

# COHO PLAN 2012 MEDICAL BENEFIT SUMMARY

## DEDUCTIBLES

The amount that a covered person must contribute toward payment of eligible medical expenses. Deductible amounts apply to all services covered under this plan with the exception of primary care provider office visits and preventive care services. A minimum of three family members must meet their annual individual deductible in order to satisfy the family deductible. The Annual Deductibles are as follows:

Type	In Network	Out of Network
Individual	\$500	\$1000
Family	\$1500	\$3000

If a member reaches the deductible amount for In Network and then seeks services from an Out Of Network provider, the accumulated In Network deductible will not apply towards the Out of network deductible.

Out of Network deductibles do not accumulate towards In Network deductibles.

## COINSURANCE

The percentage shown in the charts on the following pages, is the percentage the Plan will pay for allowable and/or usual and customary amounts (after deductibles are satisfied and in addition to copayments). Coinsurance amounts vary by network utilization and service.

## COPAYMENTS

The amount payable by the covered person for services rendered by a provider or for prescription drug purchases. The copayments are shown in the *Schedule of Benefits* on page 2. The covered person selects a provider and pays the provider the copayment. The copayment will not be applied toward the following:

- Deductible
- Coinsurance
- Out-of-Pocket Maximums

## OUT-OF-POCKET

The amount paid by the member. Once the member has paid the maximum amount, the Plan will pay all further covered services at 100% of the allowable charges or the usual, customary, and reasonable fee levels, not to exceed contracted rates, for the rest of that calendar year. A minimum of three family members must meet their annual individual out of pocket maximum in order to satisfy the family out of pocket maximum.

Type	In Network	Out of Network
Individual	\$3500	\$7500
Family	\$10,500	\$22,500

Coinsurance amounts are accumulated toward Out-of-Pocket maximum amounts on a calendar year basis. Members are still responsible for copayments after Out-of-Pocket maximums are reached.

The In Network and Out of Network Out-of-Pocket maximums will track as separate buckets (meaning that dollars that accumulate towards one maximum will not count toward the other maximum).

The following charges do not accumulate toward the out of pocket maximum:

- Deductibles
- Copayments
- Charges not covered by the Plan
- Prior Authorization penalties
- Prescription copayments
- Expenses covered under the vision and dental plans.

## SCHEDULE OF BENEFITS

### MEDICAL

This section is a listing of those medical services, supplies and conditions which are covered by the Plan.

Except as otherwise noted below, covered medical expenses are the allowable charges or the usual, customary and reasonable charges for services listed below and which are incurred by a covered person - subject to the definitions, limitations and exclusions and all other provisions of the Plan Document. In general, services and supplies must be approved by a Physician and must be medically necessary for the care and treatment of a covered sickness, accidental injury, pregnancy or other covered health care condition.

For benefit purposes medical expenses shall be deemed to be incurred on the latest of the following dates:

- the date a purchase is contracted (or)
- the date delivery is made (or)
- the actual date a service is rendered.

If any covered medical service is provided during the course of a PCP or Specialist office visit or during inpatient or outpatient treatment, benefits will be paid at the respective levels.

<b>Co-Pay Schedule</b>			
<i>All co-pays amounts apply to In Network only with the exception of Emergency Services.</i>			
Type		<b>Co-Insurance</b>	
		<i>Applies after deductible</i>	
		<i>In Network</i>	<i>Out of Network</i>
Primary Care Provider (PCP) Visits- Office or Clinic	\$30	100%	40%
Urgent Care Services	\$50	80%	40%
Emergency Services	\$200	80%	80%
Inpatient/Hospital Services	\$100/day (\$500 max)	80%	40%

**Covered Services** (see page 3)

*Deductibles apply to all covered services with the exception of PCP office visits and preventive care services.*

For Prior Authorization requirements, see page 4.

For more detailed Plan information, refer to our Plan Document at [www.samhealth.org/Healthplans](http://www.samhealth.org/Healthplans).

