

# 2008 Samaritan Select

## SUMMARY OF BENEFITS FOR PPO PLAN

Medical services—Individual lifetime maximum is \$2 million

	Preferred Providers	Non-Preferred Provider
Annual out-of-pocket maximum	\$1,000/person; \$3,000/family	\$2,000/person; \$6,000/family
Service	You Pay Preferred	You Pay Non-Preferred
<b>Office visit</b>		
Primary care office visit	\$10	30%
Specialist office visit	\$10	30%
X-ray and lab	\$0	30%
<b>Preventive care</b>		
Periodic health appraisals	\$0 <sup>1,2</sup>	30% <sup>1,2</sup>
Well-child check ups (to age 19)	\$0 <sup>1</sup>	30% <sup>1</sup>
Hearing screenings	\$0	30%
Routine immunizations	\$0	\$0
Mammography screening	\$0 <sup>1</sup>	30% <sup>1</sup>
Routine women's exam	\$0 <sup>1</sup>	30% <sup>1</sup>
Bone density screening	\$0 <sup>4</sup>	30% <sup>4</sup>
Colonoscopy screening	\$0 <sup>1</sup>	30% <sup>1</sup>
Prostate screening	\$0 <sup>1</sup>	30% <sup>1</sup>
Diabetes and asthma care	\$0	30%
<b>Hearing</b>		
Hearing exam	\$10 <sup>3</sup>	30% <sup>3</sup>
Hearing aids, up to \$4000 (every 4 years)	10% <sup>3</sup>	10% <sup>3</sup>
<b>Hospital</b>		
Ambulance	\$75 <sup>4,5</sup>	\$75 <sup>4,5</sup>
Inpatient, unlimited days	\$100/day, \$500/year	30%
Outpatient	\$10	30%
Emergency room	\$75 <sup>4,5</sup>	\$75 <sup>4,5</sup>
<b>Maternity and gynecology</b>		
Prenatal and postpartum office visits	\$10	30%
Inpatient delivery	\$100/day, \$500/year	30%
Infertility treatment	50% <sup>6</sup>	50% <sup>6</sup>
<b>Surgery</b>		
Inpatient	\$0 <sup>7</sup>	30% <sup>7</sup>
Outpatient	\$10 <sup>7</sup>	30% <sup>7</sup>
Office-based	\$10 <sup>7</sup>	30% <sup>7</sup>

*continued on next page...*

## Medical Services, *continued*

Service	You Pay Preferred	You Pay Non-Preferred
<b>Mental health and chemical dependency</b>		
Inpatient and residential	\$100/day, \$500/year <sup>6,7</sup>	30% <sup>6,7</sup>
Outpatient	\$10 <sup>6,7</sup>	30% <sup>6,7</sup>
<b>Durable medical equipment</b>	15%	30%
<b>Insulin, diabetic supplies</b>	\$0	\$0
<b>Alternative care</b>	\$15 <sup>8</sup>	\$15 <sup>8</sup>
<b>Misc. Services</b>		
Outpatient Rehab	15%	30%
Injectibles and therapeutic injectibles	15%	30%
Cardiac Rehab	15%	30%
Home health	15%	30%
Skilled nursing facility	15%	30%

## Pharmacy Services

Service	
<b>Prescription drugs</b>	<b>Participating pharmacies only</b>
<b>Retail</b>	<b>34-day supply</b>
Therapeutic	\$0
Generic	\$5
Brand	\$15
Non-preferred brand	>\$50 or 50% <sup>9</sup>
<b>Mail order</b>	<b>90-day supply</b>
Therapeutic	\$0
Generic	\$12.50
Brand	\$37.50
Non-preferred brand	>\$125 or 50% <sup>9</sup>

## Vision Services

### Routine vision care covered through VSP

1. Based on plan's frequency schedule.
2. Includes commercial driver's license medical exam for employee.
3. Hearing aids covered at \$4000 every 4 years.
4. When medically appropriate.
5. Based on criteria including prudent layperson law.
6. Some diagnoses and treatments may not be covered benefits.
7. Some services require prior authorization.
8. Includes chiropractic, naturopathic and acupuncture services. Limited to \$1,000/yr.
9. Plus the difference between generic and brand for multisource brands.  
Multisource brand—a brand where there is an exact generic equivalent available.