

Performance Gold 2000 Tier 1 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 Gold 2000 Tier 1	
Wellness Services	In-network	Out-of-network
Individual Wellness Assessment Interactive, online questionnaire that evaluates lifestyle and its impact on good health.	\$0, not subject to deductible	Not covered
Health Risk Screening Blood test identifies risks for certain diseases and medical conditions.	\$0, not subject to deductible	Not covered
Health Risk Score and Report 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
Personal Health Coaching 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
Deductible Per calendar year Combined medical and pharmacy	\$2,000 per individual \$4,000 per family	\$4,000 per individual \$8,000 per family
Out-of-pocket maximum Per calendar year Combined medical and pharmacy	\$7,900 per individual \$15,800 per family	\$15,800 per individual \$31,600 per family
Primary care Office visits, in-office procedures	\$25, not subject to deductible	50%, after deductible
Urgent care	\$60, not subject to deductible	\$60, not subject to deductible
Specialty care Office visits, in-office procedures	\$45, not subject to deductible	50%, after deductible
Emergency care Waived if admitted to hospital	\$300, then 20%, after deductible	\$300, then 20%, after deductible
Mental health and chemical dependency/substance abuse Office visits	\$25, not subject to deductible	50%, after deductible
Preventive care and services Including well baby care, routine physicals, routine gynecological exams, immunizations, colorectal screening, ACA required services	\$0, not subject to deductible	50%, after deductible
Outpatient surgery ¹ Facility and professional charges	20%, after deductible	50%, after deductible
Outpatient services ¹ Dialysis, chemotherapy, infusion, and radiation therapy	20%, after deductible	50%, after deductible
Inpatient hospital ¹	20%, after deductible	50%, after deductible
Inpatient habilitative care ¹ 30-day limit*	20%, after deductible	50%, after deductible

Medical Benefits	In-network	Out-of-network
Inpatient rehabilitative care ¹ 30-day limit*	20%, after deductible	50%, after deductible
Outpatient habilitative care Occupational, physical, speech therapy; 30-60 combined visit limit per year depending on condition*	\$45, after deductible	50%, after deductible
Outpatient rehabilitative care Occupational, physical, speech therapy; 30-60 combined visit limit per year depending on condition*	\$45, after deductible	50%, after deductible
Skilled nursing facility care ¹ 60-day limit*	\$0, not subject to deductible	50%, after deductible
Radiology ¹	20%, not subject to deductible	50%, after deductible
Lab(s) ¹	20%, not subject to deductible	50%, after deductible
Specialized surgical procedures ¹ Spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis	20%, not subject to deductible	50%, after deductible
High tech imaging ¹ MRI, CT, PET, SPECT scans	20%, not subject to deductible	50%, after deductible
Mental health and chemical dependency/substance abuse ¹ Inpatient and residential care	20%, after deductible	50%, after deductible
Allergy injections	\$5, after deductible	50%, after deductible
Injectable drugs ¹ And other drugs administered other than orally (when rendered in the office)	20%, after deductible	50%, after deductible
Ambulance, ground	20%, after deductible	20%, after deductible
Ambulance, air	20%, after deductible	20%, after deductible
Durable medical equipment (DME) ¹ Includes prosthetics, orthotics	20%, after deductible	50%, after deductible
Home health care	20%, after deductible	50%, after deductible
Hospice Respite care covered up to max 5 consecutive days, and 30 days lifetime	20%, after deductible	50%, after deductible
Pediatric vision routine exam (ages 0-19)	\$0, not subject to deductible	50%, after deductible
Pediatric vision hardware (ages 0-19)	Lenses - \$0, not subject to deductible Frames and Contacts – Each covered up to \$150 per calendar year, not subject to deductible	50%, after deductible
Hearing aids ¹	20%, after deductible	50%, after deductible
Transplants ¹	50%, after deductible	50%, after deductible
Biofeedback Limited to 10 lifetime visits*	\$25, not subject to deductible	50%, after deductible
Cardiac rehabilitation	\$45, after deductible	50%, after deductible

Medical Benefits	In-network	Out-of-network
Diabetes education	\$0, not subject to deductible	50%, after deductible
Nutritional counseling	\$0, not subject to deductible	50%, after deductible
Diabetic supplies	\$0, not subject to deductible	50%, after deductible
Alternative care \$1,000 combined limit for massage, chiropractic, acupuncture	\$25, not subject to 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 ¹	\$10, not subject to deductible	50%, after deductible
Tier 3: Preferred ¹	\$35, not subject to deductible	50%, after deductible
Tier 4: Non-preferred ¹	\$75, not subject to deductible	50%, after deductible
Tier 5: High-cost specialty drugs ¹	50%, not subject to deductible	50%, after deductible

¹ 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