

Samaritan Oregon Standard Bronze Plan 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)	Standard Bronze	
Medical Benefits	In-network	Out-of-network
Deductible Per calendar year Combined medical and pharmacy	\$6,550 per individual \$13,100 per family	\$13,100 per individual \$26,200 per family
Out-of-pocket maximum Per calendar year Combined medical and pharmacy	\$6,550 per individual \$13,100 per family	Unlimited
Primary care Office visits, in-office procedures	0%, after deductible	70%, after deductible
Urgent care	0%, after deductible	0%, after deductible
Specialty care Office visits, in-office procedures	0%, after deductible	70%, after deductible
Emergency care Waived if admitted to hospital	0%, after deductible	0%, after deductible
Mental health and chemical dependency/substance abuse Office visits	0%, after deductible	70%, 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	70%, after deductible
Outpatient surgery ¹ Facility and professional charges	0%, after deductible	70%, after deductible
Outpatient services ¹ Dialysis, chemotherapy, infusion, and radiation therapy	0%, after deductible	70%, after deductible
Inpatient hospital ¹	0%, after deductible	70%, after deductible
Inpatient habilitative care ¹ 30-day limit*	0%, after deductible	70%, after deductible
Inpatient rehabilitative care ¹ 30-day limit*	0%, after deductible	70%, after deductible
Outpatient habilitative care Occupational, physical, speech therapy; 30-60 combined visit limit per year depending on condition*	0%, after deductible	70%, after deductible
Outpatient rehabilitative care Occupational, physical, speech therapy; 30-60 combined visit limit per year depending on condition*	0%, after deductible	70%, after deductible
Skilled nursing facility care ¹ 60-day limit*	0%, after deductible	70%, after deductible
Radiology ¹	0%, after deductible	70%, after deductible
Lab(s) ¹	0%, after deductible	70%, after deductible

Medical Benefits	In-network	Out-of-network
High tech imaging ¹ MRI, CT, PET, SPECT scans	0%, after deductible	70%, after deductible
Mental health and chemical dependency/substance abuse ¹ Inpatient and residential care	0%, after deductible	70%, after deductible
Allergy injections	0%, after deductible	70%, after deductible
Injectable drugs ¹ And other drugs administered other than orally (when rendered in the office)	0%, after deductible	70%, after deductible
Ambulance, ground	0%, after deductible	0%, after deductible
Ambulance, air	0%, after deductible	0%, after deductible
Durable medical equipment (DME) ¹ Includes prosthetics, orthotics	0%, after deductible	70%, after deductible
Home health care	0%, after deductible	70%, after deductible
Hospice Respite care covered up to max 5 consecutive days, and 30 days lifetime	0%, after deductible	70%, after deductible
Pediatric vision routine exam (ages 0-19)	\$0, not subject to deductible	70%, 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	70%, after deductible
Hearing aids ¹	0%, after deductible	70%, after deductible
Transplants ¹	0%, after deductible	70%, after deductible
Biofeedback Limited to 10 lifetime visits*	0%, after deductible	70%, after deductible
Cardiac rehabilitation	0%, after deductible	70%, after deductible
Diabetes education	0%, after deductible	70%, after deductible
Nutritional counseling	0%, after deductible	70%, after deductible
Diabetic supplies	0%, after deductible	70%, after deductible

Pharmacy Benefits	In-network	Out-of-network Not covered unless urgent or emergent
Tier 1: Preventive	\$0, not subject to deductible	70%, after deductible
Tier 2: Generic ¹	0%, after deductible	70%, after deductible
Tier 3: Preferred ¹	0%, after deductible	70%, after deductible
Tier 4: Non-preferred ¹	0%, after deductible	70%, after deductible
Tier 5: High-cost specialty drugs ¹	0%, after deductible	70%, after deductible

¹May 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
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