Performance Gold 3000 Tier 1
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)

<table>
<thead>
<tr>
<th>Wellness Services</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wellness Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Wellness Assessment</td>
<td>Interactive, online questionnaire that evaluates lifestyle and its impact on good health.</td>
<td>$0, not subject to deductible</td>
</tr>
<tr>
<td>Health Risk Screening</td>
<td>Blood test identifies risks for certain diseases and medical conditions.</td>
<td>$0, not subject to deductible</td>
</tr>
<tr>
<td>Health Risk Score and Report</td>
<td>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.</td>
<td>$0, not subject to deductible</td>
</tr>
<tr>
<td>Personal Health Coaching</td>
<td>A trained, certified professional provides confidential, one-on-one sessions to assist members in reaching their health and wellness goals.</td>
<td>$0, not subject to deductible</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><strong>Medical Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td>Per calendar year Composed medical and pharmacy $3,000 per individual $6,000 per family</td>
<td>$6,000 per individual $12,000 per family</td>
</tr>
<tr>
<td>Out-of-pocket maximum</td>
<td>Per calendar year Composed medical and pharmacy $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>Office visits, in-office procedures $25, not subject to deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$60, not subject to deductible</td>
<td>$60, not subject to deductible</td>
</tr>
<tr>
<td>Specialty care</td>
<td>Office visits, in-office procedures $45, not subject to deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Emergency care</td>
<td>$300, then 20%, after deductible</td>
<td>$300, then 20%, after deductible</td>
</tr>
<tr>
<td>Mental health and chemical dependency/substance abuse</td>
<td>Office visits $25, not subject to deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Preventive care and services</td>
<td>Including well baby care, routine physicals, routine gynecological exams, immunizations, colorectal screening, ACA required services $0, not subject to deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Outpatient surgery ¹</td>
<td>Facility and professional charges 20%, after deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Outpatient services ¹</td>
<td>Dialysis, chemotherapy, infusion, and radiation therapy 20%, after deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Inpatient hospital ¹</td>
<td>20%, after deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Inpatient habilitative care ¹</td>
<td>30-day limit* 20%, after deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Medical Benefits</td>
<td>In-network</td>
<td>Out-of-network</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>---------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Inpatient rehabilitative care 1</td>
<td>20%, after deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>30-day limit*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient habilitative care</td>
<td>$45, after deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Occupational, physical, speech therapy; 30-60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>combined visit limit per year depending on condition*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient habilitative care</td>
<td>$45, after deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Occupational, physical, speech therapy; 30-60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>combined visit limit per year depending on condition*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing facility care 1</td>
<td>$0, not subject to deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>60-day limit*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology 1</td>
<td>20%, not subject to deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Lab(s) 1</td>
<td>20%, not subject to deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Specialized surgical procedures 1</td>
<td>20%, not subject to deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Spine surgery for pain, arthroscopies, shoulder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>surgery for osteoarthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High tech imaging 1</td>
<td>20%, not subject to deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>MRI, CT, PET, SPECT scans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health and chemical dependency/substance abuse 1</td>
<td>20%, after deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Inpatient and residential care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy injections</td>
<td>$5, after deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Injectable drugs 1</td>
<td>20%, after deductible</td>
<td>50%, 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>Ambulance, ground</td>
<td>20%, after deductible</td>
<td>20%, after deductible</td>
</tr>
<tr>
<td>Ambulance, air</td>
<td>20%, after deductible</td>
<td>20%, after deductible</td>
</tr>
<tr>
<td>Durable medical equipment (DME) 1</td>
<td>20%, after deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Includes prosthetics, orthotics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>20%, after deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Hospice</td>
<td>20%, after deductible</td>
<td>50%, 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>Pediatric vision routine exam (ages 0-19)</td>
<td>$0, not subject to deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Pediatric vision hardware (ages 0-19)</td>
<td>Lenses - $0, not subject to</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Frames and Contacts – Each covered up to $150 per</td>
<td>deductible</td>
<td></td>
</tr>
<tr>
<td>calendar year, not subject to deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing aids 1</td>
<td>20%, after deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Transplants 1</td>
<td>50%, after deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Biofeedback</td>
<td>$25, not subject to deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Limited to 10 lifetime visits*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac rehabilitation</td>
<td>$45, after deductible</td>
<td>50%, 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>50%, after deductible</td>
</tr>
<tr>
<td>Nutritional counseling</td>
<td>$0, not subject to deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Diabetic supplies</td>
<td>$0, not subject to deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Alternative care</td>
<td>$25, not subject to deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>$1,000 combined limit for massage, chiropractic, acupuncture</td>
<td>$25, not subject to deductible</td>
<td>50%, after deductible</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>50%, after deductible</td>
</tr>
<tr>
<td>Tier 2: Generic</td>
<td>$10, not subject to deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Tier 3: Preferred</td>
<td>$35, not subject to deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Tier 4: Non-preferred</td>
<td>$75, not subject to deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Tier 5: High-cost specialty drugs</td>
<td>50%, not subject to deductible</td>
<td>50%, 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
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Corvallis, OR 97330
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