Samaritan Health Plans

2020 Summary of Benefits Plan Comparison

The tables below summarize the 2020 benefits for the Samaritan Choice Medical Plan options (Wellness & HSA Eligible High-Deductible). Please refer to your plan documents for a detailed description of your benefits.

Samaritan Choice Plan Options: In-Network ONLY

Service	2020 WELLNESS PLAN Member Pays	2020 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
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
EDUCATION SERVICES		
Office visit for specified education services	$0, after deductible	$0, after deductible

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Samaritan Choice Plan Options: In-Network ONLY

Service	2020 WELLNESS PLAN Member Pays	2020 HSA ELIGIBLE HIGH-DEDUCTIBLE PLAN Member Pays
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
Emergency room department visits (unless admitted to hospital)	$150, after deductible	$150, after deductible
Radiology	$25, after deductible	$25, after deductible
Electrocardiograms (ECG/EKG)	$25, after deductible	$25, after deductible
Lab	$0, after deductible	$0, after deductible

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Service	2020 WELLNESS PLAN Member Pays	2020 HSA ELIGIBLE HIGH-DEDUCTIBLE PLAN Member Pays
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
SUBSTANCE USE DISORDER		
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 disorder	30%, after deductible	30%, after deductible
Residential programs	30%, after deductible	30%, after deductible
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

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Samaritan Choice Plan Options: In-Network ONLY

Service	2020 WELLNESS PLAN Member Pays	2020 HSA ELIGIBLE HIGH-DEDUCTIBLE PLAN Member Pays
MENTAL HEALTH (continued)		
Residential programs	30%, after deductible	30%, after deductible
OTHER COVERED SERVICES		
Physical therapy (SHS physical therapy providers)	$30, after deductible	$30, after deductible
Physical therapy (non-SHS physical therapy providers)	$35, after deductible	$35, 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), Prosthetics, Orthotics, and Medical Supplies	30%, after deductible	30%, after deductible
Continuous glucose monitors[7]	0%, after deductible	0%, after deductible
Home health care	$30, after deductible	$30, after deductible
Hospice	$0, after deductible	$0, after deductible

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Samaritan Choice Plan Options: In-Network ONLY

Service	2020 WELLNESS PLAN Member Pays	2020 HSA ELIGIBLE HIGH-DEDUCTIBLE PLAN Member Pays
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 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 800-832-4580 (TTY 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 the annual deductibles and out-of-pocket limits. Services will only be covered when gastric bypass has been rendered by contracted provider.

2020 Summary of Benefits: Prescription Drug

Drug Tiers	2020 Wellness Plan Pharmacy Benefits	2020 HSA Eligible High-Deductible Plan Pharmacy Benefits
Tier 1: Preventive	$0, not subject to deductible	$0, not subject to deductible
Tier 2: Low-cost therapeutic	$0, not subject to deductible	$0, after deductible
Tier 3: Preferred	$7 or 20% (whichever is greater), not subject to deductible	$7 or 20% (whichever is greater), after deductible
Tier 4: High-cost preferred	$25 or 25% (whichever is greater), not subject to deductible	$25 or 25% (whichever is greater), after deductible
Tier 5: Non-preferred	50%, not subject to deductible	50%, after deductible
Tier 6: High-cost specialty	10%, not subject to deductible	10%, after deductible

Annual Individual and Family Deductibles

Annual Deductible	2020 Wellness Plan	2020 HSA Eligible High-Deductible Plan
Individual	$400 (Medical only)	$2,800 (Integrated Medical & Pharmacy Deductible)
Family	$1,200 (Medical only)	$5,600 (Integrated Medical & Pharmacy Deductible)

Out-of-Pocket Limits

In-Network Out-of-Pocket (OOP) Limit	2020 Wellness Plan	HSA Eligible High-Deductible Plan
Per member	$7,200 (Integrated Medical & Pharmacy OOP Limit)	$5,000 (Integrated Medical & Pharmacy OOP Limit)
Per family	$14,400 (Integrated Medical & Pharmacy OOP Limit)	$10,000 (Integrated Medical & Pharmacy OOP Limit)
Out-of-Network Out-of-Pocket (OOP) Limit		
Per member	Unlimited (Integrated Medical & Pharmacy OOP Limit)	Unlimited (Integrated Medical & Pharmacy OOP Limit)
Per family	Unlimited (Integrated Medical & Pharmacy OOP Limit)	Unlimited (Integrated Medical & Pharmacy OOP Limit)