

# Performance Bronze 6750 HSA For Small Groups in Oregon

The benefits information provided is only a summary and not a complete description of benefits. Limitations and exclusions apply.

2019 BENEFITS (Member pays)	Performance Bronze 6750 HSA	
Wellness Services	In-network	Out-of-network
<b>Individual Wellness Assessment</b> Interactive, online questionnaire that evaluates lifestyle and its impact on good health.	\$0, not subject to deductible	Not covered
<b>Health Risk Screening</b> Blood test identifies risks for certain diseases and medical conditions.	\$0, not subject to deductible	Not covered
<b>Health Risk Score and Report</b> Provides a snapshot of the member's current health and recommends appropriate action items. Requires completion of Individual Wellness Assessment and Health Risk Screening test.	\$0, not subject to deductible	Not covered
<b>Personal Health Coaching</b> A trained, certified professional provides confidential, one-on-one sessions to assist members in reaching their health and wellness goals.	\$0, not subject to deductible	Not covered

Medical Benefits	In-network	Out-of-network
<b>Deductible</b> Per calendar year Combined medical and pharmacy	\$6,750 per individual \$13,500 per family	\$13,500 per individual \$27,000 per family
<b>Out-of-pocket maximum</b> Per calendar year Combined medical and pharmacy	\$6,750 per individual \$13,500 per family	Unlimited
<b>Primary care</b> Office visits, in-office procedures	0%, after deductible	50%, after deductible
<b>Urgent care</b>	0%, after deductible	0%, after deductible
<b>Specialty care</b> Office visits, in-office procedures	0%, after deductible	50%, after deductible
<b>Emergency care</b> Waived if admitted to hospital	0%, after deductible	0%, after deductible
<b>Mental health and chemical dependency/substance abuse</b> Office visits	0%, after deductible	50%, after deductible
<b>Preventive care and services</b> Including well baby care, routine physicals, routine gynecological exams, immunizations, colorectal screening, ACA required services	\$0, not subject to deductible	50%, after deductible
<b>Outpatient surgery</b> <sup>1</sup> Facility and professional charges	0%, after deductible	50%, after deductible
<b>Outpatient services</b> <sup>1</sup> Dialysis, chemotherapy, infusion, and radiation therapy	0%, after deductible	50%, after deductible
<b>Inpatient hospital</b> <sup>1</sup>	0%, after deductible	50%, after deductible
<b>Inpatient habilitative care</b> <sup>1</sup> 30-day limit*	0%, after deductible	50%, after deductible

Medical Benefits	In-network	Out-of-network
<b>Inpatient rehabilitative care</b> <sup>1</sup> 30-day limit*	0%, after deductible	50%, after deductible
<b>Outpatient habilitative care</b> Occupational, physical, speech therapy; 30-60 combined visit limit per year depending on condition*	0%, after deductible	50%, after deductible
<b>Outpatient rehabilitative care</b> Occupational, physical, speech therapy; 30-60 combined visit limit per year depending on condition*	0%, after deductible	50%, after deductible
<b>Skilled nursing facility care</b> <sup>1</sup> 60-day limit*	0%, after deductible	50%, after deductible
<b>Radiology, labs</b> <sup>1</sup>	0%, after deductible	50%, after deductible
<b>Lab(s)</b> <sup>1</sup>	0%, after deductible	50%, after deductible
<b>Specialized surgical procedures</b> <sup>1</sup> Spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis	0%, after deductible	50%, after deductible
<b>High tech imaging</b> <sup>1</sup> MRI, CT, PET, SPECT scans	0%, after deductible	50%, after deductible
<b>Mental health and chemical dependency/substance abuse</b> <sup>1</sup> Inpatient and residential care	0%, after deductible	50%, after deductible
<b>Allergy injections</b>	0%, after deductible	50%, after deductible
<b>Injectable drugs</b> <sup>1</sup> And other drugs administered other than orally (when rendered in the office)	0%, after deductible	50%, after deductible
<b>Ambulance, ground</b>	0%, after deductible	0%, after deductible
<b>Ambulance, air</b>	0%, after deductible	0%, after deductible
<b>Durable medical equipment (DME)</b> <sup>1</sup> Includes prosthetics, orthotics	0%, after deductible	50%, after deductible
<b>Home health care</b>	0%, after deductible	50%, after deductible
<b>Hospice</b> Respite care covered up to max 5 consecutive days, and 30 days lifetime	0%, after deductible	50%, after deductible
<b>Pediatric vision routine exam (ages 0-19)</b>	0%, after deductible	50%, after deductible
<b>Pediatric vision hardware (ages 0-19)</b>	0%, after deductible	50%, after deductible
<b>Hearing aids</b> <sup>1</sup>	0%, after deductible	50%, after deductible
<b>Transplants</b> <sup>1</sup>	0%, after deductible	50%, after deductible
<b>Biofeedback</b> Limited to 10 lifetime visits*	0%, after deductible	50%, after deductible
<b>Cardiac rehabilitation</b>	0%, after deductible	50%, after deductible

