

# SAMARITAN HEALTHY KIDSCONNECT 2012 SUMMARY OF BENEFITS

THIS SUMMARY OF BENEFITS IS FOR THOSE MEMBERS ON SAMARITAN HEALTHY KIDSCONNECT PLANS WHO HAVE BEEN DETERMINED TO BE **ABOVE 300% OF THE FEDERAL POVERTY LEVEL (FPL)**.

This is only a brief summary of benefits. Please refer to your Member Handbook for a detailed explanation of benefits, including limitations and exclusions.

|   | <b>INDIVIDUAL</b>                        |
|---|--|
| Annual out-of-pocket <b>MEDICAL</b> limit                   | \$6,000<br><i>(including deductible)</i> |
| Annual <b>MEDICAL</b> deductible                            | \$1,000                                  |
| Annual out-of-pocket <b>PRESCRIPTION DRUG</b> limit         | None                                     |
| Annual out-of-pocket <b>DENTAL</b> limit                    | \$200                                    |
| Annual out-of-pocket <b>VISION</b> limit                    | None                                     |
| Lifetime Maximum  | None                                     |
| Pre-existing conditions waiting period, including pregnancy | None                                     |

## Deductibles and out-of-pocket limits

- The **annual deductible** amount that needs to be met for the Medical benefit plan is \$1,000.
- **Annual out-of-pocket medical limit** is \$6,000 per person per calendar year; deductible is included in this total.
- Once the applicable out-of-pocket limit has been met, this plan will pay 100% of covered charges for services at the applicable preferred or non-preferred benefit level for the rest of that calendar year.
- Non-covered services and charges do not accumulate towards the maximum out-of-pocket expense.

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
- Routine immunizations
- One PKU test
- Well-baby/well-child care
- Outpatient diabetic instruction
- Transplant facilities that are participating providers

**Services are covered only when obtained from in-network providers, except when urgent or emergent or when out-of-network services have been prior authorized. In these circumstances, normal in-network cost-sharing would apply.**

**THIS IS NOT A CONTRACT. THIS BENEFIT SUMMARY DOES NOT FULLY DESCRIBE THE BENEFIT COVERAGE WITH SAMARITAN HEALTHY KIDSCONNECT.**

# Samaritan Healthy KidsConnect 2012 Summary of MEDICAL BENEFITS



| SERVICE   | YOU PAY IN-NETWORK<br><i>(after deductible has been met)</i> |
|---|--|
| <b>Preventive services*</b>   |  |
| Women's health care services  | 0%   |
| Men's health care services  | 0%   |
| Routine Immunizations   | 0%   |
| Well baby (0-24 months)   | 0%   |
| Well Child (2-18 years)   | 0%   |
| Diabetic Education  | 0%   |
| <b>Professional services</b>  |  |
| Office visits   | 20%  |
| Urgent care services  | 20%  |
| <b>Hospital and inpatient services</b>                                      |  |
| Emergency room visit <i>(waived if admitted)</i>                            | 20%  |
| Inpatient rehabilitation  | 20%  |
| Transplants   | 20%  |
| Hospital inpatient care – per admission (includes inpatient maternity care) | 20%  |
| <b>Outpatient services</b>  |  |
| Alternative medicine  | 20%  |
| Speech-language pathology, audiology, hearing aid services                  | 20%  |
| Outpatient rehabilitation   | 20%  |
| Outpatient surgery  | 20%  |
| Diagnostic x-ray, imaging, labs, diagnostic procedures                      | 20%  |
| <b>Mental health and chemical dependency</b>                                |  |
| <b>Mental health</b>  |  |
| Inpatient psychiatric care  | 20%  |
| Residential/day treatment   | 20%  |
| Outpatient treatment  | 20%  |
| <b>Chemical dependency</b>  |  |
| Inpatient psychiatric care  | 20%  |
| Residential/day treatment   | 20%  |
| Outpatient treatment  | 20%  |
| <b>Other covered services</b>   |  |
| Skilled nursing facility – 60 day limit/year                                | 20%  |
| Home health care  | 20%  |
| Hospice care  | 20%  |
| Durable medical equipment   | 20%  |
| Ambulance   | 20%  |

THIS IS NOT A COMPLETE LIST OF SERVICES AND THESE SERVICES MAY HAVE OTHER LIMITATIONS AND EXCLUSIONS. PLEASE REVIEW YOUR MEMBER HANDBOOK. Non-covered services do not apply to out-of-pocket maximum. Please see the attached Prior Authorization list. \* **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 are covered without cost sharing and are considered preventive services.**

# Samaritan Healthy KidsConnect 2012 Summary of DRUG BENEFITS



| GENERIC | PREFERRED                                   | NON-PREFERRED                                |
|---------|---|--|
| \$5     | \$50 or 50%, <i>whichever is the lesser</i> | \$50 or 50%, <i>whichever is the lesser*</i> |

\* Samaritan Healthy KidsConnect (SHKC) covers non-preferred prescription drugs only when your doctor has requested a medication exception for you and we have approved the request. In such cases, you would pay the preferred co-pay of \$10 for your non-preferred prescription drug.

