Samaritan Health Plans

2019 Summary of Benefits Plan Comparison

The tables below summarize the 2019 benefits for the Samaritan Choice Medical Plan options (Wellness & HSA Eligible High-Deductible). Please refer to your plan documents and your Summary of Material Modifications (SMM) for a detailed description of your benefits.

Samaritan Choice Plan Options: In-Network ONLY

Service	2019 WELLNESS PLAN Member Pays	2019 HSA ELIGIBLE HIGH-DEDUCTIBLE PLAN Member Pays
PREVENTIVE SERVICES		
Well baby care	$0, not subject to deductible	$0, not subject to deductible
Routine physicals	$0, not subject to deductible	$0, not subject to deductible
Routine gynecological exams	$0, not subject to deductible	$0, not subject to deductible
Immunizations	$0, not subject to deductible	$0, not subject to deductible
Colorectal screening	$0, not subject to deductible	$0, not subject to deductible
PROFESSIONAL SERVICES		
Primary care visits [1]	$25, after deductible	$25, after deductible
In-office procedures	$25, after deductible	$25, after deductible
Specialist visits	$40, after deductible	$40, after deductible
In-office procedures	$40, after deductible	$40, after deductible
Urgent care center visits	$40, after deductible	$40, after deductible
Surgery professional (at hospital or ASC)	$60, after deductible	$60, after deductible
PRIMARY CARE HOME (PCH) SERVICES- In-Network Wellness Plan only. All eligible services that are rendered and billed by assigned Primary Care Homes (PCH) are 100% covered by the Samaritan Choice Wellness Plan option. Eligibility criteria will apply. 100% coverage only if the Wellness program identified that the member would benefit from these services. You may be required to participate in these programs.		
Primary Care Home (PCH) services	$0, not subject to deductible	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, after deductible	$0, after deductible

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Service	2019 WELLNESS PLAN Member Pays	2019 HSA ELIGIBLE HIGH-DEDUCTIBLE PLAN Member Pays
EDUCATION SERVICES		
Office visit for specified education services	$0, after deductible	$0, after deductible
HEART HEALTH AND WELLBEING (HHWB) PROGRAM- In-Network Wellness Plan 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.		
Cardiac rehabilitation services	$0	Benefit category not available
HOSPITAL / INPATIENT SERVICES		
Inpatient room and board (SHS facility)	$175/day, up to $875 maximum per stay; after deductible	$175/day, up to $875 maximum per stay; after deductible
Inpatient room and board (non-SHS facility)	$300/day, up to $1,500 maximum per stay; after deductible	$300/day, up to $1,500 maximum per stay; after deductible
Inpatient rehabilitative care (SHS facility)	$175/day, up to $875 maximum per stay; after deductible	$175/day, up to $875 maximum per stay; after deductible
Inpatient rehabilitative care (non-SHS facility)	$300/day, up to $1,500 maximum per stay; after deductible	$300/day, up to $1,500 maximum per stay; after deductible
Skilled nursing facility care	$0, after deductible	$0, after deductible
Bariatric surgery/gastric banding (lap band) surgery [2]	$5,000, not subject to deductible (Does not apply to OOP [5] limit)	$5,000, after deductible
OUTPATIENT SERVICES		
Outpatient surgery (does not include in-office procedures) (SHS designated facility)	$150, after deductible	$150, after deductible
Outpatient surgery (does not include in-office procedures) (non-SHS facility)	$250, after deductible	$250, after deductible

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Service	2019 WELLNESS PLAN Member Pays	2019 HSA ELIGIBLE HIGH-DEDUCTIBLE PLAN Member Pays
OUTPATIENT SERVICES (continued)		
Emergency room department visits (unless admitted to hospital)	$150, after deductible	$150, after deductible
Radiology	$25, after deductible	$25, after deductible
Lab	$0, after deductible	$0, after deductible
VALUE-BASED SERVICES		
Specified surgical procedures (spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis)	$400, not subject to deductible [3,4] (Does not apply to OOP [5] limit)	$400, after deductible
High-tech imaging services (CT scans, MRIs, and PET scans)	$200, not subject to deductible [3,4] (Does not apply to OOP [5] limit)	$400, after deductible
CHEMICAL DEPENDENCY		
Office visits	$40, after deductible	$40, after deductible
Inpatient care (SHS facility)	$175/day, up to $875 maximum per stay; after deductible	$175/day, up to $875 maximum per stay; after deductible
Inpatient care (non-SHS facility)	$300/day, up to $1,500 maximum per stay; after deductible	$300/day, up to $1,500 maximum per stay; after deductible
Outpatient intensive services and programs (including partial hospitalization) for substance use	30%, after deductible	30%, after deductible
Residential programs	30%, after deductible	30%, after deductible

