2018 Summary of Benefits Plan Comparison

The tables below summarize the 2018 benefits for the Samaritan Choice Medical Plan options (Wellness and High-Deductible). Please refer to your plan document and/or your Summary of Material Modifications (SMM) for a detailed description of your benefits. Important Notice: All services apply to the deductible unless otherwise specified.

Samaritan Choice Plan Options: In-Network ONLY

Service	2018 WELLNESS PLAN Member pays	2018 HIGH-DEDUCTIBLE PLAN Member pays
PREVENTIVE SERVICES (These services are not applied to your deductible and some services will not have a cost share.)		
Well baby care	$0	$0
Routine physicals	$0	$0
Routine gynecological exams	$0	$0
Immunizations	$0	$0
Colorectal screening	$0	$0
PROFESSIONAL SERVICES		
Primary care visits [1]	$25	$20
In-office procedures	$25	$20
Specialist visits	$40	$35
In-office procedures	$40	$35
Urgent care center visits	$40	$20
Surgery professional (at hospital)	$60	$50
PRIMARY CARE HOME (PCH) SERVICES - In-Network WELLNESS PLAN Only. All eligible services that are rendered and billed by assigned PCH are 100% covered by the Samaritan Choice Wellness Plan Option. Eligibility criteria will apply. 100% coverage only if the Wellness program identifies that the member would benefit from these services. You may be required to participate in these programs. No cost shares or deductibles apply.		
Primary Care Home (PCH) services	$0	Benefit category not available
CARE COORDINATION SERVICES - For asthma, diabetes, Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Chronic Obstructive Pulmonary Disease (COPD).		
Office visit	$0	Benefit category not available

Samaritan Choice Plan Options: In-Network ONLY

Service	2018 WELLNESS PLAN Member pays	2018 HIGH-DEDUCTIBLE PLAN Member pays
EDUCATION SERVICES		
Office visit for specified education services	$0	$0
HEART HEALTH AND WELLBEING PROGRAM - In-Network WELLNESS PLAN services only. All eligible services that are rendered and billed by assigned Program Coach are 100% covered only to those who are eligible for this Program. No cost shares or deductibles apply.		
Cardiac rehabilitation services	$0	Benefit category not available
HOSPITAL / INPATIENT SERVICES		
Inpatient room and board	SHS facility: $175/day, up to 5 days or $875 Non-SHS facility: $300/day, up to 5 days or $1,500	$100/day, up to 5 days or $500
Inpatient rehabilitative care	SHS facility: $175/day, up to 5 days or $875 Non-SHS facility: $300/day, up to 5 days or $1,500	$100/day, up to 5 days or $500
Skilled Nursing Facility care	$0	$0
Bariatric surgery/ gastric banding (Lap band) surgery[2]	$5,000	$5,000
OUTPATIENT SERVICES		
Outpatient surgery (does not include in office procedures)	SHS facility: $150 Non-SHS facility: $250	$150
Emergency department visits (unless admitted to hospital)	$150	$100
Radiology	$25	$0
Lab	$0	$0

Samaritan Choice Plan Options: In-Network ONLY

Service	2018 WELLNESS PLAN Member pays	2018 HIGH-DEDUCTIBLE PLAN Member pays
VALUE-BASED SERVICES - In-Network only (Specified Surgical Procedures & High Tech Imaging)		
Specified surgical procedures (spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis)	$400 [3,4] (does not apply to member OOP[5] maximum)	Value based benefit administration is not available
High tech imaging services (CT scans, MRIs and PET scans)	$200 [3,4] (does not apply to member OOP[5] maximum)	Value based benefit administration is not available CT, PET scans $0 MRI $150
CHEMICAL DEPENDENCY		
Office visits	$40	$35
Inpatient care	SHS facility: $175/day, up to 5 days or $875 Non-SHS facility: $300/day, up to 5 days or $1,500	$100/day, up to 5 days or $500
Residential programs	30%	30%
MENTAL HEALTH		
Office visits	$25	$35
Inpatient care	SHS facility: $175/day, up to 5 days or $875 Non-SHS facility: $300/day, up to 5 days or $1,500	$100/day, up to 5 days or $500
Residential programs	30%	30%
OTHER COVERED SERVICES		
Physical therapy	$35	$25
SHS Physical therapy providers	$30	$20
Occupational therapy	$35	$25
Speech therapy	$35	$25
Allergy injections (most) [6]	$15	$5
Injectables and other drugs administered other than orally (when rendered in the office)[6]	20%	10%

