

# Performance Silver 2000 Tier 3 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 Silver 2000 Tier 3	
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	\$2,000 per individual \$4,000 per family	\$4,000 per individual \$8,000 per family
<b>Out-of-pocket maximum</b> Per calendar year Combined medical and pharmacy	\$7,900 per individual \$15,800 per family	\$15,800 per individual \$31,600 per family
<b>Primary care</b> Office visits, in-office procedures	\$50, not subject to deductible	70%, after deductible
<b>Urgent care</b>	\$90, not subject to deductible	\$90, not subject to deductible
<b>Specialty care</b> Office visits, in-office procedures	\$70, not subject to deductible	70%, after deductible
<b>Emergency care</b> Waived if admitted to hospital	\$500, then 50%, after deductible	\$500, then 50%, after deductible
<b>Mental health and chemical dependency/substance abuse</b> Office visits	\$50, not subject to deductible	70%, 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	70%, after deductible
<b>Outpatient surgery</b> <sup>1</sup> Facility and professional charges	50%, after deductible	70%, after deductible
<b>Outpatient services</b> <sup>1</sup> Dialysis, chemotherapy, infusion, and radiation therapy	50%, after deductible	70%, after deductible
<b>Inpatient hospital</b> <sup>1</sup>	50%, after deductible	70%, after deductible
<b>Inpatient habilitative care</b> <sup>1</sup> 30-day limit*	50%, after deductible	70%, after deductible

Medical Benefits	In-network	Out-of-network
<b>Inpatient rehabilitative care</b> <sup>1</sup> 30-day limit*	50%, after deductible	70%, after deductible
<b>Outpatient habilitative care</b> Occupational, physical, speech therapy; 30-60 combined visit limit per year depending on condition*	\$70, after deductible	70%, after deductible
<b>Outpatient rehabilitative care</b> Occupational, physical, speech therapy; 30-60 combined visit limit per year depending on condition*	\$70, after deductible	70%, after deductible
<b>Skilled nursing facility care</b> <sup>1</sup> 60-day limit*	\$0, not subject to deductible	70%, after deductible
<b>Radiology</b> <sup>1</sup>	50%, after deductible	70%, after deductible
<b>Lab(s)</b> <sup>1</sup>	50%, not subject to deductible	70%, after deductible
<b>Specialized surgical procedures</b> <sup>1</sup> Spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis	50%, not subject to deductible	70%, after deductible
<b>High tech imaging</b> <sup>1</sup> MRI, CT, PET, SPECT scans	50%, after deductible	70%, after deductible
<b>Mental health and chemical dependency/substance abuse</b> <sup>1</sup> Inpatient and residential care	50%, not subject to deductible	70%, after deductible
<b>Allergy injections</b>	\$5, after deductible	70%, after deductible
<b>Injectable drugs</b> <sup>1</sup> And other drugs administered other than orally (when rendered in the office)	50%, after deductible	70%, after deductible
<b>Ambulance, ground</b>	50%, after deductible	50%, after deductible
<b>Ambulance, air</b>	50%, after deductible	50%, after deductible
<b>Durable medical equipment (DME)</b> Includes prosthetics, orthotics	50%, after deductible	70%, after deductible
<b>Home health care</b>	50%, after deductible	70%, after deductible
<b>Hospice</b> Respite care covered up to max 5 consecutive days, and 30 days lifetime	50%, after deductible	70%, after deductible
<b>Pediatric vision routine exam (ages 0-19)</b>	\$0, not subject to deductible	70%, after deductible
<b>Pediatric vision hardware (ages 0-19)</b>	Lenses - \$0, not subject to deductible Frames and Contacts – Each covered up to \$150 per calendar year, not subject to deductible	70%, after deductible
<b>Hearing aids</b> <sup>1</sup>	50%, after deductible	70%, after deductible
<b>Transplants</b> <sup>1</sup>	50%, after deductible	70%, after deductible
<b>Biofeedback</b> Limited to 10 lifetime visits*	\$50, not subject to deductible	70%, after deductible
<b>Cardiac rehabilitation</b>	\$70, after deductible	70%, after deductible

Medical Benefits	In-network	Out-of-network
Diabetes education	\$0, not subject to deductible	70%, after deductible
Nutritional counseling	\$0, not subject to deductible	70%, after deductible
Diabetic supplies	\$0, not subject to deductible	70%, after deductible
Alternative care \$1,000 combined limit for massage, chiropractic, acupuncture	\$25, not subject to deductible	70%, after deductible

Pharmacy Benefits	In-network	Out-of-network
Tier 1: Preventive	\$0, not subject to deductible	70%, after deductible
Tier 2: Generic <sup>1</sup>	\$15, not subject to deductible	70%, after deductible
Tier 3: Preferred <sup>1</sup>	\$50, not subject to deductible	70%, after deductible
Tier 4: Non-preferred <sup>1</sup>	\$100, not subject to deductible	70%, after deductible
Tier 5: High-cost specialty drugs <sup>1</sup>	50%, not subject to deductible	70%, 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.

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