recover from any type of motor vehicle insurance coverage.

Here are some rules, which apply with regard to motor vehicle insurance coverage:

- If a claim for health care expenses arising out of a motor vehicle accident is filed with us and motor vehicle insurance has not yet paid, we may advance benefits as long as you or your covered dependent agrees in writing:
 - To give information about any motor vehicle insurance coverage which may be available to you or your covered dependent; and
 - to hold the proceeds of any recovery from motor vehicle insurance in trust for us and reimburse us as provided in the following paragraphs.
- If we have paid benefits before motor vehicle insurance has paid, we are entitled to have the amount of the benefit we have paid separated from any subsequent motor vehicle insurance recovery or payment made to or on behalf of you or your covered dependent held in trust for us. This is true whether such

recovery or payment is from primary medical payments coverage, uninsured motorist coverage or underinsured motorist coverage.

- If you or your covered dependent incurs health care expenses for treatment of an illness or injury arising out of a motor vehicle accident after receiving a recovery from uninsured or underinsured motor vehicle coverage, we will exclude benefits for otherwise eligible charges until the total amount of health care expenses incurred after the recovery exceed the Net Recovery Amount (as defined in the “Third Party Liability” provision).
- You or your covered dependent who was involved in a motor vehicle accident may have rights both under motor vehicle insurance coverage and against a third party who may be responsible for the accident. In that case, both this provision and the “Third Party Liability” provision apply.

Third-party liability and right of subrogation

This provision applies when you or a covered dependent incurs health care expenses in connection with an illness or injury for which one or more third parties may be responsible. In that situation, benefits for such expenses are excluded under this policy to the extent you or your covered dependent receives a recovery from or on behalf of the responsible third party.

Here are some rules, which apply in these third-party liability situations: If a claim for health care cost is filed with us and you have not yet received recovery from the responsible person, we may advance benefits for covered expenses if you or your covered dependent agrees to hold, or directs you or your covered dependent attorney or other representative to hold, the recovery against the other party in trust for us up to the amount of benefits we paid in connection with the illness or injury. We will require that you or your covered dependent sign and deliver to us an agreement (called a trust agreement) guaranteeing our rights under this provision before we advance any benefits.

If we pay benefits, we will be entitled to have the amount of the benefits we have paid separated from the proceeds of any recovery you or your covered dependent receives from or on behalf of the third party and held in trust for payment to us.

• We are entitled to the amount of benefits we have paid in connection with the illness or injury, regardless of whether you or your covered dependent has been made whole, from the proceeds of any settlement, arbitration award, or judgment that results in a recovery for you or your covered dependent, the third party's insurer, or any other insurance recovery. This is so regardless of whether: the third party or the third party's insurer admits liability; - the health care expenses are itemized or expressly excluded in the third-party recovery; or the recovery includes any amount (in whole or in part) for services, supplies, or accommodations covered under the policy. The amount to be in trust shall be calculated based upon claims that are incurred on or before the date of settlement or judgment, unless agreed to otherwise by the parties.

• If you or your dependent makes a recovery and fails to hold in trust for us the amount of paid benefits and to pay us that amount as required by this Third Party Liability provision, we may exclude future benefits for otherwise covered expenses for any illness or injury up to the amount of benefits we paid for the illness or injury caused by the third party.

• As long as you or your covered dependent has signed a trust agreement, we will allow a deduction of a proportionate share of the reasonable expenses of getting a recovery, such as attorney fees and court expenses from the amount to be reimbursed to us. • If you or your dependent incurs health care expenses for treatment of the illness or injury after recovery, we will exclude benefits for otherwise eligible charges until the total amount of health care expenses incurred after the recovery exceeds the net recovery amount.

The term “net recovery amount” is calculated as follows:

the amount of recovery; plus

the amount you or your covered dependent recovered from any other source such as other insurance as a result of the illness or injury;

Minus

the difference between the total amount of third-party related health expenses incurred prior to the recovery and the benefits we paid before the recovery toward such cost;

Minus

the amount you or your covered dependent reimbursed to us out of the recovery for benefits we paid before the recovery;

Minus

the total expenses paid by you or your covered dependent or on your or your covered dependent's behalf in getting the recovery such as reasonable attorney fees and court expenses; shall equal • the “net recovery amount.”