**PLEASE REVIEW THE DEDUCTIBLES AND OUT-OF-POCKET LIMITS SECTION OF THIS DOCUMENT**

**Generic medications** – The FDA (Federal Drug Administration) has approved generic drugs that have the same active ingredient as the brand name. Generally, when a generic version of a drug is available, SHKC requires that members use the generic 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** – Samaritan Healthy KidsConnect does not cover these medications without an approved medication exception through our Pharmacy Department.

## Prescription summary

### Maximum quantities

The largest amount allowed at one time for outpatient prescription drugs 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 filled up to a 90-day supply. For more information and appropriate forms, please call the Customer Service Department or visit our website at [www.samhealth.org/healthplans](http://www.samhealth.org/healthplans).

### Samaritan Healthy KidsConnect Health Plan Customer Service Department

#### Members call:

Monday through Friday  
8 a.m. to 5 p.m.  
(541) 768-4550  
1-800-832-4580  
TTY 1-800-735-2900

**Services are covered only when provided by in-network providers except in emergencies or when out-of-network services have been prior authorized. In these circumstances, normal cost-sharing would apply.**

#### Providers/pharmacies call:

(541) 768-5207  
1-888-435-2396

# Samaritan Healthy KidsConnect 2012 Summary of VISION BENEFITS



| SERVICE  | YOU PAY IN-NETWORK            |
|--|-------------------------------|
| Examinations: one (1) exam every benefit year  | \$0                           |
| Ocular prosthetics, artificial eye   | \$0                           |
| Vision therapy services  | \$0                           |
| Post-surgical care   | \$0                           |
| Radiological services  | \$0                           |
| <b>Prescription lenses, frames and contacts</b>  | <b>Your Benefit Allowance</b> |
| Every benefit year you pay any amount over maximum allowance that is listed: lenses, frames and contacts <i>(combined)</i> | \$200/year                    |

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 below, 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 above annually. This time period begins January 1<sup>st</sup> every benefit year following; this is a per calendar year benefit.

**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.**

# Samaritan Healthy KidsConnect 2012 Summary of DENTAL BENEFITS



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

| SERVICE  | YOU PAY IN-NETWORK |
|--|--------------------|
| <b>Diagnostic and preventive</b>   |                    |
| Examinations   | \$0                |
| X-rays   | \$0                |
| Cleanings  | \$0                |
| Fluoride Treatment   | \$0                |
| Sealants   | \$0                |
| <b>ADDITIONAL SERVICES</b>   |                    |
| <b>Restorative, Oral Surgery, and Endodontics</b>                        |                    |
| Amalgams   | \$10               |
| Composite Resin Restorations   | \$10               |
| Crowns   | \$30 per crown     |
| Extractions  | \$10               |
| Root Canal Therapy   | \$10               |
| Surgical Extractions   | \$10               |
| <b>Periodontics</b>  |                    |
| Space and periodontal maintenance  | \$10               |
| Stabilization of periodontal health                                      | \$10               |
| <b>Prosthodontics (Removable)</b>  |                    |
| Complete and Partial Dentures  | \$30               |
| Repairs to Complete and Partial Dentures                                 | \$15               |
| Denture Rebase and Reline Procedures                                     | \$15               |
| <b>Orthodontics</b>  |                    |
| Covered for patients who have a diagnosis of Cleft Palate with Cleft Lip | \$30               |

\*This is the maximum amount you will pay for covered dental benefits per individual, per calendar year, before your plan will begin paying 100% for covered services.

**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.**

## Samaritan Healthy KidsConnect 2012 PRIOR AUTHORIZATION LIST

### SAMARITAN HEALTHY KIDSCONNECT

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)

**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.

**\*All non-contracted services require prior authorization from Samaritan Healthy KidsConnect Health Plan. Samaritan Healthy KidsConnect Health Plan reserves the right to review or otherwise deny payment for services that are not found to be medically necessary. "Prior authorization" means a decision made by an insurer before services are obtained that the insurer will provide payment for the services**

**Contact us...**Samaritan Healthy KidsConnect (541) 768-4550 | 1-800-832-4580 | TTY 1-800-735-2900