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]

2019 BENEFITS (Member pays)	Samaritan Everyday Choices HSA 2700 Schedule of Benefits	
Wellness Services	In-network	Out-of-network
Individual Wellness Assessment Interactive, online questionnaire that evaluates lifestyle and its impact on good health.	$0, not subject to deductible	Not Covered
Health Risk Screening Blood test identifies risks for certain diseases and medical conditions.	$0 not subject to deductible	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 subject to deductible	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 subject to deductible	Not Covered

Medical Benefits	In-network	Out-of-network
Deductible Per calendar year Medical and Pharmacy	Individual: $2,700 Family: $5,400	Individual: $5,400 Family: $10,800
Out-of-pocket maximum Per calendar year Medical and Pharmacy	Individual: $6,750 Family: $13,500	Individual: $13,500 Family: $27,000
Primary care Office visits and in-office procedure	20%, after deductible	50%, after deductible
Urgent care	20%, after deductible	20%, after deductible
Specialty care Office visits and in-office procedures	20%, after deductible	50%, after deductible
Radiology [1]	20%, after deductible	50%, after deductible
Labs [1]	20%, after deductible	50%, after deductible
Emergency care Waived if admitted to hospital	20%, after deductible	20%, after deductible
Mental health and Substance Use Disorder Office visits	20%, after deductible	50%, after deductible

Women's health services and reproductive rights	$0, not subject to deductible	50%, after deductible
Preventive care and services 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 [1] Facility and professional charges	20%, after deductible	50%, after deductible
Outpatient services [1] Dialysis, chemotherapy, infusion, and radiation therapy (Medication may require authorization)	20%, after deductible	50%, after deductible
Outpatient rehabilitative Includes physical therapy, occupational therapy, and speech therapy	20%, after deductible	50%, after deductible
Outpatient habilitative Includes physical therapy, occupational therapy, and speech therapy	20%, after deductible	50%, after deductible
Inpatient hospital [1]	20%, after deductible	50%, after deductible
Inpatient rehabilitative care [1] Up to 30 days*	20%, after deductible	50%, after deductible
Inpatient habilitative care [1] Up to 30 days*	20%, after deductible	50%, after deductible
Skilled nursing facility care [1] Up to 60 days per benefit year	20%, after deductible	50%, after deductible
Outpatient intensive services and programs for substance use [1] Including partial hospitalization, and intensive outpatient	20%, after deductible	Not Covered
Bariatric surgery Does not apply to member out-of-pocket; listed copay does not include other applicable cost shares	20%, after deductible	Not Covered
Specialized surgical procedures [1] Spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis	20%, after deductible	Not Covered
High tech imaging services [1] CT scans, MRIs and PET scans	20%, after deductible	50%, after deductible
Mental health and Substance Use Disorder [1] Inpatient care and Residential programs	20%, after deductible	50%, after deductible
Allergy injections [2]	20%, after deductible	50%, after deductible
Injectable drugs [1] 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) [1] Includes prosthetic and orthotic devices	20%, after deductible	50%, after deductible
Home health care	20%, after deductible	50%, after deductible
Hospice	20%, after deductible	50%, after deductible
Hearing aids [1]	20%, after deductible	50%, after deductible
Transplants [1]	50%, after deductible	50%, after deductible
Cardiac rehab	20%, after deductible	50%, after deductible
Diabetes education	20%, after deductible	50%, after deductible
Nutritional counseling	$0, not subject to deductible	50%, after deductible
Diabetic supplies	20%, after deductible	50%, after deductible

Pharmacy Benefits	In-network	Out-of-network
Tier 1: Preventive	$0, not subject to deductible	50%, after deductible
Tier 2: Generic [1]	20%, after deductible	50%, after deductible
Tier 3: Preferred [1]	20%, after deductible	50%, after deductible
Tier 4: Non-preferred [1]	20%, after deductible	50%, after deductible
Tier 5: High-cost specialty drugs [1] Includes non-formulary drugs	50%, after deductible	50%, after deductible

[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
* Limits do not apply to those services rendered to a member with a Mental Health or Substance Use Disorder diagnosis