Medical Benefits	In-network	Out-of-network
Diabetes education	0%, after deductible	50%, after deductible
Nutritional counseling	0%, after deductible	50%, after deductible
Diabetic supplies	0%, after deductible	50%, after deductible
Alternative care \$1,000 combined limit for massage, chiropractic, acupuncture	0%, after deductible	50%, after deductible

Pharmacy Benefits	In-network	Out-of-network Not covered unless urgent or emergent
Tier 1: Preventive	\$0, not subject to deductible	50%, after deductible
Tier 2: Generic <sup>1</sup>	0%, after deductible	50%, after deductible
Tier 3: Preferred <sup>1</sup>	0%, after deductible	50%, after deductible
Tier 4: Non-preferred <sup>1</sup>	0%, after deductible	50%, after deductible
Tier 5: High-cost specialty drugs <sup>1</sup>	0%, after deductible	50%, after deductible

<sup>1</sup> May require Prior Authorization. See Prior Authorization list or Formulary for specific services or drugs that require authorization.

\* Limits do not apply to those services rendered to members with a Mental Health or Chemical Dependency/Substance Abuse diagnosis.

## Additional Information

### In-network providers

The covered services or supplies that you receive from an in-network provider who has a contract with Samaritan Health Plans and who has agreed to provide services to members of a plan. You generally will have a reduced out-of-pocket expense if you see a provider in the network.

### Out-of-network providers

Hospitals, physicians, providers, professionals and facilities that have not contracted with Samaritan Health Plans to provide benefits to persons covered under this plan (sometimes referred to as non-participating providers). Out-of-network providers will be reimbursed at the allowable fee for the service provided.

### Deductible and out-of-pocket maximums

Please refer to the additional information provided in your Member Certificate for a further explanation of benefits including limitations and exclusions.

### Your Deductible

The portion of the cost of covered services a member is obligated to pay before the plan will provide payment for benefits. Deductibles do not apply to preventive benefits. Both the deductible and out-of-pocket maximum are accumulated on a calendar year basis.

### Out-of-pocket limit

The maximum amount you must pay for essential health benefits (for example, deductibles, coinsurance and copays) during a calendar plan year before the plan begins to pay 100% of the allowed amount. The out-of-pocket limit for a calendar year will not exceed the annual cost sharing limit for such year as established by the U.S. Centers for Medicare and Medicaid. The out-of-pocket limit is accumulated on a calendar year.

Expenses for the following DO NOT count toward your out-of-pocket maximum limit:

- Charges over usual, customary, and reasonable amounts
- Benefits paid in full
- Incurred charges that exceed amounts allowed under this plan
- Non-medically necessary services, such as excluded services or those deemed to be not medically necessary by the plan
- Non-covered services, including those where a third party is responsible (COB, settlements, motor vehicle claims)

### Member services department

The Samaritan Health Plans home office in Corvallis is maintained to meet your servicing needs. Contact us at: 541-768-4550, toll free 1-800-832-4580 or TTY 1-800-735-2900. Our Member Services Department hours are 8 a.m. to 8 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 Small Group Benefit Plan  
Samaritan Health Plans  
2300 NW Walnut Boulevard  
Corvallis, OR 97330  
samhealthplans.org