Samaritan Everyday Choices
For Large Groups in Oregon
The benefits information provided is a summary and not a complete description of benefits. Limitations and exclusions apply.

**[Employer Group Name]**

<table>
<thead>
<tr>
<th>Wellness Services</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Wellness Assessment</strong></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><strong>Health Risk Screening</strong></td>
<td>Blood test identifies risks for certain diseases and medical conditions.</td>
<td>$0 not subject to deductible</td>
</tr>
<tr>
<td><strong>Health Risk Score and Report</strong></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><strong>Personal Health Coaching</strong></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>

**Medical Benefits**

<table>
<thead>
<tr>
<th>Deductible³</th>
<th>Per calendar year</th>
<th>Medical and Pharmacy</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family: $5,000</td>
<td>Individual: $2,500</td>
<td>Family: $10,000</td>
<td>Individual: $5,000</td>
<td></td>
</tr>
<tr>
<td>Out-of-pocket maximum</td>
<td>Per calendar year</td>
<td>Medical and Pharmacy</td>
<td>Individual: $6,750</td>
<td>Individual: $13,500</td>
</tr>
<tr>
<td>Family: $13,500</td>
<td>Individual: $13,500</td>
<td>Family: $27,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care</td>
<td>Office visits and in-office procedure</td>
<td>20%, after deductible</td>
<td>50%, after deductible</td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td>20%, after deductible</td>
<td>20%, after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty care</td>
<td>Office visits and in-office procedures</td>
<td>20%, after deductible</td>
<td>50%, after deductible</td>
<td></td>
</tr>
<tr>
<td>Radiology ¹</td>
<td>20%, after deductible</td>
<td>50%, after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labs ¹</td>
<td>20%, after deductible</td>
<td>50%, after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency care</td>
<td>Waived if admitted to hospital</td>
<td>20%, after deductible</td>
<td>20%, after deductible</td>
<td></td>
</tr>
<tr>
<td>Mental health and Substance Use Disorder</td>
<td>Office visits</td>
<td>20%, after deductible</td>
<td>50%, after deductible</td>
<td></td>
</tr>
<tr>
<td>Women’s health services and reproductive rights</td>
<td>$0, not subject to deductible</td>
<td>50%, after deductible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Preventive care and services
Including well baby care, routine physicals, routine gynecological exams, immunizations, colorectal screening, ACA required services.

- Preventive care and services: $0, not subject to deductible, 50%, after deductible

### Outpatient surgery
Facility and professional charges

- Outpatient surgery: 20%, after deductible, 50%, after deductible

### Outpatient services
Dialysis, chemotherapy, infusion, and radiation therapy
(Medication may require authorization)

- Outpatient services: 20%, after deductible, 50%, after deductible

### Outpatient rehabilitative
Includes physical therapy, occupational therapy, and speech therapy

- Outpatient rehabilitative: 20%, after deductible, 50%, after deductible

### Outpatient habilitative
Includes physical therapy, occupational therapy, and speech therapy

- Outpatient habilitative: 20%, after deductible, 50%, after deductible

### Inpatient hospital

- Inpatient hospital: 20%, after deductible, 50%, after deductible

### Inpatient rehabilitative care
Up to 30 days*

- Inpatient rehabilitative care: 20%, after deductible, 50%, after deductible

### Inpatient habilitative care
Up to 30 days*

- Inpatient habilitative care: 20%, after deductible, 50%, after deductible

### Skilled nursing facility care
Up to 60 days per benefit year

- Skilled nursing facility care: 20%, after deductible, 50%, after deductible

### Outpatient intensive services and programs for substance use
Including partial hospitalization and intensive outpatient

- Outpatient intensive services and programs for substance use: 20%, after deductible, Not Covered

### Bariatric surgery
Does not apply to member out-of-pocket; listed copay does not include other applicable cost shares

- Bariatric surgery: 20%, after deductible, Not Covered

### Specialized surgical procedures
Spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis

- Specialized surgical procedures: 20%, after deductible, Not Covered

### High tech imaging services
CT scans, MRIs and PET scans

- High tech imaging services: 20%, after deductible, 50%, after deductible

### Mental health and Substance Use Disorder
Inpatient care and Residential programs

- Mental health and Substance Use Disorder: 20%, after deductible, 50%, after deductible

### Allergy injections

- Allergy injections: 20%, after deductible, 50%, after deductible

### Injectable drugs
And other drugs administered other than orally (when rendered in the office)

- Injectable drugs: 20%, after deductible, 50%, after deductible

### Ambulance, ground

- Ambulance, ground: 20%, after deductible, 20%, after deductible

### Ambulance, air

- Ambulance, air: 20%, after deductible, 20%, after deductible

### Durable medical equipment (DME)
Includes prosthetic and orthotic devices

- Durable medical equipment (DME): 20%, after deductible, 50%, after deductible
<table>
<thead>
<tr>
<th>Service</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<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>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>Cardiac rehab</td>
<td>20%, after deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Diabetes education</td>
<td>20%, after 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>20%, after deductible</td>
<td>50%, after deductible</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Pharmacy Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
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<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 ¹</td>
<td>20%, after deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Tier 3: Preferred ¹</td>
<td>20%, after deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Tier 4: Non-preferred ¹</td>
<td>20%, after deductible</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>Tier 5: High-cost specialty drugs ¹</td>
<td>50%, after deductible</td>
<td>50%, after deductible</td>
</tr>
</tbody>
</table>

¹ May require a Prior Authorization
² Contact Customer Service at 541-768-4550 or 1-800-832-4580 to determine your co-pay or co-insurance levels
³ Aggregate deductible
* Limits do not apply to those services rendered to a member with a Mental Health or Substance Use Disorder diagnosis