SAMARITAN OREGON STANDARD BRONZE PLAN

FOR SMALL GROUP EMPLOYERS IN OREGON

2017 BENEFITS (Member pays)
The benefits information provided is a brief summary and not a complete description of benefits. Limitations and exclusions apply.

MEDICAL BENEFITS	BRONZE STANDARD In-network	BRONZE STANDARD Out-of-network
Deductible Per calendar year Combined medical and pharmacy	$7,150 per individual $14,300 per family	$14,300 per individual $28,600 per family
Out-of-pocket maximum Per calendar year Combined medical and pharmacy	$7,150 per individual $14,300 per family	Unlimited
Lifetime benefit maximum	None	None
Primary care [1] Office visits, in-office procedures	$70, not subject to deductible	70%, after deductible
Urgent care [1]	$100, not subject to deductible	$100, not subject to deductible
Specialist visit [1] Office visits, in office procedures	$115, not subject to deductible	70%, after deductible
Emergency care Waived if admitted to hospital	$0, after deductible	$0, after deductible
Mental health and chemical dependency [1] Office visits	$70, not subject to deductible	70%, after deductible
Preventive care and services [1] 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 (facility) [2]	$0, after deductible	70%, after deductible
Outpatient Surgery (professional) [2]	$0, after deductible	70%, after deductible
Inpatient hospital [2]	$0, after deductible	70%, after deductible
Inpatient rehabilitative/ habilitative care [2] 30 day limit*	$0, after deductible	70%, after deductible
Skilled nursing facility care [2] 60 day limit*	$0, after deductible	70%, after deductible
Radiology, labs [2]	$0, after deductible	70%, after deductible
High tech imaging [2] MRI, CT, PET Scans	$0, after deductible	70%, after deductible
Mental health and chemical dependency [2] Inpatient care and residential programs	$0, after deductible	70%, after deductible
Physical therapy (rehabilitative/ habilitative) 30-60 combined visit limit per year depending on condition*	$0, after deductible	70%, after deductible
Occupational therapy (rehabilitative/ habilitative) 30-60 combined visit limit per year depending on condition *	$0, after deductible	70%, after deductible
Speech therapy (rehabilitative/ habilitative) 30-60 combined visit limit per year depending on condition *	$0, after deductible	70%, after deductible

Samaritan Health Plans

2017 BENEFITS (Member pays)	BRONZE STANDARD	
MEDICAL BENEFITS	**In-network**	**Out-of-network**
Injectable drugs [2] 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) [2] 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, & 30 days lifetime	$0, after deductible	70%, after deductible
Hearing aids/ cochlear implants [2] 1 pair / 4 years for each impaired ear	$0, after deductible	70%, after deductible
Pediatric vision routine exam (ages 0-19) [1]	$0, after deductible (some may have cost)	70%, after deductible
Pediatric vision hardware (ages 0-19) [1]	$0, after deductible, contacts and frames are covered up to $150 per calendar year. Some lenses are at $0 after deductible. Call health plan for specific coverage and cost.	70%, after deductible
Transplants [2]	$0, after deductible	70%, after deductible
PHARMACY BENEFITS		
Preventive [1]	$0, not subject to deductible	70%, Not covered unless urgent or emergent, after deductible
Generic [1, 2]	$35, not subject to deductible	70%, Not covered unless urgent or emergent, after deductible
Preferred [2]	$0, after deductible	70%, Not covered unless urgent or emergent, after deductible
Non-preferred [2]	$0, after deductible	70%, Not covered unless urgent or emergent, after deductible
High-cost specialty drugs [2]	$0, after deductible	70%, Not covered unless urgent or emergent, after deductible

[1] Not subject to deductible. For in network services, the deductible for the Bronze Standard plan is an integrated deductible.
[2] May require Prior Authorization
*Limits do not apply to those services rendered to members with a mental health or chemical dependency diagnosis.

Samaritan Health Plans

In-network provider benefit
Patient receives care from an in-network provider or facility, which has an effective provider Plan contract with Samaritan Health Plans to provide services and supplies to the covered individuals.

Out-of-network provider benefit
Patient receives care from a provider that has no affiliation or contractual arrangement with the Plan. At the out-of-network benefit level, payment to providers is based on the Samaritan Health Plans fee allowance or the billed amount, whichever is less. The fee allowance is often lower than, or discounted from, the physician's usual charge.

Medical deductible and out-of-pocket maximums
Please refer to the additional information provided in your Member Certificate and your Summary of Benefits and Coverage for a further explanation of benefits including limitations and exclusions.

Your deductible
The deductible is the portion of covered benefit costs each member is obligated to pay before Samaritan Health Plans will provide benefits. The deductible amount for individuals and families is listed above. The deductible for the Samaritan Oregon Standard Bronze Plan is an combined deductible applicable to all services except preventive services and medications, and services specifically identified to not apply to the preferred provider deductible.

The following services, but not limited to, do not apply to your in-network provider deductible costs:

- Women's preventive services
- Men's preventive services
- Routine physical examinations
- Colorectal cancer screenings and exams
- Immunizations
- PKU test
- Well-baby/well-child care
- Outpatient diabetic instruction and supplies
- Preventive and generic medications

Your annual out-of-pocket limit
You are responsible for the co-insurance or co-payment amount for each covered medical service listed under the Plan Benefits section of your Member Certificate until your medical out-of-pocket covered expenses reach your maximum out-of-pocket cost amount. The maximum out-of-pocket medical amount accumulates based on your own covered expenses every calendar year. This plan has in-network, out-of-pocket limits to protect you from excessive medical expenses. The summary above shows your plan's annual out-of-pocket limit. If you incur covered expenses over that amount, this plan will pay 100% of eligible charges for the rest of the calendar year for those services which are applicable to the out-of-pocket limit. Out-of-network services do NOT have an out-of-pocket limit.

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)

Prescription out-of-pocket maximum
The Samaritan Oregon Standard Bronze Plan has a combined pharmacy and medical out-of-pocket (OOP) maximum.

Member services department
The Samaritan Health Plans home office in Corvallis is maintained to meet your servicing needs. Come see us at 2300 NW Walnut Boulevard or 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
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samhealthplans.org

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