Samaritan Choice Plans

PPO Plan Schedule of Benefits

Samaritan Health Plans

This is a summary of key services offered by your plan and how much you will pay. See your Member Handbook for a full description of your Plan's benefits and provisions.

Note about Prior Authorization:

Some Services may require Prior Authorization, please see your Member Handbook or Prior Authorization List for details.

Benefit	In-Network	Out-of-Network
Deductible • Per Calendar Year. • Medical only. • Some Services do not apply to the Deductible, as indicated below.	Individual: $500 Family: $1000	There is no separate Deductible for Out-of-Network Services
Out-of-Pocket Maximum • Per Calendar Year. • Medical and Pharmacy.	Individual: $7,200 Family: $14,400	Individual: Unlimited Family: Unlimited

Benefit	In-Network	Out-of-Network
Preventive Care		
Annual gynecological exams	No charge, deductible does not apply	30%, deductible does not apply
Breast pumps and breast pump Supplies	No charge, deductible does not apply	30%, deductible does not apply
Colorectal screening	No charge, deductible does not apply	30%, deductible does not apply
Immunizations	No charge, deductible does not apply	30%, deductible does not apply
Routine exams and well-childcare	No charge, deductible does not apply	30%, deductible does not apply

Benefit	In-Network	Out-of-Network
Routine mammograms	No charge, deductible does not apply	30%, deductible does not apply
Tobacco Use cessation	No charge, deductible does not apply	30%, deductible does not apply
Physician Services/Professional Services		
Primary Care[1] Services when rendered in office	$25, deductible does not apply	30%, deductible applies
Specialty Care Services when rendered in office	$40, deductible does not apply	30%, deductible applies
Surgery Professional (at hospital or Ambulatory Surgery Center)	$60, deductible applies	30%, deductible applies
Allergy injections	$15, deductible applies	30%, deductible applies
Chronic Care Asthma, diabetes, congestive heart failure (CHF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD)	No charge, deductible applies	30%, deductible applies
Naturopath[1]	$25, deductible does not apply	30%, deductible applies
Telehealth	No charge, deductible does not apply	30%, deductible applies
Specified surgical procedures (including surgery and anesthesia)	20%, deductible applies	30%, deductible applies
Emergency Services		
Ambulance, air	20%, deductible applies	20%, deductible applies
Ambulance, ground	20%, deductible applies	20%, deductible applies
Emergency room ER professional or ancillary Services billed separately. Refer to the applicable benefit in this Document for additional Cost Share information. Cost Share is waived if admitted to the Hospital and all Services subject to inpatient benefits.	$150, deductible applies	$150, deductible applies
Urgent Care	$40, deductible applies	$40, deductible applies

Benefit	In-Network	Out-of-Network
Inpatient Care		
Inpatient Hospital (facility)		
SHS Facility	$175/day, up to $875 maximum per stay, deductible applies	N/A
Non-SHS Facility	$300/day, up to $1,500 maximum per stay, deductible applies	30%, deductible applies
Inpatient Habilitative and Rehabilitative Services Limited to 30 days per Calendar Year. Limits do not apply for Mental Health and Substance Use Disorder Services.		
SHS Facility	$175/day, up to $875 maximum per stay, deductible applies	N/A
Non-SHS Facility	$300/day, up to $1,500 maximum per stay, deductible applies	30%, deductible applies
Maternity Services and routine nursery care	$40, deductible applies	30%, deductible applies
Skilled nursing facility care	No charge, deductible applies	30%, deductible applies
Outpatient Care		
Outpatient Rehabilitative Services		
Occupational Therapy	$35, deductible applies	30%, deductible applies
Physical Therapy (SHS providers)	$30, deductible applies	N/A
Physical Therapy (non SHS providers)	$35, deductible applies	30%, deductible applies
Speech Therapy	$35, deductible applies	30%, deductible applies
Outpatient Services Includes surgery performed in an Ambulatory Surgery Center or outpatient Hospital facility, chemotherapy, dialysis, infusion, injections and radiation therapy.		
SHS Facility	$150, deductible applies	N/A
Non-SHS Facility	$250, deductible applies	30%, deductible applies

Benefit	In-Network	Out-of-Network
Diagnostic Services		
Diagnostic radiology Includes diagnostic and therapeutic Services, electrocardiograms, fluoroscopy, ultrasounds and X-rays.	$25, deductible applies	30%, deductible applies
High-tech imaging Includes CT scans, MRIs, PET scans and SPECT scans.	20%, deductible applies	30%, deductible applies
Laboratory	No charge, deductible applies	30%, deductible applies
Mental Health and Substance Use Disorder Services		
Office visits	$25, deductible does not apply	30%, deductible applies
Inpatient care		
SHS Facility	$175/day, up to $875 maximum per stay, deductible applies	30%, deductible applies
Non-SHS Facility	$300/day, up to $1,500 maximum per stay, deductible applies	30%, deductible applies
Residential programs Includes detoxification and partial hospitalization	30%, deductible applies	30%, deductible applies
Other Services		
Injectables and other drugs administered in the office (other than oral medications)[4]	20%, deductible applies	20%, deductible applies
Panniculectomy[5, 6]	50%, deductible does not apply	Not covered
Diabetes education	No charge, deductible applies	30%, deductible applies
Diabetic Supplies; including Continuous Glucose Monitors. Supplies purchased from a pharmacy will fall under Pharmacy benefit (please refer to formulary)	No charge, deductible applies	50%, deductible applies

