SAMARITAN OREGON STANDARD SILVER PLAN

FOR SMALL GROUP EMPLOYERS IN OREGON

2018 BENEFITS (Member pays)
The benefits information provided is a brief summary and not a complete description of benefits. Limitations and exclusions apply.

	SILVER STANDARD	
MEDICAL BENEFITS	**In-network**	**Out-of-network**
Deductible Per calendar year Medical only	$2,500 per individual $5,000 per family	$5,000 per individual $10,000 per family
Out-of-pocket maximum Per calendar year Combined medical and pharmacy	$7,350 per individual $14,700 per family	Unlimited
Lifetime benefit maximum	None	None
Primary care [1] Office visits, in-office procedures	$40, not subject to deductible	70%, after deductible
Urgent care [1]	$70, not subject to deductible	$70, not subject to deductible
Specialist visit [1] Office visits, in office procedures	$80, not subject to deductible	70%, after deductible
Emergency care Waived if admitted to hospital	30%, after deductible	30%, after deductible
Mental health and chemical dependency / substance abuse [1] Office visits	$40, 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]	30%, after deductible	70%, after deductible
Outpatient surgery (professional) [2]	30%, after deductible	70%, after deductible
Inpatient hospital [2]	30%, after deductible	70%, after deductible
Inpatient habilitative care [2] 30 day limit*	30%, after deductible	70%, after deductible
Inpatient rehabilitative care [2] 30 day limit*	30%, after deductible	70%, after deductible

Samaritan Health Plans

2018 BENEFITS (Member pays)	SILVER STANDARD	
MEDICAL BENEFITS	**In-network**	**Out-of-network**
Outpatient habilitative care [1] Occupational, physical, speech therapy; 30-60 combined visit limit per year depending on condition	$40, not subject to deductible	70%, after deductible
Outpatient rehabilitative care [1] Occupational, physical, speech therapy; 30-60 combined visit limit per year depending on condition	$40, not subject to deductible	70%, after deductible
Skilled nursing facility care [2] 60 day limit*	30%, after deductible	70%, after deductible
Radiology, labs [2]	30%, after deductible	70%, after deductible
High tech imaging [2] MRI, CT, PET, SPECT scans	30%, after deductible	70%, after deductible
Mental health and chemical dependency / substance abuse [2] Inpatient care and residential programs	30%, after deductible	70%, after deductible
Injectable drugs And other drugs administered other than orally (when rendered in the office)	30%, after deductible	70%, after deductible
Ambulance, ground	30%, after deductible	30%, after deductible
Ambulance, air	30%, after deductible	30%, after deductible
Durable medical equipment (DME) [2] Includes prosthetics, orthotics	30%, after deductible	70%, after deductible
Home health care	30%, after deductible	70%, after deductible
Hospice Respite care covered up to max 5 consecutive days, & 30 days lifetime	30%, after deductible	70%, after deductible
Hearing aids / cochlear implants 1 pair / 48 months for each impaired ear	30%, after deductible	70%, after deductible
Pediatric vision routine exam (ages 0-19)	$0, for specific codes. Cost share may apply for other codes. Call health plan for specific coverage information.	70%, after deductible
Pediatric vision hardware (ages 0-19)	$0, for specific codes. Cost share may apply for other codes. Contacts and frames are each covered up to $150 per calendar year. Call health plan for specific coverage information.	70%, after deductible

2018 BENEFITS (Member pays)	SILVER STANDARD	
MEDICAL BENEFITS	**In-network**	**Out-of-network**
Transplants [2]	30%, after deductible	70%, after deductible
Diabetes education [1]	$0, not subject to deductible	70%, after deductible
Nutritional counseling [1]	$0, not subject to deductible	70%, after deductible
Diabetic supplies [1]	$0, not subject to deductible	70%, after deductible
PHARMACY BENEFITS	**In-network**	**Out-of-network**
Deductible Per calendar year	$0 per individual $0 per family	Combined with medical
Tier 1: Preventive [1]	$0, not subject to deductible	70%, not covered unless urgent or emergent, after deductible
Tier 2: Generic [1, 2]	$15, not subject to deductible	70%, not covered unless urgent or emergent, after deductible
Tier 3: Preferred [1, 2]	$60, not subject to deductible	70%, not covered unless urgent or emergent, after deductible
Tier 4: Non-preferred [1, 2]	50%, not subject to deductible	70%, not covered unless urgent or emergent, after deductible
Tier 5: High-cost specialty drugs [1, 2]	50%, not subject to deductible	70%, not covered unless urgent or emergent, after deductible

[1] Not subject to deductible. The deductible for the Samaritan Silver Standard Plan applies to all services except prescription drugs, preventive services, office visits and urgent care.

[2] May require Prior Authorization. See Prior Authorization list for 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.

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 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 Silver Plan applies to all services except prescription drugs, preventive services, office visits and urgent care.

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
- Office visits
- Urgent care
- Physical therapy
- Occupational therapy
- Speech therapy
- Outpatient diabetic instruction and supplies
- Covered 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 Silver Plan does not have a separate pharmacy deductible, but a combined 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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Samaritan Health Plans