Performance Silver 3500 HSA
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 Silver 3500 HSA	
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	$3,500 per individual $7,000 per family	$7,000 per individual $14,000 per family
Out-of-pocket maximum Per calendar year Combined medical and pharmacy	$6,750 per individual $13,500 per family	Unlimited
Primary care Office visits, in-office procedures	20%, after deductible	50%, after deductible
Urgent care	20%, after deductible	20%, after deductible
Specialty care Office visits, in-office procedures	20%, after deductible	50%, after deductible
Emergency care Waived if admitted to hospital	20%, after deductible	20%, after deductible
Mental health and chemical dependency/substance abuse Office visits	20%, after 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

Samaritan Health Plans

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*	20%, after deductible	50%, after deductible
Outpatient rehabilitative care Occupational, physical, speech therapy; 30-60 combined visit limit per year depending on condition*	20%, after deductible	50%, after deductible
Skilled nursing facility care [1] 60-day limit*	20%, after deductible	50%, after deductible
Radiology [1]	20%, after deductible	50%, after deductible
Lab(s) [1]	20%, after deductible	50%, after deductible
Specialized surgical procedures [1] Spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis	20%, after deductible	50%, after deductible
High tech imaging [1] MRI, CT, PET, SPECT scans	20%, after deductible	50%, after deductible
Mental health and chemical dependency/substance abuse [1] Inpatient and residential care	20%, after deductible	50%, after deductible
Allergy injections	20%, 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)	20%, after deductible	50%, after deductible
Pediatric vision hardware (ages 0-19)	20%, after 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*	20%, after deductible	50%, after deductible
Cardiac rehabilitation	20%, after deductible	50%, after deductible

Medical Benefits	In-network	Out-of-network
Diabetes education	20%, after deductible	50%, after deductible
Nutritional counseling	20%, after deductible	50%, after deductible
Diabetic supplies	20%, after deductible	50%, after deductible
Alternative care $1,000 combined limit for massage, chiropractic, acupuncture	20%, after 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]	20%, after deductible	50%, after deductible
Tier 3: Preferred [1]	20%, after deductible	50%, after deductible
Tier 4: Non-preferred [1]	20%, after deductible	50%, after deductible
Tier 5: High-cost specialty drugs [1]	50%, after 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
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