Benefit	In-Network	Out-of-Network
Durable Medical Equipment (DME), prosthetics, orthotics and Medical Supplies Includes artificial limbs and eyes, diabetic equipment, enteral and parenteral formula.	30%, deductible applies	50%, deductible applies
Hearing aids	Covered up to $3000 every three years, deductible applies. No limit for dependents 20 years old and younger	Covered up to $3000 every three years, deductible applies. No limit for dependents 20 years old and younger
Home Health Care	$30, deductible applies	30%, deductible applies
Hospice Respite care is covered for up to a maximum of five consecutive days and a lifetime limit of 30 days.	No charge, deductible applies	30%, deductible applies
Fertility Services[6] Assistant reproductive technology Services (ARTs) and artificial insemination. $20,000 annual limit $60,000 lifetime limit	20%, deductible does not apply	20%, deductible does not apply
Other Fertility Services[6] $20,000 annual limit $60,000 lifetime limit	50%, deductible does not apply	50%, deductible does not apply
Bariatric surgery[2, 6]	$5,000, deductible does not apply	Not covered
Wigs See Member Handbook for additional benefit information	20%, deductible applies	20%, deductible applies
Acupuncture	$35, deductible applies	30%, deductible applies
Chiropractic care[3] Coverage for up to 12 spinal manipulation visits per Calendar Year.	$25, deductible applies	30%, deductible applies

Prescription Drugs

Certain drugs require Prior Authorization. See the Formulary for details.

Insulin prescribed for the treatment of diabetes is not subject to a Deductible and may not exceed $75 for each 30-day supply.

Please visit **samhealthplans.org/Find-a-Drug** to view your Formulary or call Customer Service to request a copy.

Benefit	In-Network	Out-of-Network
Tier 1: Preventive drugs	**1 to 90-day supply:** No charge, deductible does not apply	Not covered
Tier 2: Low-cost therapeutic	**1 to 34-day supply:** $3, deductible does not apply **35 to 90-day supply:** $9, deductible does not apply	Not covered
Tier 3: Preferred	**1 to 34-day supply:** $15, deductible does not apply **35 to 90-day supply**: $45, deductible does not apply	Not covered
Tier 4: High-cost preferred	**1 to 34-day supply:** $25 or 25% (whichever is less), deductible does not apply	Not covered
Tier 5: Non-preferred	**1 to 34-day supply:** $250 or 50% (whichever is less), deductible does not apply	Not covered
Tier 6: High-cost specialty	**1 to 34-day supply:** 15%, deductible does not apply	Not covered

1 Primary care provider visit is defined as services provided by a pediatric, family medicine, internal medicine, naturopath or OB-GYN.

2 Bariatric surgery is covered only at in-network/designated facilities and subject to their policies and surgical criteria.

3 Chiropractic benefit only includes manipulations and exams. This benefit does not include X-rays, labs, radiology or other Services that are not considered to be a manipulation treatment.

4 Contact Customer Service to determine your copay or coinsurance levels and applicable Services.

5 Panniculectomy 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.

6 Services do not apply to Out-of-Pocket Maximum.

Additional information

In-Network

A Provider who or facility that has a contract with Samaritan Health Plans and that has agreed to provide Services to Members of a Plan. You generally have a reduced Out-of-Pocket expense if you see a Provider in the network.

Out-of-Network Providers

Hospitals, Physicians, Providers, professionals and facilities that have not contracted with Samaritan Health Plans to provide benefits to persons covered under this Plan (sometimes referred to as non-participating Providers). You usually pay more to see an Out-of-Network Provider than an In-Network Provider.

Deductible

The portion of the cost of Covered Services you are obligated to pay before the Plan will provide payment for benefits that are subject to the Deductible. Both the Deductible and Out-of-Pocket Maximum are accumulated on a Calendar Year basis. When applying any Deductibles or Out-of-Pocket Maximums of the prior Plan, Samaritan Health Plans will credit any applicable Deductibles and Out-of-Pocket Maximums incurred by you. This means the Deductible and Out-of-Pocket Maximum credit shall be given only to the extent the expenses are recognized under the terms of this Plan and are subject to a similar Deductible or Out-of-Pocket Maximum. Please contact your Plan Administrator for complete details.

Out-of-Pocket Limit

The maximum amount you must pay for Essential Health Benefits and Non-Essential Health Benefits (for example, Deductibles, Coinsurance and Copays) during a Calendar Year before the Plan begins to pay 100% of the allowed amount. The Out-of-Pocket Limit for a Calendar Year will not exceed the annual cost sharing limit for such year as established by the Internal Revenue Service. The Out-of-Pocket Limit is accumulated on a Calendar Year.

Expenses for the following **do not** count toward your Out-of-Pocket Limit:

- Benefits paid in full.
- Charges over the Maximum Plan Allowable.
- Incurred charges that exceed amounts allowed under this Plan.
- Non-covered Services, including those where a third-party is responsible (COB, settlements, motor vehicle Claims).
- Non-Medically Necessary Services, such as excluded Services or those deemed to be not Medically Necessary by the Plan.

Customer Service Department

Contact Samaritan Health Plans at **541-768-4550**, toll free **800-832-4580** (TTY **800-735-2900**). Customer Service hours are 8 a.m. to 8 p.m., Monday through Friday.

Statements made by applicants, policy holder or insured are representations and not warranties.

2300 NW Walnut Blvd., Corvallis, OR 97330
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