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Service	2019 WELLNESS PLAN Member Pays	2019 HSA ELIGIBLE HIGH-DEDUCTIBLE PLAN Member Pays
MENTAL HEALTH		
Office visits	$25, after deductible	$40, after deductible
Inpatient care (SHS facility)	$175/day, up to $875 maximum per stay; after deductible	$175/day, up to $875 maximum per stay; after deductible
Inpatient care (non-SHS facility)	$300/day, up to $1,500 maximum per stay; after deductible	$300/day, up to $1,500 maximum per stay; after deductible
Partial hospitalization	30%, after deductible	30%, after deductible
Residential programs	30%, after deductible	30%, after deductible
OTHER COVERED SERVICES		
Physical therapy	$35, after deductible	$35, after deductible
SHS Physical therapy providers	$30, after deductible	$30, after deductible
Occupational therapy	$35, after deductible	$35, after deductible
Speech therapy	$35, after deductible	$35, after deductible
Allergy injections (most) [6]	$15, after deductible	$15, after deductible
Injectables and other drugs administered other than orally (when rendered in the office) [6]	20%, after deductible	20%, after deductible
Ambulance, ground	30% after $100 copay; after deductible	30% after $100 copay; after deductible
Ambulance, air	30%, after deductible (Does not apply to OOP [5] limit)	30%, after deductible
Durable Medical Equipment (DME) and Prosthetics	30%, after deductible	30%, after deductible

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Samaritan Choice Plan Options: In-Network ONLY

Service	2019 WELLNESS PLAN Member Pays	2019 HSA ELIGIBLE HIGH-DEDUCTIBLE PLAN Member Pays
OTHER COVERED SERVICES (continued)		
Continuous glucose monitors [7]	10%, after deductible	0%, after deductible
Home health care	$30, after deductible	$30, after deductible
Hospice	$0, after deductible	$0, after deductible
Hearing aids	Covered up to $1,000/year, after deductible No limit for children ages 20 and under	Covered up to $1,000/year, after deductible No limit for children ages 20 and under
Acupuncture	$35, after deductible	$35, after deductible
Chiropractic [8]	$25, after deductible Covered up to $850/year	$25, after deductible Covered up to $850/year
Panniculectomy	50%, not subject to deductible [9] (Does not apply to OOP [5] limit)	50%, after deductible

[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 is covered only at in-network/designated facilities and subject to its policies and surgical criteria.

[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 the annual deductibles and out-of-pocket limits. Regular copayment or coinsurance must be separately paid as applicable.

[5] OOP: Out-of-pocket limit.

[6] Contact Customer Service at 541-768-4550 or toll free 1-800-832-4580 (TTY: 1-800-735-2900) to determine your copayment or coinsurance levels for applicable services.

[7] Procedure codes that apply to the continuous glucose monitor benefit are as follows: A9276, A9277, A9278, K0553, and K0554.

[8] Chiropractic benefit only includes manipulations and exams. 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.

2019 Summary of Benefits: Prescription Drug

Drug Tiers	Wellness Plan Pharmacy Benefits	HSA High-Deductible Plan Pharmacy Benefits
Tier 1- Preventive	$0	$0
Tier 2- Preferred Generic	$7 or 20% (whichever is greater)	$7 or 20% (whichever is greater), after deductible
Tier 3- Preferred Brand	$25 or 25% (whichever is greater)	$25 or 25% (whichever is greater), after deductible
Tier 4- Non-Preferred	50%	50%, after deductible
Tier 5- High-Cost Specialty	10%	10%, after deductible

Annual Individual and Family Deductibles

Plan	Annual Individual Deductible	Annual Family Deductible
Wellness Plan	$350 (Medical only)	$1,050 (Medical only)
HSA Eligible High-Deductible Plan	$2,700 (Integrated Medical & Pharmacy Deductible)	$5,400 (Integrated Medical & Pharmacy Deductible)

Out-of-Pocket Limits

Wellness Plan	In-Network Medical & Pharmacy Out-of-Pocket Limit	Out-of-Network Medical & Pharmacy Out-of-Pocket Limit
Per member	$7,200	Unlimited
Per family	$14,400	Unlimited
HSA Eligible High-Deductible Plan	In-Network Medical & Pharmacy Out-of-Pocket Limit	Out-of-Network Medical & Pharmacy Out-of-Pocket Limit
Per member	$5,000	Unlimited
Per family	$10,000	Unlimited