

# 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]

## Samaritan Everyday Choices HSA 2500 Schedule of Benefits

### 2019 BENEFITS (Member pays)

Wellness Services	In-network	Out-of-network
<b>Individual Wellness Assessment</b> Interactive, online questionnaire that evaluates lifestyle and its impact on good health.	\$0, not subject to deductible	Not Covered
<b>Health Risk Screening</b> Blood test identifies risks for certain diseases and medical conditions.	\$0 not subject to deductible	Not Covered
<b>Health Risk Score and Report</b> 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
<b>Personal Health Coaching</b> 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
<b>Deductible<sup>3</sup></b> Per calendar year Medical and Pharmacy	Individual: \$2,500 Family: \$5,000	Individual: \$5,000 Family: \$10,000
<b>Out-of-pocket maximum</b> Per calendar year Medical and Pharmacy	Individual: \$6,750 Family: \$13,500	Individual: \$13,500 Family: \$27,000
<b>Primary care</b> Office visits and in-office procedure	20%, after deductible	50%, after deductible
<b>Urgent care</b>	20%, after deductible	20%, after deductible
<b>Specialty care</b> Office visits and in-office procedures	20%, after deductible	50%, after deductible
<b>Radiology<sup>1</sup></b>	20%, after deductible	50%, after deductible
<b>Labs<sup>1</sup></b>	20%, after deductible	50%, after deductible
<b>Emergency care</b> Waived if admitted to hospital	20%, after deductible	20%, after deductible
<b>Mental health and Substance Use Disorder</b> Office visits	20%, after deductible	50%, after deductible
<b>Women's health services and reproductive rights</b>	\$0, not subject to deductible	50%, after deductible



<b>Preventive care and services</b> Including well baby care, routine physicals, routine gynecological exams, immunizations, colorectal screening, ACA required services.	\$0, not subject to deductible	50%, after deductible
<b>Outpatient surgery</b> <sup>1</sup> Facility and professional charges	20%, after deductible	50%, after deductible
<b>Outpatient services</b> <sup>1</sup> Dialysis, chemotherapy, infusion, and radiation therapy (Medication may require authorization)	20%, after deductible	50%, after deductible
<b>Outpatient rehabilitative</b> Includes physical therapy, occupational therapy, and speech therapy	20%, after deductible	50%, after deductible
<b>Outpatient habilitative</b> Includes physical therapy, occupational therapy, and speech therapy	20%, after deductible	50%, after deductible
<b>Inpatient hospital</b> <sup>1</sup>	20%, after deductible	50%, after deductible
<b>Inpatient rehabilitative care</b> <sup>1</sup> Up to 30 days*	20%, after deductible	50%, after deductible
<b>Inpatient habilitative care</b> <sup>1</sup> Up to 30 days*	20%, after deductible	50%, after deductible
<b>Skilled nursing facility care</b> <sup>1</sup> Up to 60 days per benefit year	20%, after deductible	50%, after deductible
<b>Outpatient intensive services and programs for substance use</b> <sup>1</sup> Including partial hospitalization and intensive outpatient	20%, after deductible	Not Covered
<b>Bariatric surgery</b> Does not apply to member out-of-pocket; listed copay does not include other applicable cost shares	20%, after deductible	Not Covered
<b>Specialized surgical procedures</b> <sup>1</sup> Spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis	20%, after deductible	Not Covered
<b>High tech imaging services</b> <sup>1</sup> CT scans, MRIs and PET scans	20%, after deductible	50%, after deductible
<b>Mental health and Substance Use Disorder</b> <sup>1</sup> Inpatient care and Residential programs	20%, after deductible	50%, after deductible
<b>Allergy injections</b> <sup>2</sup>	20%, after deductible	50%, after deductible
<b>Injectable drugs</b> <sup>1</sup> And other drugs administered other than orally (when rendered in the office)	20%, after deductible	50%, after deductible
<b>Ambulance, ground</b>	20%, after deductible	20%, after deductible
<b>Ambulance, air</b>	20%, after deductible	20%, after deductible
<b>Durable medical equipment (DME)</b> <sup>1</sup> Includes prosthetic and orthotic devices	20%, after deductible	50%, after deductible

<b>Home health care</b>	20%, after deductible	50%, after deductible
<b>Hospice</b>	20%, after deductible	50%, after deductible
<b>Hearing aids</b> <sup>1</sup>	20%, after deductible	50%, after deductible
<b>Transplants</b> <sup>1</sup>	50%, after deductible	50%, after deductible
<b>Cardiac rehab</b>	20%, after deductible	50%, after deductible
<b>Diabetes education</b>	20%, after deductible	50%, after deductible
<b>Nutritional counseling</b>	\$0, not subject to deductible	50%, after deductible
<b>Diabetic supplies</b>	20%, after deductible	50%, after deductible

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

<sup>1</sup> May require a Prior Authorization

<sup>2</sup> Contact Customer Service at 541-768-4550 or 1-800-832-4580 to determine your co-pay or co-insurance levels

<sup>3</sup> Aggregate deductible

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