

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 5250 Schedule of Benefits

2019 BENEFITS (Member pays)

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: \$5,250 Family: \$10,500	Individual: \$10,500 Family: \$21,000
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