Service Type	Co-Insurance <i>Applies after deductible</i>	
	In Network	Out of Network
Allergy Testing & Injections	80%	40%
Ambulance	80%	80%
Anesthesia	80%	40%
Blood Transfusions	80%	40%
Chemotherapy	80%	40%
Chiropractic Care \$20 (Limited to 1 manipulation per day, 20 per year) after deductible	n/a	n/a
Contraception (other than pharmaceutical)	80%	40%
Diagnostic Services	80%	40%
Diagnostic Radiology (CT, PET, MRI, MRA)	80%	40%
Drugs- Inpatient	80%	40%
Durable Medical Equipment	80%	40%
Fertility Testing	80%	40%
Hearing Aids and Examinations	80%	40%
Home Health Care (Limited to 60 visits per year)	80%	40%
Hospice Care	100%	100%
Medical Eye Coverage	80%	40%
Medical Hearing Coverage	80%	40%
Medical Supplies	80%	40%
Mental Health (Office Visits, Inpatient, Residential Programs)	80%	40%
Newborn Care	80%	40%
Nutritional Counseling (Limited to 12 visits per year)	80%	40%
Occupational/Speech Therapy (Limited to \$2000 per year)	80%	40%
Outpatient Surgery	80%	40%
Physical Therapy	80%	40%
Physician Services (other than office or clinic)	80%	40%
Pregnancy (member and spouse only)	80%	40%
Preventive Care Services- No Deductible- (out of network benefit-\$500 per yr)	100%	40%
Prosthetics	80%	40%
Radiation Therapy	80%	40%
Rehabilitation Services	80%	40%
Respiratory Therapy	80%	40%
Second Surgical Opinion	80%	80%
Skilled Nursing Facility (Limited to 60 days per year)	80%	40%
Sleep Studies/Sleep Disorders	80%	40%
Specialist (office or clinic)	80%	40%
Specialized Nursing Services	80%	40%
Substance Use Disorder (Office Visits, Inpatient, Residential Programs)	80%	40%
Sterilization Procedures	80%	40%

Transplants	80%	40%
Weight Reduction/Control or Obesity (limited to \$35,000 Lifetime Benefit)	80%	40%

**PRIOR AUTHORIZATION LIST**

Authorization must be obtained prior to obtaining the services listed below. A hospital or physician who is a contracted provider may request prior authorization by phone, fax, or mail. Please call Samaritan Health Services Customer Service at 1-800- 832-4580 or 541-768-4550 or fax the prior authorization request to 1-541-768-4211. The request will be reviewed and the covered person will be notified of the number of approved hospital days for the requested admission.

Prior authorization is not a guarantee of coverage. The prior authorization program is designed ONLY to determine whether or not a proposed course of treatment is medically necessary and appropriate. Benefits under the Plan will depend upon the person’s eligibility for coverage and the Plan’s limitations and exclusions.

**If services are received from a non-contracted provider, the member is responsible to make certain the compliance procedures of this program are completed.** To minimize the risk of reduced benefits, an Employee should contact Samaritan Health Services to make sure that the hospital or attending physician has initiated the necessary prior authorization process. Prior authorization by the Plan is required for the following medical services and surgical procedures:

- Emergency Admissions, notification required within 48 hours
- Clinical Trials
- Chemotherapy and Dialysis
- Durable Medical Equipment (DME) including insulin pumps, prosthesis, oxygen, and oxygen supplies, with line items 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 and / or services (for the following):
  - o Allergy testing
  - o Bariatric surgery
  - o Genetic testing except standard prenatal testing which includes Cystic Fibrosis where indicated
  - o Home health services
  - o Hysterectomy
  - o Laminectomy, with or without fusion
  - o Pain management clinics-hospital based outpatient only
  - o Palatoplasty
  - o Reconstructive surgery – regardless of place of service
  - o Sclerotherapy
  - o Sleep study
  - o Tonsillectomy and adenoidectomy
  - o Uvulopharyngopalatoplasty
- Inpatient Hospital Care, including:
  - o Mental Health and Substance Abuse
  - o Exception of Maternity delivery services\*
  - o Rehabilitative Services
- Potentially cosmetic and/or experimental surgery and services
- Radiological Services (for the following):
  - o Computer Axial Tomography (CT) Scan
  - o Positron Emission Tomography (PET) Scans
  - o Magnetic Resonance Angiography (MRA)
  - o Magnetic Resonance Imaging (MRI)
  - o Virtual Colonoscopy
- Residential and Inpatient Treatment for chemical dependency and mental health.
- Skilled nursing facility services
- Transplant services (Including Evaluation)
- Specialty Medication (preauthorization from Healthtrans-call 1-866-805-1690)