This provision applies if you or your covered dependent has made or is entitled to make a claim for workers' compensation. Benefits for treatment of an illness or injury arising out of or in the course of employment or self-employment for wages or profit are excluded under this policy. The only exception would be if you or your covered dependent is exempt from state or federal workers' compensation law. Here are some rules, which apply in situations where a workers' compensation claim has been filed:

You must notify us in writing within 5 days of filing a workers' compensation claim.

If the entity providing workers' compensation coverage denies your claims and you have filed an appeal, we may advance benefits if you or your covered dependent agrees in writing to hold any recovery you or your dependent obtains from the entity providing workers' compensation coverage in trust for us according to the Third-Party Liability provision.

Medicare

In certain situations, this plan is primary to Medicare. This Medicare and this policy at the same time, we pay benefits for eligible charges first and Medicare pays second. Those situations are:

- When you or your spouse is age 65 or over and by law Medicare is secondary to your employer group health plan.
- when you or your covered dependent incurs eligible charges for kidney transplant or kidney dialysis and by law Medicare is secondary to your employer group health plan; and

- When you or your covered dependent is entitled to benefits under section 226(b) of the social Security Act (Medicare disability) and by law Medicare is secondary to your employer group health plan.
- In all other instances, we will not pay benefits toward any part of a covered cost to the extent the covered cost is actually paid or would have been paid under Medicare Part A or B had you or your covered dependent properly applied for benefits. Furthermore, when we are paying secondary to Medicare, we will not pay any part of expenses a Medicare-eligible covered member incurs from providers who have opted out of Medicare participation.

Coordination of benefits

Coordination of this group contract's benefits with other benefits This Coordination of Benefits (COB) section applies when a Member has health care coverage under more than one Plan. The term "Plan" is defined below for the purposes of this COB section. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable cost.

Definitions relating to coordination of benefits Plan – Plan means any of the following that provides benefits or services for medical, vision or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage listed under (1) or (2) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This plan – This plan means, as used in this COB section, the part of this contract to which this COB section applies and which may be reduced because of the benefits of other plans. Any other part of this contract providing health care benefits is separate from This plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits. The order of benefit determination rules listed in section 8.2.2 determine whether this plan is a Primary plan or Secondary plan when a Member has health care coverage under more than one Plan.

When this plan is primary, we determine payment for our benefits first before those of any other Plan without considering any other Plan's benefits. When this plan is secondary, we determine our benefits after those of another Plan and may reduce the benefits we pay so that all Plan benefits do not exceed 100% of the total Allowable cost.

Allowable cost – Allowable cost means a health care cost, including deductibles, co-insurance and co-payments, that is covered at least in part by any Plan covering a Member. When a Plan provides benefits in the form of services, the reasonable cash value of each Service will be considered an Allowable cost and a benefit paid. A cost that is not covered by any Plan covering a Member is not an Allowable cost. In addition, any cost that a provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable cost.

The following are examples of expenses that are NOT Allowable expenses:

The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable cost, unless one of the Plans provides coverage for private hospital room expenses.

If you are covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable cost.

If you are covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable cost.

If you are covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable cost for all plans. However, if the provider has contracted with the Secondary plan to provide the benefit or Service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable cost used by the Secondary plan to determine its benefits.

The amount of any benefit reduction by the Primary plan because you have failed to comply with the plan provisions is not an Allowable cost. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and in-network provider arrangements.

Closed panel plan A closed panel plan is a Plan that provides health care benefits to members primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial parent A custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the

Dependent child resides more than one half of the calendar year excluding any temporary visitation.

Order of benefit determination rules When a member is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other plan.

Except as provided in Paragraph (2) below, a plan that does not contain a COB provision that is consistent with the State of Oregon's COB regulations is always primary unless the provisions of both plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverage that are superimposed over base plan hospital and surgical benefits, and insurance type coverage that are written in connection with a Closed panel plan to provide out-of-network benefits.

A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Non-dependent or dependent. The plan that covers a member other than as a Dependent, for example as an employee, Subscriber or retiree is the Primary plan and the plan that covers the member as a Dependent is the Secondary plan. However, if the member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the member as a Dependent; and primary to the pan covering the member as other than a Dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the member as an employee,

subscriber or retiree is the Secondary plan and the other plan is the Primary plan.

Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a member is a Dependent child and is covered by more than one plan the order of benefits is determined as follows:

a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

i. The plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

ii. If both parents have the same birthday, the plan that has covered the parent the longest is the Primary plan.

b) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;

ii. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the Dependent child are as follows:

- The plan covering the Custodial parent, first;
- The plan covering the spouse of the Custodial parent second;

- The plan covering the non-custodial parent, third; and then;
 - The plan covering the Dependent spouse of the non-custodial parent, last;
- c) For a Dependent child covered under more than one plan of individuals who are not the parents of the Dependent child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the Dependent child.

Active employee or retired or laid-off employee. The plan that covers a member as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The plan covering that same member as a retired or laid-off employee is the Secondary plan. The same would hold true if a member is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

COBRA or state continuation coverage. If a member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the member as an employee, subscriber or retiree or covering the member as a Dependent of an employee, Subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

Longer or shorter length of coverage. The plan that covered the member as an employee, Subscriber or retiree longer is the Primary plan and the Plan that covered the member the shorter period of time is the Secondary plan.

If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this plan will not pay more than we would have paid had we been the Primary plan.

Effect on the benefits of this plan When this plan is secondary, we may reduce our benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable cost under its plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total Allowable cost for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a member is enrolled in two or more Closed panel plans and if, for any reason, including the provision of services by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that plan and other Closed panel plans.

Right to receive and release needed information Certain facts about health care coverage and services are needed to apply this COB section and to determine benefits payable under this plan and other plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying this section and determining benefits payable under this plan and other plans covering a member claiming benefits. We need not tell, or get the consent of, any person to do this. Each member claiming benefits under this plan must give us any facts we need to apply this section and determine benefits payable.

Facility of payment A payment made under another plan may include an amount that should have been paid under this plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term “payment made” includes providing benefits in the

form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of recovery If the amount of the payments made by us is more than we should have paid under this COB section, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the member. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Other claims recoveries If we mistakenly make a payment for you or your covered dependent to which you or your covered dependent is not entitled, or if we pay a person who is not eligible for payments at all, we have the right to recover the payment from the person we paid or anyone else who benefits from it, including a provider of services. Our right to recovery includes the right to deduct the amount paid by mistake from future benefits we would provide for you or any of your covered dependents even if the mistaken payment was not made on that person’s behalf.

We regularly engage in activities to identify and recover claims payments, which should not have been paid (for example, claims which are the responsibility of another, duplicates, errors, fraudulent claims, etc.). We will credit to your group’s experience or the experience of the pool under which your group is rated all amounts that we recover, less our reasonable expenses in getting the recoveries.

If you have questions please contact our Customer Service Department

Samaritan Healthy KidsConnect Health Plan

Samaritan Health Plans
815 NW Ninth St, Suite 101
P.O. Box 131 0
Corvallis, OR 97339

HIPAA privacy notice

Federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you upon enrollment and is available from the benefits manager.

This Plan, and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, if you have questions about the privacy of your health information, or if you wish to file a complaint under HIPAA, please contact Samaritan Healthy KidsConnect Health Plan at (541)-768-4550, toll free 800-832-4580 or TTY 1-800-735-2900. Our Customer Service Department hours are 8:00 a.m. to 5 p.m., Monday through Friday

Patient Protection Act: your rights and responsibilities

In accordance with Oregon law (Senate Bill 21, known as Patient Protection Act), the following Disclosure Statement includes questions and answers to fully inform you and your covered dependents about the benefits and policies of this health insurance plan.

Your rights as a member

- You have a right to receive information about Samaritan Healthy KidsConnect Health Plan, our services, our providers, and your rights and responsibilities.
- You have a right to be treated with respect and recognition of your diversity and right to privacy.
- You have a right to participate with your healthcare provider in decision making regarding your care.
- You have a right to honest discussion of appropriate or medically necessary treatment options.
- You are entitled to discuss those options regardless of how much the treatment expenses or if it is covered by this plan.
- You have a right to the confidential protection of your medical information and records.
- You have a right to voice complaints about Samaritan Healthy KidsConnect Health Plan or the care you receive, and to appeal decisions you believe are wrong.
- You have the right to continue care from an individual provider for a limited period of time after the medical services contract terminates.

