

2021 Schedule of Benefits: Plan Comparison



The table below summarizes the 2021 medical benefits for the Samaritan Choice Wellness and HSA Eligible High-Deductible plans. Please refer to your plan documents for a detailed description of your benefits.

Samaritan Choice plan options: In-network ONLY

	2021 WELLNESS PLAN Member Pays	2021 HSA ELIGIBLE HIGH-DEDUCTIBLE PLAN Member Pays
DEDUCTIBLE	<ul style="list-style-type: none"> - Per calendar year - Medical - Some services do not apply to the deductible, as indicated below 	<ul style="list-style-type: none"> - Per calendar year - Medical and pharmacy - Some services do not apply to the deductible, as indicated below
Individual	\$450	\$2,800
Family	\$1,350	\$5,600
OUT-OF-POCKET LIMIT	<ul style="list-style-type: none"> - Per calendar year - Medical and pharmacy 	<ul style="list-style-type: none"> - Per calendar year - Medical and pharmacy
Individual	\$7,200	\$5,000
Family	\$14,400	\$10,000
All copay costs shown in this chart are after your deductible has been met, if a deductible applies.		
PREVENTIVE SERVICES		
Well baby care	No charge, deductible does not apply	No charge, deductible does not apply
Routine physicals	No charge, deductible does not apply	No charge, deductible does not apply
Routine gynecological exams	No charge, deductible does not apply	No charge, deductible does not apply
Immunizations	No charge, deductible does not apply	No charge, deductible does not apply
Colorectal screening	No charge, deductible does not apply	No charge, deductible does not apply
PROFESSIONAL SERVICES		
Primary care visits ¹	\$25, deductible applies	\$25, deductible applies
In-office procedures	\$25, deductible applies	\$25, deductible applies
Specialist visits	\$40, deductible applies	\$40, deductible applies
In-office procedures	\$40, deductible applies	\$40, deductible applies

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PROFESSIONAL SERVICES (continued)		
Telehealth visit	No charge, deductible does not apply	No charge, deductible applies
Urgent care center visits	\$40, deductible applies	\$40, deductible applies
Surgery professional (at hospital or ASC)	\$60, deductible applies	\$60, deductible applies
CARE COORDINATION SERVICES - For asthma, diabetes, congestive heart failure (CHF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD).		
Office visit	No charge, deductible applies	No charge, deductible applies
EDUCATION SERVICES		
Office visit for specified education services	No charge, deductible applies	No charge, deductible applies
HOSPITAL / INPATIENT SERVICES		
Inpatient room and board (SHS facility)	\$175/day, up to \$875 maximum per stay, deductible applies	\$175/day, up to \$875 maximum per stay, deductible applies
Inpatient room and board (non-SHS facility)	\$300/day, up to \$1,500 maximum per stay, deductible applies	\$300/day, up to \$1,500 maximum per stay, deductible applies
Inpatient rehabilitative care (SHS facility)	\$175/day, up to \$875 maximum per stay, deductible applies	\$175/day, up to \$875 maximum per stay, deductible applies
Inpatient rehabilitative care (non-SHS facility)	\$300/day, up to \$1,500 maximum per stay, deductible applies	\$300/day, up to \$1,500 maximum per stay, deductible applies
Skilled nursing facility care	No charge, deductible applies	No charge, deductible applies
Bariatric surgery ²	\$5,000, deductible does not apply (Does not apply to OOP ⁵ limit)	\$5,000, deductible applies

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OUTPATIENT SERVICES		
Outpatient surgery (does not include in-office procedures) (SHS designated facility)	\$150, deductible applies	\$150, deductible applies
Outpatient surgery (does not include in-office procedures) (non-SHS facility)	\$250, deductible applies	\$250, deductible applies
Emergency department visits (unless admitted to hospital)	\$150, deductible applies	\$150, deductible applies
Radiology	\$25, deductible applies	\$25, deductible applies
Electrocardiograms (ECG/EKG)	\$25, deductible applies	\$25, deductible applies
Lab	No charge, deductible applies	No charge, deductible applies
VALUE-BASED SERVICES		
Specified surgical procedures (spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis)	\$400, deductible does not apply ^{3, 4} (Does not apply to OOP ⁵ limit)	\$400, deductible applies
High-tech imaging services (CT scans, MRIs, PET scans)	\$200, deductible does not apply ^{3, 4} (Does not apply to OOP ⁵ limit)	\$400, deductible applies
SUBSTANCE USE DISORDER		
Office visits	\$40, deductible applies	\$40, deductible applies
Inpatient care (SHS facility)	\$175/day, up to \$875 maximum per stay, deductible applies	\$175/day, up to \$875 maximum per stay, deductible applies
Inpatient care (non-SHS facility)	\$300/day, up to \$1,500 maximum per stay, deductible applies	\$300/day, up to \$1,500 maximum per stay, deductible applies
Outpatient intensive services and programs (including partial hospitalization) for substance use disorder	30%, deductible applies	30%, deductible applies

