

SAMARITAN EVERYDAY CHOICES

FOR LARGE GROUPS 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.

SAMARITAN EVERYDAY CHOICES HIGH DEDUCTIBLE HEALTH PLAN 2500 (HSA ELIGIBLE)

WELLNESS SERVICES

Members have a \$0 cost share.
Services are coordinated by Samaritan Health Plans.
Service delivery is based on employer's needs.

The wellness services provided by Samaritan Health Plans are value added services and not part of the insured High Deductible Health Plan. There is no impact on the tax treatment of any Health Savings Account contributions or distributions as a result of utilizing these services.

Individual wellness assessment

An interactive, online questionnaire that when completed can provide you with important information, resources, and tools for your life-health and well-being.

Health risk screening

Short, confidential health examination that identifies your risk for certain diseases and medical conditions. It helps you understand where you should take action to improve your health.

Personal health coach

A trained and certified professional that works with you in confidential, one-on-one sessions to assist you in reaching your health and wellness goals.

	In-network	Out-of-network
MEDICAL BENEFITS		
Deductible Per calendar year medical & pharmacy	\$2,500 per individual \$5,000 per family	\$5,000 per individual \$10,000 per family
Out-of-pocket maximum Per calendar year medical & pharmacy	\$6,550 per individual \$13,100 per family	Unlimited
Lifetime benefit maximum	Unlimited	Unlimited
Primary care Office visits, in-office procedures, and professional charges	20%, after deductible	50%, after deductible
Urgent care	20%, after deductible	20%, after deductible
Specialty care Office visits, in-office procedures, and professional charges	20%, after deductible	50%, after deductible
Emergency care Waived if admitted to hospital	20%, after deductible	20%, after deductible
Mental health and chemical dependency Office visits	20%, after deductible	50%, after deductible
Preventive care and services ^{1,2} 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 ³ Facility and professional charges	20%, after deductible	50%, after deductible
Inpatient hospital ³	20%, after deductible	50%, after deductible
Inpatient rehabilitative care ³	20%, after deductible	50%, after deductible
Skilled nursing facility care ³ Up to 60 days per benefit year*	20%, after deductible	50%, after deductible
Radiology, labs ³	20%, after deductible	50%, after deductible

**SAMARITAN EVERYDAY CHOICES
HIGH DEDUCTIBLE HEALTH PLAN 2500
(HSA ELIGIBLE)**

2017 BENEFITS (Member pays)

In-network

Out-of-network

MEDICAL BENEFITS

Specialized surgical procedures Spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis	20%, after deductible	50%, after deductible
High tech imaging services ³ CT scans, MRIs and PET scans	20%, after deductible	50%, after deductible
Mental health and chemical dependency ³ Inpatient care	20%, after deductible	50%, after deductible
Mental health and chemical dependency ³ Residential programs	20%, after deductible	50%, after deductible
Physical therapy	20%, after deductible	50%, after deductible
Occupational therapy	20%, after deductible	50%, after deductible
Speech therapy	20%, after deductible	50%, after deductible
Allergy injections	20%, after deductible	50%, after deductible
Injectables ⁴ 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) ³ Includes prosthetics and orthotics	20%, after deductible	50%, after deductible
Home health care	20%, after deductible	50%, after deductible
Hospice	20%, after deductible	50%, after deductible
Hearing aids, cochlear implants ³	20%, after deductible	50%, after deductible
Transplants ³	50%, after deductible	50%, after deductible

PHARMACY BENEFITS

Preventive ^{1, 2, 3}	\$0, after deductible, for: • Specified generic drugs • Selected asthma medications • Tobacco cessation drugs/ supplies • Preventive medications	50%, after deductible
Generic ³	20%, after deductible	50%, after deductible
Preferred ³	20%, after deductible	50%, after deductible
Non-preferred ³	20%, after deductible	50%, after deductible
High-cost specialty drugs ³	50%, after deductible	50%, after deductible

**VISION COVERAGE AVAILABLE
ALTERNATIVE CARE RIDERS AVAILABLE**

¹ These services are not subject to the deductible.

² 100% covered by the plan

³ May require a Prior Authorization

⁴ Contact Customer Service at 541-768-4550 or 1-800-832-4580 to determine your co-pay or co-insurance levels

^{*}Limits do not apply to those services rendered to a member with a Mental Health or Chemical Dependency diagnosis