Your responsibilities as a member

- You are responsible for providing Samaritan Healthy KidsConnect Health Plan and our providers with the information we need to care for you.
- You are responsible for following treatment plans or instructions agreed on by you and your healthcare providers.
- You are responsible for payment of co-pays at the time of service and be on time for that service.
- You are responsible for reading and understanding all materials about your health plan benefits and for making sure that family members covered under this plan also understand them.

You are responsible for making sure services are prior authorized when required by this plan before receiving medical care.

How do I access care in the event of an emergency? If you or your covered dependent experiences an emergency situation, you or your covered dependent should obtain care from the nearest appropriate facility, or dial 911 for help. If there is any doubt about whether your or your covered dependent's condition requires emergency treatment, you or your covered dependent can always call the provider for advice. The provider is able to assist you or your covered dependent in coordinating medical care and is an excellent resource to direct you or your covered dependent to the appropriate care since he or she is familiar with your or your covered dependent's medical history.

How will I know if my benefits change or are terminated? Oregon Private Health Partnerships (OPHP) will notify you of changes or termination of coverage 30 days prior to the effective date of change or termination. OPHP has the right to make changes that are in best interest of its members and/or its independent contractor's.

What happens if I am receiving care and my doctor is no longer a contracting provider? When a professional provider's contact with us ends for any reason, we will give notice to those covered that we know, or should reasonably know, are under the care of the provider of their rights to receive continued care (called "continuity of care"). We will send this notice no later than 10 days after the provider's termination date or 10 days after the date we learn the identity of an affected covered individual, whichever is later. The exception to our sending the notice is when the professional provider is part of a group of providers and we have agreed to allow the provider group to provide continuity of care notification to those covered.

When continuity of care applies If you or your covered dependent is undergoing an active course of treatment by an in-network professional provider and benefits for that provider would be denied (or paid at a level below the benefits for an out-of-area provider) if the provider's in-network contract with us is terminated or the provider is no longer participating in our in-network provider network, we will continue to pay plan benefits for services and supplies provided by the professional provider as long as:

- you or your covered dependent and the professional provider agree that continuity of care is desirable and you or your covered dependent requests continuity of care from us;
- the care is medically necessary and otherwise covered under the plan;
- you or your covered dependent remains eligible for benefits and covered under the plan; and
- the plan has not terminated.

Continuity of care does not apply if the contractual relationship between the professional provider and us ends in accordance with quality of care provisions of the contract between the provider and us, or because the professional provider:

- retires;
- dies;
- no longer holds an active license;
- has relocated outside of our service area;
- has gone on sabbatical; or
- its prevented from continuing to care for patients because of other circumstances.

How long continuity of care lasts Except as follows for pregnancy care, we will provide continuity of care until the earlier of the following dates:

- the day following the date on which the active course of treatment entitling you
- or your covered dependent to continuity of care is completed; or the 120th day after notification of continuity of care.

If you or your covered dependent becomes eligible for continuity of care after the second trimester of pregnancy, we will provide continuity of care for that pregnancy until the earliest of the following dates:

- the 45th day after the birth;
- the day following the date on which the active course of care treatment entitling you or your covered dependent to continuity of care is completed; or
- the 120th day after notification of continuity of care.

The notification of continuity of care will be the earliest of the date we or, if applicable, the provider group notifies you of your or your covered dependent of

the right to continuity of care, or the date we receive or approve the request for continuity of care.

Medical necessity of continuing care If questions arise about the medical necessity of continued care for treatment or services, the Plan may ask the attending physician to provide evidence supporting the need for this care. The Plan can discontinue payment of benefits if the medical information from your physician does not clearly indicate that continued care for treatment or services is Medically Necessary.

Quality of medical care The Covered Person always has the right to choose his or her own Hospital or physician. The Plan is not responsible for the quality of medical care the Covered Person receives. The Plan cannot be held liable for any claims or damages connected with injuries suffered by the Covered Person while receiving medical services and supplies.