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

Emergency Services will not require prior authorization in accordance with Patient Protection and Affordability Care Act. We request notification of any emergency admissions and observation stays, which are not previously described in this document, which exceed 48 hours in order to ensure that all of the member’s care is appropriately coordinated.

If the prior authorization requirements are not completed by the member and provider for non-contracted facilities or providers or if the claim is retro-authorized, a \$200 penalty will be imposed. If no authorization is obtained, the claim will be denied.

Any additional share of expenses which becomes the member’s responsibility for failure to comply with these requirements will not be considered eligible medical expenses and will not apply to any deductible, coinsurance, or out-of-pocket maximum of the Plan.

If the prior authorization requirements are not completed by the member for non-contracted facilities or providers, or if the claim is retro-authorized, a \$200 penalty will be imposed. If no authorization is obtained, the claim will be denied.

Any additional share of expenses which becomes the member’s responsibility for failure to comply with these requirements will not be considered eligible medical expenses and will not apply to any deductible, coinsurance, or out-of-pocket maximums of the Plan.

## PHARMACEUTICAL

Pharmaceutical Services		
Type	Co Pay	
	30 Day Supply	90 Day Supply
Generic RX	<i>the greater of \$15 or 20% with a maximum of \$30</i>	<i>the greater of \$37.50 or 20% with a maximum of \$75</i>
Formulary RX	<i>the greater of \$35 or 20% with a maximum of \$70</i>	<i>the greater of \$87.50 or 20% with a maximum of \$175</i>
Non Formulary RX	<i>the greater of \$60 or 20% with a maximum of \$120</i>	<i>the greater of \$150 or 20% with a maximum of \$300</i>
Specialty Medications- Prior Authorization Required from Healthtrans	<i>Lesser of \$250 or 20% coinsurance</i>	NA

Outpatient prescription drugs can be obtained from any pharmacy that recognizes HealthTrans Pharmaceutical coverage. Reference the HealthTrans website at [www.healthtrans.com](http://www.healthtrans.com) for valuable information and forms or call 1-877-839-8119.

## VISION

Vision benefits are administered by VSP. VSP in network providers must be used to ensure maximum benefits. Reference the VSP website at [www.vsp.com](http://www.vsp.com) for valuable information and forms or call 1-800-877-7195.

Covered services include:

- Exam with refraction - every 12 months
- Lenses - every 12 months (single vision, lined bifocal and lined trifocal lenses)
- Frames - every 24 months (up to \$120, with a 20% discount off any out of pocket costs)
- Contacts - every 12 months (including fitting and evaluation up to \$105). If Contacts are chosen, member will be eligible for a frame 12 months from the date the contacts were obtained.

Co-pays:

- Exam \$10.00
- Prescription Glasses – one-time \$25.00 for lenses and/or frames
- Contact Lens Exam- \$60\*

If services are obtained from an out of network provider, co pays still apply excluding the contact lens exam co pay. Lesser benefit levels will apply, resulting in higher out of pocket costs. Payment in full is required at time of appointment. The member then submits claim directly to VSP for partial reimbursement. See separate VSP documentation for additional information.

\*The contact lens exam (fitting and evaluation) is covered in full with a co pay not to exceed \$60 for all contact lens wearers (standard and premium fit). Members will also receive 15% off the contact lens exam. Contact lens exam co pays and discounts are not applicable out of network.