Performance Silver 6850 Tier 3
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 6850 Tier 3
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<table>
<thead>
<tr>
<th>Wellness Services</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Wellness Assessment</td>
<td>$0, not subject to deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Health Risk Screening</td>
<td>$0, not subject to deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Health Risk Score and Report</td>
<td>$0, not subject to deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Personal Health Coaching</td>
<td>$0, not subject to deductible</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$6,850 per individual $13,700 per family</td>
<td>$10,000 per individual $20,000 per family</td>
</tr>
<tr>
<td>Out-of-pocket maximum</td>
<td>$7,900 per individual $15,800 per family</td>
<td>$15,800 per individual $31,600 per family</td>
</tr>
<tr>
<td>Primary care</td>
<td>$50, not subject to deductible</td>
<td>70%, after deductible</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$90, not subject to deductible</td>
<td>$90, not subject to deductible</td>
</tr>
<tr>
<td>Specialty care</td>
<td>$70, not subject to deductible</td>
<td>70%, after deductible</td>
</tr>
<tr>
<td>Emergency care</td>
<td>$500, then 50%, after deductible</td>
<td>$500, then 50%, after deductible</td>
</tr>
<tr>
<td>Mental health and chemical dependency/substance abuse</td>
<td>$50, not subject to deductible</td>
<td>70%, after deductible</td>
</tr>
<tr>
<td>Preventive care and services</td>
<td>$0, not subject to deductible</td>
<td>70%, after deductible</td>
</tr>
<tr>
<td>Outpatient surgery</td>
<td>50%, after deductible</td>
<td>70%, after deductible</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>50%, after deductible</td>
<td>70%, after deductible</td>
</tr>
<tr>
<td>Inpatient hospital</td>
<td>50%, after deductible</td>
<td>70%, after deductible</td>
</tr>
<tr>
<td>Inpatient habilitative care</td>
<td>50%, after deductible</td>
<td>70%, after deductible</td>
</tr>
</tbody>
</table>

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1. 30-day limit*
<table>
<thead>
<tr>
<th>Medical Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient rehabilitative care</strong></td>
<td>$50%, after deductible</td>
<td>$70%, after deductible</td>
</tr>
<tr>
<td>30-day limit*</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient habilitative care</strong></td>
<td>$70, after deductible</td>
<td>$70%, after deductible</td>
</tr>
<tr>
<td>Occupational, physical, speech therapy; 30-60 combined visit limit per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>depending on condition*</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient rehabilitative care</strong></td>
<td>$70, after deductible</td>
<td>$70%, after deductible</td>
</tr>
<tr>
<td>Occupational, physical, speech therapy; 30-60 combined visit limit per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>depending on condition*</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Skilled nursing facility care</strong></td>
<td>$0, not subject to deductible</td>
<td>$70%, after deductible</td>
</tr>
<tr>
<td>60-day limit*</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Radiology</strong></td>
<td>$50%, after deductible</td>
<td>$70%, after deductible</td>
</tr>
<tr>
<td><strong>Lab(s)</strong></td>
<td>$50%, not subject to deductible</td>
<td>$70%, after deductible</td>
</tr>
<tr>
<td><strong>Specialized surgical procedures</strong></td>
<td>$50%, not subject to deductible</td>
<td>$70%, after deductible</td>
</tr>
<tr>
<td>Spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>High tech imaging</strong></td>
<td>$50%, after deductible</td>
<td>$70%, after deductible</td>
</tr>
<tr>
<td>MRI, CT, PET, SPECT scans</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental health and chemical dependency/substance abuse</strong></td>
<td>$50%, not subject to deductible</td>
<td>$70%, after deductible</td>
</tr>
<tr>
<td>Inpatient and residential care</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Allergy injections</strong></td>
<td>$5, after deductible</td>
<td>$70%, after deductible</td>
</tr>
<tr>
<td><strong>Injectable drugs</strong></td>
<td>$50%, after deductible</td>
<td>$70%, after deductible</td>
</tr>
<tr>
<td>And other drugs administered other than orally (when rendered in the office)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance, ground</strong></td>
<td>$50%, after deductible</td>
<td>$50%, after deductible</td>
</tr>
<tr>
<td><strong>Ambulance, air</strong></td>
<td>$50%, after deductible</td>
<td>$50%, after deductible</td>
</tr>
<tr>
<td><strong>Durable medical equipment (DME)</strong></td>
<td>$50%, after deductible</td>
<td>$70%, after deductible</td>
</tr>
<tr>
<td>Includes prosthetics, orthotics</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home health care</strong></td>
<td>$50%, after deductible</td>
<td>$70%, after deductible</td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td>$50%, after deductible</td>
<td>$70%, after deductible</td>
</tr>
<tr>
<td>Respite care covered up to max 5 consecutive days,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and 30 days lifetime</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pediatric vision routine exam (ages 0-19)</strong></td>
<td>$0, not subject to deductible</td>
<td>$70%, after deductible</td>
</tr>
<tr>
<td><strong>Pediatric vision hardware (ages 0-19)</strong></td>
<td>Lenses - $0, not subject to deductible Frames and Contacts – Each covered up to $150 per calendar year, not subject to deductible</td>
<td>$70%, after deductible</td>
</tr>
<tr>
<td><strong>Hearing aids</strong></td>
<td>$50%, after deductible</td>
<td>$70%, after deductible</td>
</tr>
<tr>
<td><strong>Transplants</strong></td>
<td>$50%, after deductible</td>
<td>$70%, after deductible</td>
</tr>
<tr>
<td><strong>Biofeedback</strong></td>
<td>$50, not subject to deductible</td>
<td>$70%, after deductible</td>
</tr>
<tr>
<td>Limited to 10 lifetime visits*</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cardiac rehabilitation</strong></td>
<td>$70, after deductible</td>
<td>$70%, after deductible</td>
</tr>
</tbody>
</table>
## Medical Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes education</td>
<td>$0, not subject to deductible</td>
<td>70%, after deductible</td>
</tr>
<tr>
<td>Nutritional counseling</td>
<td>$0, not subject to deductible</td>
<td>70%, after deductible</td>
</tr>
<tr>
<td>Diabetic supplies</td>
<td>$0, not subject to deductible</td>
<td>70%, after deductible</td>
</tr>
<tr>
<td>Alternative care</td>
<td>$25, not subject to deductible</td>
<td>70%, after deductible</td>
</tr>
<tr>
<td>$1,000 combined limit for massage,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>chiropractic, acupuncture</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Pharmacy Benefits

<table>
<thead>
<tr>
<th>Tier</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1: Preventive</td>
<td>$0, not subject to deductible</td>
<td>70%, after deductible</td>
</tr>
<tr>
<td>Tier 2: Generic ¹</td>
<td>$15, not subject to deductible</td>
<td>70%, after deductible</td>
</tr>
<tr>
<td>Tier 3: Preferred ¹</td>
<td>$50, not subject to deductible</td>
<td>70%, after deductible</td>
</tr>
<tr>
<td>Tier 4: Non-preferred ¹</td>
<td>$100, not subject to deductible</td>
<td>70%, after deductible</td>
</tr>
<tr>
<td>Tier 5: High-cost specialty drugs ¹</td>
<td>50%, not subject to deductible</td>
<td>70%, after deductible</td>
</tr>
</tbody>
</table>

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
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Corvallis, OR 97330
samhealthplans.org