Complaint and appeals: if I am not satisfied with my health plan or provider what can do to file a complaint or get outside assistance? To voice a complaint with us, simply follow the process outlined in the **Member Appeals and Grievances** section of this booklet, including, if applicable, information about filing an appeal to be reviewed by an independent physician without charge to you.

You and your covered dependents also have the right to file a complaint and seek assistance from the director of the Department of Consumer and Business Services (DCBS). You or your covered dependent can write to the Director of the DCBS at:

**Oregon Insurance division Consumer Protection Unit 0
Winter Street NE, Room 0-2
Salem, OR 97310**

Or call: 503-947-7984
Or e-mail: dcbs.inmail@state.or.us

What are your pre-authorization and utilization review criteria? Pre-authorization, also known as prior authorization is the process we use to determine the medical necessity of a service before it is rendered. Contact our

Customer Service Department at the phone number on the back of your identification card and also review the **Prior Authorization List** section of the handbook. Many types of treatment may be available for certain conditions. The pre-authorization process helps the provider work together with you or your covered dependent, other providers, and us to determine the treatment that best meets your or your covered dependent's medical needs and to avoid duplication of services.

This teamwork helps save thousands of dollars in premiums each year, which then translates into savings for you. And, pre-authorization is you and your covered dependents' assurance that medical services will not be denied because they are not medically necessary.

Utilization review is a process in which we examine services you receive to ensure that they are medically necessary—appropriate with regard to widely accepted standards of good medical practice. For further explanation, look at the definition of medically necessary in the DEFINITIONS Section of this booklet.

Let us know if you or your covered dependent would like a written summary of information that we may consider in our utilization review of a particular condition or disease. Simply call the Customer Service Department phone number on the back of your identification card.

How important documents (such as my medical records) are kept confidential? We have a written plan to protect the confidentiality of health information. Only employees who need to know in order to do their jobs may access your personal information. Disclosure outside the company is permitted only when necessary to perform functions related to providing you or your covered dependent's coverage and/or when otherwise allowed by law. Note that with certain limited exceptions, Oregon law requires insurers to obtain a written authorization from you or your representative before disclosing personal information. One exception to the need for a written authorization is disclosure to a designee acting on behalf of the insurer for the purpose of utilization management, quality assurance, or peer review.

My neighbor has a question about the plan that he has with you and doesn't speak English very well. Can you help? Yes. Simply have your

neighbor call our Customer Service Department at the number on his or her identification card. One of our representatives will coordinate the services of an interpreter over the phone. We can help with sign language as well as spoken languages.

What additional information can I get from you upon request? The following documents are available by calling a Customer Service Department:

- Rules related to our medication formulary, including information on whether a particular medication is included or excluded from the formulary and information on what medications require pre-authorization from Samaritan Healthy KidsConnect Health Plan.
- Provisions for referrals for specialty care, behavioral health services, and hospital services, and how you may obtain the care or services.
- A copy of our annual report on complaints and appeals.
- A description of our risk-sharing arrangements with physicians and other providers consistent with risk-sharing information required by the Health Care Financing Administration.
- A description of our efforts to monitor and improve the quality of health services.
- Information about procedures for credentialing network providers and how to obtain the names, qualifications, and titles of the providers responsible for your care.

- Information about our prior authorization and utilization review procedures.

What other source can I turn to for more information about your company?

The following information regarding the health benefit plans of Samaritan Health Plans is available from the Oregon Insurance Division:

- The results of all publicly available accreditation surveys.
- A summary of our health promotion and disease prevention activities.
- Samples of the written summaries delivered to plan holders.
- An annual summary of grievances and appeals.
- An annual summary of utilization review policies.
- An annual summary of quality assessment activities.
- An annual summary of scope of network and accessibility of services.

To obtain the mentioned information, write to:

Oregon Insurance division Consumer Protection Unit 0
Winter Street NE, Room 0-2
Salem, Oregon 97310
Call: 503-947-7984

Or e-mail: dcbs.insmail@state.or.us

Plan administration

Governing law

The interpretation and validity of this contract will be governed by the laws of the State of Oregon without regard to its conflict of law rules. If there is conflict between the provisions of this plan and Oregon State or Federal Laws, Oregon State or Federal Laws will take precedence over the provisions of this plan.