Samaritan Choice Plan Options: In-Network ONLY

Service	2018 WELLNESS PLAN Member pays	2018 HIGH-DEDUCTIBLE PLAN Member pays
Ambulance, ground	30% after $100	30% after $100
Ambulance, air [7]	30%	30%
Durable Medical Equipment (DME)	30%	30%
Home health care	$30	$15
Hospice	$0	$0
Hearing aids	Plan pays up to $1,000 limit/year No limit for children age 20 and under	Plan pays up to $700 limit/year No limit for children age 20 and under
Acupuncture	$35	$35
Chiropractic [8]	$25 $850 limit/year	Benefit is not available
Panniculectomy [9]	50%	50%

[1] Primary Care Provider visit is defined as services provided by a Pediatric, Family Medicine, Internal Medicine, or OB-GYN provider.
[2] Bariatric Surgery and Gastric Banding (Lap band) surgery copays do not apply to Out-of-Pocket Limit or deductibles.
[3] Does not apply if coded as Emergency Services. Cost shares will default to normal benefit for Emergency Services.
[4] These Value-based copays do not count towards annual deductibles and Out-of-Pocket Limits. Regular copayment or coinsurance must be separately paid as applicable.
[5] OOP: Out-of–Pocket Maximum or Limit.
[6] Contact Customer Service at 541-768-4550 or 1-800-832-4580 to determine your copayment or coinsurance levels for applicable services.
[7] Air Ambulance does not apply to Out-of-Pocket Maximum.
[8] Chiropractic benefit only includes manipulation. This benefit does not include x-rays, labs, other radiology or other services that are not considered to be a manipulation treatment.
[9] Panniculectomy coinsurance does not apply to Out-of-Pocket Limit or deductibles. Services will only be covered when gastric bypass has been rendered by contracted provider.

2018 Prescription Drug Summary of Benefits

Tier 1 - Therapeutic and Preventive	Tier 2 - Preferred Generic	Tier 3 - Preferred Brand	Tier 4 - Non-Preferred	Tier 5 - High-Cost Specialty
$0 for: • 9 specified generic drugs • Selected asthma medications • Tobacco cessation drugs/supplies • Diabetic insulin, syringes, and needles	$7 or 20% whichever is greater	$25 or 25% whichever is greater	50%	10%

IMPORTANT NOTES:

- The Therapeutic benefit for the administration of insulin applies to all Samaritan Choice Plan options.
- All medications covered by SCP are subject to the Pharmacy & Therapeutics Committee and are approved to be on the formulary list of covered drugs. Reference the Plan's formulary for more specific medication coverage information.

Annual individual and family deductibles

Your annual deductibles	WELLNESS PLAN	HIGH-DEDUCTIBLE PLAN
Annual individual deductible	$300	$2,500
Annual family deductible	$900	$7,500

Out-of-pocket limits

Please refer to the additional information throughout your Plan Document for further explanations of your benefits including limitations and exclusions.

Your out-of-pocket max	WELLNESS PLAN	HIGH-DEDUCTIBLE PLAN	SAMARITAN CHOICE PHARMACY
Annual per member	$3,000	$3,150	$4,200
Annual per family	$6,000	$6,300	$8,400
There is no out-of-pocket limit for non-preferred providers.			

Your annual out-of-pocket limit

This plan has an out-of-pocket limit to protect you from excessive medical expenses. The Summary of Benefits shows your plan's annual out-of-pocket limit. If you incur covered expenses over that amount, this plan will pay 100% of eligible charges for the rest of the calendar year. Those services that do not apply to your out-of-pocket limit will not be covered at 100% after your out-of-pocket limit has been met. Regular cost sharing will apply to those benefits.

Expenses for the following DO NOT count toward your out-of-pocket limit:

- Prescription drugs (separate out-of-pocket limit applies)
- Charges over usual, customary, and reasonable amounts
- Air ambulance
- Benefits paid in full (for example, vision hardware)
- 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)
- Bariatric and Gastric banding surgery co-pays
- Value-based service co-pays
- Panniculectomies
- Other services that are specifically called out in this document