BENEFIT EXCLUSIONS

FOR SMALL GROUP (< 50 EMPLOYEES)

The information provided is only a summary and not a full list of the Plans' benefit exclusions. The member policy is the only legal document to provide a full list of benefit specifics for the plan options.

SURGERIES AND PROCEDURES

- Gastric bypass and bariatric surgery
- Panniculectomies
- Cosmetic or reconstructive surgery except when medically necessary
- Abdominoplasty
- Treatment for infertility, including artificial insemination, in vitro fertilization, or GIFT procedures
- Surgery to reverse voluntary sterilization
- Routine foot care such as treatment for corns and calluses, toenail conditions, hypertrophy or hyperplasia of the skin and nails unless, the patient has diabetes, peripheral vascular disease, or recurrent infections
- Surgical procedures that alter the refractive character of the eye, unless medically necessary Custodial care, including routine nursing care and rest cures and hospitalization for environmental change
- Treatment to augment or reduce the upper or lower jaw, except when medically necessary Temporomandibular joint (TMJ) or myofascial pain treatment, advice, or appliances
- Services for dental implants, or improving placement of dentures
- Sex transformations are excluded when not medically necessary or when not related to a mental health condition
- Sexual Dysfunction is excluded when not medically necessary or when not related to a mental health condition
- Eye surgeries to improve vision such as, Lasik, unless medically necessary
- Myeloablative high dose chemotherapy, except when the related transplant is covered Services, supplies, testing or treatment for sterility, infertility, impotency, frigidity, or sexual inadequacy, unless medically necessary or when not related to a mental health condition
- Custodial care, including routine nursing care, and rest cures, and hospitalization for environmental change

MEDICAL EQUIPMENT AND DEVICES

- Eyeglasses or contact lenses (exclusion applies to adults only), vision therapy, orthoptics and visual appliances (colored lenses, prisms and special glasses) for reading, learning or behavioral disabilities or dyslexia, except as outlined for pediatric vision benefit
- Routine supplies and equipment used for comfort, convenience, cosmetic purposes, or environmental control. This includes appliances like air conditioners, air filters, whirlpools, hot tubs, heat lamps, or tanning lights. It also includes personal items like telephones and televisions, and maintenance supplies or equipment commonly used for purposes other than medical care.

MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES

- Marital, family, career, or personal growth counseling, unless it is a part of an individual's treatment plan and billed specifically for the individual
- Educational programs , including some court-ordered programs that do not require coverage by the state of Oregon
- Voluntary mutual support groups like Alcoholics Anonymous, unless court ordered
- Counseling in the absence of illness
- Psychological testing that is not medically necessary
- Any mental health services unrelated to the treatment or diagnosis of a mental disorder

HEALTH RELATED CONDITIONS, SERVICES OR SUPPLIES

- Homeopathic treatment
- Biofeedback, for diagnosis other than migraine headaches and incontinence
- Hypnosis
- Experimental or investigational

OTHER EXLUSIONS

- Any charge over the Usual and Customary or Reasonable charge for services or supplies
- Hospital, Skilled nursing facility or other facility services that began before the covered person's coverage began, including services and supplies
- Treatment incurred prior to enrollment and coverage under this Plan or after coverage terminates. The only exception is that if this plan is replaced by a group health policy while you are hospitalized, Samaritan Health Plans will continue paying covered hospital expenses until you are released or your benefits are exhausted, whichever occurs first.
- Services or supplies otherwise available (such services or supplies will be covered if otherwise required by law)
- Services provided by an immediate family member, including parents, grandparents, spouse/domestic partner, siblings, children and grandchildren
- Services or supplies for which no charge is made, or for which no charge is normally made in the absence of insurance
- Services or supplies for which the covered person is not charged or cannot be held liable because of an agreement between the provider rendering the service and another third-party payer that has already paid for the service.
- Services or supplies with no charge, or which your employer would have paid for if you had applied
- Charges that are the responsibility of a third party, such as, personal injury protection insurance, motor vehicle liability insurance, or uninsured or underinsured motorists
- Charges for services or supplies if you are not willing to release medical information to Samaritan Health Plans in order to determine eligibility for payment
- Charges for travel or work related expenses, telephone consultations, missed appointments, get acquainted visits, completion of claim forms or completion of reports requested by the Claims Administrator in order to process claims
- Care designed mainly to help with daily activities such as walking, getting out of bed, bathing, dressing, eating, and preparing meals
- Services and supplies not specifically described as benefits under this Plan

VISION

- Visual field charting
- Fitting charges
- Orthoptics or vision training
- Lenticular lenses
- Contact lenses, except as shown in the vision benefit plan provisions
- Subnormal vision aids
- Aniseikonic lenses
- High index lenses
- Photochromatic and transition lenses
- Hardware repairs
- Nonprescription lenses
- 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 can be covered under the medical provisions of the plan
- Services and supplies that are payable under an occupational disease law
- 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
- Any cost paid in whole or in part by any other provision of the Group Health Insurance Plan provided by the Policyholder.
- Any cost which results from an act of declared or undeclared war or armed aggression

DRUGS AND MEDICATIONS

- Prescription drugs used primarily for weight control or obesity, regardless of the diagnosis (including, but not limited to, amphetamines).
- Non-prescription drugs: Drugs, which by law do not require a prescription order, except for insulin, and certain over-the-counter drugs specifically covered by this Prescription drug coverage. These medications covered by the Plan are considered OTC, require a written prescription from a physician to be covered under the plan. *Note*: You or your physician may submit a medication exception request for OTC medications not listed in the formulary.
- Immunizations or services in anticipation of exposure through travel, school or work
- Vitamins except those which by law require a prescription order, or are required by law to be covered by the plan
- Drugs with no proven therapeutic indication
- Drugs used for other than medically necessary indications.
- The following miscellaneous drugs are specifically excluded:
  - Rogaine
  - Yohimbine
- Drugs for which claims are submitted 12 months or more after the date of purchase
- Drugs or devices used for infertility.
- Drugs or devices used for impotence and sexual dysfunction (e.g., Viagra, MUSE, Yohimbine, Osphena, etc.), unless medically necessary or as a result of a mental health diagnosis
- Drugs or devices used for cosmetic reasons (e.g., Propecia, Botox, Renova, etc.) unless medically necessary