Compliance with state and federal mandates

To the extent applicable, the Plan will provide benefits in accordance with the requirements of all applicable laws and as described in the Plan Document, including

- Civil rights and employment laws including, but not limited to Titles VI and VII of the Civil Rights Act of 1964, Sections 503 and 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, Executive Order 11246, the Age Discrimination in Employment Act of 1967, and the Age Discrimination Act of 1975;
- Laws protecting privacy and security, including, but not limited to the Health Insurance Portability and Accountability Act of 1996;
- Laws protecting benefits rights of veterans, including, but not limited to the Vietnam Era Veterans' Readjustment Assistance Act of 1974 and the Uniformed Services Employment and Reemployment Rights Act of 1994;
- Laws providing for portability of benefits, including HIPAA, and the American Reinvestment and Recovery Act of 2009;
- Medicare secondary payer laws, including, but not limited to the Social Security Number reporting requirements in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), 42 U.S.C.

§1395y (b)(7);

- The Affordable Care Act. For purposes of compliance with the Affordable Care Act, Contractor shall assume that the Plan does not have "grandfathered" status;
- Laws governing Contractor's responsibility for health care for Emergency Medical Conditions, Stabilization, and Post-Stabilization Services;
- Any Oregon state laws corresponding to or implementing the above federal laws;
- The Oregon Consumer Identity Theft Protection Act, ORS 646A.600 to 646A.628, including, but not limited to the notice of breach of security provisions;
- If the Contractor is an insurance company, the Insurance Code as defined in ORS 731.004, or if Contractor is a health care service contractor within the meaning of ORS 750.005, the portions of the Insurance Code that ORS 750.055 applies to health care service contractors;
- 2009 Oregon House Bill 2116 and 2011 SB 514;
- All regulations and administrative rules established pursuant to the foregoing laws; and
- All Bulletins of the Insurance Division.

Other authorities and responsibilities

Samaritan Health Plans has the discretionary authority to interpret and has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

Samaritan Health Plans, as the plan administrator, may give other decision makers the authority to interpret the plan, to resolve and interpret any ambiguities that exist, and to make factual determinations on behalf of Samaritan Healthy KidsConnect Health Plan.

Changing this contract

This document is your contract with Samaritan Healthy KidsConnect Health Plan. This contract cannot be changed except by a written endorsement or notification to you issued by us or Oregon Private Health Partnerships (OPHP) that have been approved by an officer of Samaritan Health Plans. We may change this contract by giving you 30-days advance written notice; but we may do so only if we are changing all contracts of the same form and class and approved by OPHP.

Contract renewal and termination

The Contract will renew automatically from year to year unless terminated as otherwise provided in the Contract. Termination of the member under the Contract for any reason will completely end all obligations of the Company to provide the member with Benefits after the date of termination

Relationship to Samaritan Health Services

The group on behalf of itself and its covered participants hereby expressly acknowledges its understanding that this plan constitutes a plan solely between the group and Oregon Private Health Partnerships through Samaritan Healthy KidsConnect Health Plan acting as the Plan Administrator. The group on behalf of itself and its covered participants further acknowledges and agrees that it has not entered into this plan based upon representations by any person or entity other than Samaritan Healthy KidsConnect Health Plan and that no person or

entity other than Samaritan Healthy KidsConnect Health Plan shall be held accountable or liable to the group or the covered participants for any of our obligations to the group or the covered employees created under this plan. This paragraph shall not create any additional obligations whatsoever on the part of Samaritan Healthy KidsConnect Health Plan other than those obligations created under other provisions of this plan.

Portability

Portability plans are governed by Oregon Revised Statute (ORS) 743.760 and 743.761 and Oregon Administrative Rule (OAR) Division 836, Chapter 53. If you find that there is a discrepancy between the governing law and this document, the governing law supersedes.

What is a portability plan? Portability plans offer coverage to those who have otherwise lost other continuous coverage for health care benefits. Samaritan Healthy KidsConnect Health Plan, as your group health benefits plan, offers Portability plan options to those who have become ineligible for our Samaritan Healthy KidsConnect Health Plan. These Portability plans will allow you to have no lapse in coverage. If you have questions about portability plan benefits please call our Customer Service Department: (541) 768-4550; Toll Free 1-800-832-4580 or TTY 1-800-735-2900.

