

SAMARITAN EVERYDAY CHOICES

FOR LARGE GROUPS IN OREGON

[EMPLOYER GROUP NAME]

2018 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 OPTION 1

WELLNESS SERVICES	In-network	Out-of-network
Individual Wellness Assessment Interactive, online questionnaire that evaluates lifestyle and its impact on good health.	\$0	Not covered
Health Risk Screening Blood test identifies risks for certain diseases and medical conditions.	\$0	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 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 covered
MEDICAL BENEFITS		
Deductible Per calendar year [medical only] [medical & pharmacy]	Individual: [\$0 - \$7,350] Family: [\$0 - \$14,700]	Individual: [\$0- \$14,700] Family: [\$0 - \$29,400]
Out-of-pocket maximum Per calendar year [medical only] [medical & pharmacy]	Individual: [\$0 - \$7,350] Family: [\$0 - \$14,700]	Individual: [\$0- \$14,700] Family: [\$0 - \$29,400]
Lifetime benefit maximum	Unlimited	Unlimited
Primary care ¹ Office visits, in-office procedures, and professional charges	\$20, not subject to deductible	50%, after deductible
Urgent care ¹	\$20, not subject to deductible	\$20, not subject to deductible
Specialty care ¹ Office visits, in-office procedures, and professional charges	\$35, not subject to deductible	50%, after deductible
Radiology/Labs ^{1,2,3}	\$0, not subject to deductible	50%, after deductible
Emergency care Waived if admitted to hospital	[\$100 - \$350], after deductible	[\$100 - \$350], after deductible
Mental health and chemical dependency ¹ Office visits	\$15, not subject to 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	\$0, after deductible	50%, after deductible
Bariatric surgery/gastric banding ^{1,3} Lap band surgery	\$5,000 - does not accrue to member out-of-pocket or deductible limits; listed copay does not include other applicable cost shares	Not covered



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MEDICAL BENEFITS	In-network	Out-of-network
Specialized surgical procedures ¹ Spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis	\$400, not subject to deductible	50%, after deductible
High tech imaging services ³ MRI, CT, PET, SPECT scans	\$200, 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	30%, after deductible	50%, after deductible
Physical therapy	\$25, after deductible	50%, after deductible
Occupational therapy	\$25, after deductible	50%, after deductible
Speech therapy	\$25, after deductible	50%, after deductible
Allergy injections	\$5, after deductible	50%, after deductible
Injectables ⁴ And other drugs administered other than orally (when rendered in the office)	10%, after deductible	50%, after deductible
Ambulance, ground	\$100 and 30%, after deductible	\$100 and 30%, after deductible
Ambulance, air	30%, after deductible	30%, after deductible
Durable Medical Equipment (DME) ³	30%, after deductible	50%, after deductible
Home health care	\$15, after deductible	50%, after deductible
Hospice	\$0, after deductible	50%, after deductible
Hearing aids, cochlear implants ³	One pair per four years, after deductible per impaired ear	50%, after deductible
Transplants ³	50%, after deductible	50%, after deductible
PHARMACY BENEFITS		
Tier 1: Preventive ^{1, 2, 3}	\$0, not subject to deductible, for: <ul style="list-style-type: none"> • Specified generic drugs • Selected asthma medications • Tobacco cessation drugs/supplies • Preventive medications 	50%, after deductible
Tier 2: Generic ^{1, 2, 3}	\$0, not subject to deductible	50%, after deductible
Tier 3: Preferred ^{1, 3}	\$25, not subject to deductible	50%, after deductible
Tier 4: Non-preferred ^{1, 3}	\$75, not subject to deductible	50%, after deductible
Tier 5: High-cost specialty drugs ^{1, 3}	10%, not subject to deductible	50%, after deductible

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