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SUBSTANCE USE DISORDER (continued)		
Residential programs	30%, deductible applies	30%, deductible applies
MENTAL HEALTH		
Office visits	\$25, deductible applies	\$40, deductible applies
Inpatient care (SHS facility)	\$175/day, up to \$875 maximum per stay, deductible applies	\$175/day, up to \$875 maximum per stay, deductible applies
Inpatient care (non-SHS facility)	\$300/day, up to \$1,500 maximum per stay, deductible applies	\$300/day, up to \$1,500 maximum per stay, deductible applies
Partial hospitalization	30%, deductible applies	30%, deductible applies
Residential programs	30%, deductible applies	30%, deductible applies
OTHER COVERED SERVICES		
Physical therapy (SHS physical therapy providers)	\$30, deductible applies	\$30, deductible applies
Physical therapy (non-SHS physical therapy providers)	\$35, deductible applies	\$35, deductible applies
Occupational therapy	\$35, deductible applies	\$35, deductible applies
Speech therapy	\$35, deductible applies	\$35, deductible applies
Allergy injections (most) ⁶	\$15, deductible applies	\$15, deductible applies
Injectables and other drugs administered in the office (other than oral medications) ⁶	20%, deductible applies	20%, deductible applies
Ambulance, ground	30% after \$100 copay, deductible applies	30% after \$100 copay, deductible applies
Ambulance, air	30%, deductible applies (Does not apply to OOP ⁵ limit)	30%, deductible applies

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OTHER COVERED SERVICES (continued)		
Durable medical equipment (DME), prosthetics, orthotics and medical supplies	30%, deductible applies	30%, deductible applies
Continuous glucose monitors ⁷	No charge, deductible applies	No charge, deductible applies
Home health care	\$30, deductible applies	\$30, deductible applies
Hospice	No charge, deductible applies	No charge, deductible applies
Hearing aids	Covered up to \$1,000/year, deductible applies No limit for children ages 20 and under	Covered up to \$1,000/year, deductible applies No limit for children ages 20 and under
Acupuncture	\$35, deductible applies	\$35, deductible applies
Chiropractic ⁸	\$25, deductible applies Covered up to \$850/year	\$25, deductible applies Covered up to \$850/year
Panniculectomy	50%, deductible does not apply ⁹ (Does not apply to OOP ⁵ limit)	50%, deductible applies

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 Value-based copays do not apply if coded as emergency department services. Cost shares will default to normal benefit for emergency department services.

⁴ Value-based copays do not count towards the annual deductibles and out-of-pocket (OOP) limits. Regular copayment or coinsurance must be separately paid as applicable (e.g., office visits, lab, services, etc.).

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 out-of-pocket limit or deductible. Services will only be covered when bariatric surgery has been performed at an in-network provider facility and will only be allowed after bariatric surgery has been authorized and performed by an in-network/designated facility.

2021 Schedule of Benefits: Prescription Drug

The table below summarizes the 2021 pharmacy benefits for the Samaritan Choice Wellness & HSA Eligible High-Deductible Plans. Please refer to your plan documents for a detailed description of your benefits.

Drug Tiers	2021 Wellness Plan Pharmacy Benefits	2021 HSA Eligible High-Deductible Plan Pharmacy Benefits
Tier 1: Preventive	No charge, deductible does not apply	No charge, deductible does not apply
Tier 2: Low-cost therapeutic	No charge, deductible does not apply	No charge, deductible applies
Tier 3: Preferred	\$7 or 20% (whichever is greater), deductible does not apply	\$7 or 20% (whichever is greater), deductible applies
Tier 4: High-cost preferred	\$25 or 25% (whichever is greater), deductible does not apply	\$25 or 25% (whichever is greater), deductible applies
Tier 5: Non-preferred	50%, deductible does not apply	50%, deductible applies
Tier 6: High-cost specialty	15%, deductible does not apply	15%, deductible applies