You are eligible if The following qualifications are met and eligibility is guaranteed when you have no other coverage and live in the Linn, Benton, Lincoln, or Tillamook county service area:

- Continuously covered for 180 days under Samaritan Healthy KidsConnect Health Plan; OR
- Continuously covered 180 days under a combination of Samaritan Healthy KidsConnect Health Plan and one or more Oregon group health benefit plans prior to termination, with Samaritan Healthy KidsConnect as your last group coverage.

You have 63 days from your group termination date to apply for portability coverage. When we have determined that the qualifications for coverage are met, the portability coverage will be effective from the day your previous group health benefit plan ended, so there is not a lapse or break in coverage.

Contact us: (541) 768-4550; Toll Free 1-800-832-4580 or TTY 1-800-735-2900

For further information contact our Customer Service Department

Samaritan Portability Benefit Plans:

PO Box 1310

Corvallis, OR 97339-0336

Phone 541-768-4550 or 1-800-832-4580

As soon as we receive notice from the member's group administrator that the group health benefits plan has ended, we will automatically mail the member portability plan information with the options available to them, including the benefit summary, rates and application. The member has 63 days from their group termination date to apply for portability coverage. When the qualifications for coverage are met, the portability coverage will be effective from the day the member's group health benefit plan ended, so there is not a lapse or break in coverage.

Certificate of creditable coverage

A Covered Person who ceases to be covered under the Plan will be provided a certificate that evidences the Covered Person's creditable coverage and the period of that creditable coverage. The time as of which the certificate will be provided and the contents of the certificate are explained below. For the basis of this section **Portability Coverage** is defined as 180 days of continuous coverage with an applicable plan.

Rights to receive certificates A certificate of creditable coverage will automatically be provided to a Covered Person upon the occurrence of certain events. In certain cases, a Covered Person, or someone on behalf of the Covered Person, may also request a certificate.

Automatic provision of certificate A Covered Person whose coverage under the Plan is to end (or which would end but for the right to elect a portability plan continuation coverage) will automatically be provided a creditable coverage certificate. In that event, the certificate will be provided at the time the Covered Person will lose coverage under the Plan or within a reasonable time after such date.

In the case of a Covered Person who has elected a portability plan, a certificate of creditable coverage will automatically be provided to the Covered Person within a reasonable time (10 days) after the date such continuation coverage ends. In the event that such continuation coverage ends because of the non-payment of the required continuation coverage premium payments, then the

certificate will be provided within a reasonable time after the end of any applicable payment grace period. A certificate automatically provided to a Covered Person will disclose the last period of the Covered Person's continuous coverage under the Plan.

Provision of certificate upon request A Covered Person, or someone on behalf of a Covered Person, may request a certificate of creditable coverage at any time within 24 months of the date that coverage under the Plan ended. A request for a certificate can be made even if a certificate was previously provided, including upon a prior request. A certificate provided upon request will disclose each period of continuous coverage that ceased during the 24-month period ending on the date of the request, or which was continuing on the date of the request. A separate certificate may be provided for each period of continuous coverage.

Specification of benefits A group health plan or issuer may request on behalf of a Covered Person who was previously provided a certificate of creditable coverage for specific information regarding categories of benefits that had been provided under the Plan to the Covered Person. The Plan may charge the requesting plan or issuer for the reasonable cost of providing such benefit information. Subject to the payment of such expenses, the plan will promptly provide to the requesting entity all of the requested information that is reasonably available to the Plan

Customer service department

The Samaritan Healthy KidsConnect Health Plan home office in Corvallis is maintained to meet your servicing needs. Come see us at 815 NW Ninth Street, Suite 101 or contact us at (541)-76 8-4550, toll free 800-832-4580 or TTY 1-800-735-2900. Our Customer Service Department hours are 8:00 a.m. to 5 p.m., Monday through Friday. We look forward to serving you.

Statements made by applicants, policy holder or insured are representations and not warranties

Samaritan Healthy KidsConnect Health Plan

Samaritan Health Plans

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P.O. Box 131 0

Corvallis, OR 97339

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