



Samaritan Advantage Health Plans
2024 Summary of Benefits

Samaritan Advantage Premier Plan (HMO)
Samaritan Advantage Premier Plan Plus (HMO)

This document is available in other formats such braille, large print, audio or in non-English languages. To request a copy, call us at 800-832-4580 (TTY 800-725-2900).

2024 Samaritan Advantage Summary of Benefits

The benefit information provided here does **not** list every service that we cover or every limitation or exclusion. For details, see the Evidence of Coverage (EOC) available on our website at samhealthplans.org/Medicare.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as Samaritan Advantage Premier Plan Plus or Samaritan Advantage Premier Plan).

Tips for comparing your Medicare choices

This booklet will give you a summary of what Samaritan Advantage Premier Plan Plus and Samaritan Advantage Premier Plan cover, and what you will pay as a member of our plan.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on [medicare.gov](https://www.medicare.gov).
- If you want to know more about the coverage and costs of Original Medicare, look in your current “Medicare & You” handbook. View it online at [medicare.gov](https://www.medicare.gov) or get a copy by calling 800-MEDICARE (800-633-4227), 24 hours a day, seven days a week. TTY users should call 877-486-2048.

Hours of operation & contact information

- From Oct. 1 to March 31, we’re open 8 a.m. to 8 p.m. local time, seven days a week.
- From April 1 to Sept. 30, we’re open 8 a.m. to 8 p.m. local time, Monday through Friday.
- Call us toll free at **866-747-5267** (TTY **800-735-2900**) or **541-768-4550**.
- Visit our website at samhealthplans.org/Medicare.

Samaritan Advantage Premier Plan

Samaritan Advantage Premier Plan Plus

Who can join?

To join Samaritan Advantage Premier Plan Plus or Samaritan Advantage Premier Plan, you must be enrolled in Medicare Part A and Medicare Part B, and you must live in our service area. Our service area includes these counties in Oregon: Benton, Lincoln, and Linn.

Which doctors, hospitals and pharmacies can I use?

Samaritan Advantage Premier Plan Plus and Samaritan Advantage Premier Plan have an extensive network of doctors, hospitals, pharmacies and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can view our pharmacy directory and use our online tool to search for in-network providers at our website at samhealthplans.org/Medicare. Or, call Customer Service to request a copy.

Out-of-network/non-contracted providers are under no obligation to treat Samaritan Advantage Health Plan members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

If you have any questions about these plan's benefits or costs, please contact Samaritan Advantage Health Plans at 866-747-5267 (TTY 800-735-2900) or 541-768-4550 for details.

	Samaritan Advantage Premier Plan (HMO)	Samaritan Advantage Premier Plan Plus (HMO)
Monthly premium, deductible, and limits on how much you pay for covered services		
Monthly Plan Premium	\$19 per month. In addition, you must keep paying your Medicare Part B premium.	\$134 per month. In addition, you must keep paying your Medicare Part B premium.
Deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: \$175 for Tiers 3, 4 and 5.	Medical Deductible: Not Applicable. Prescription Drug Deductible: Not Applicable.
Maximum Out-of-Pocket Responsibility	Your maximum yearly out-of-pocket costs for this plan: <ul style="list-style-type: none"> • \$5,000 for in-network covered Medicare Part A and Part B services. Does not include Medicare Part D drug costs	Your maximum yearly out-of-pocket costs for this plan: <ul style="list-style-type: none"> • \$4,800 for in-network covered Medicare Part A and Part B services. Does not include Medicare Part D drug costs

Covered medical and hospital benefits		
<p>Inpatient Hospital</p> <p><i>Prior Authorization is required for inpatient hospital care (including inpatient rehabilitation care).</i></p> <p><i>Prior Authorization is required for labor and delivery stay greater than 96 hours.</i></p> <p><i>Prior Authorization is required for newborn stay greater than 96 hours.</i></p>	<p>Gold Tier Providers: Days 1-5: \$350 copay per day. Days 6-90: \$0 copay per day.</p> <p>Silver Tier Providers: Days 1-5: \$425 copay per day. Days 6-60: \$35 copay per day. Days 61-90: \$0 copay per day.</p>	<p>Days 1-5: \$325 copay per day. Days 6-90: \$0 copay per day.</p>

Samaritan Advantage Premier Plan
Samaritan Advantage Premier Plan Plus

	Samaritan Advantage Premier Plan (HMO)	Samaritan Advantage Premier Plan Plus (HMO)
<p>Outpatient Hospital <i>Prior Authorization is required for elective/planned surgeries performed in an operating room, surgical suite, or hospital.</i></p> <p><i>Prior Authorization is required for spinal injections for pain management.</i></p>	<p>Gold Tier Providers: Outpatient hospital services: \$350 copay per service. Medicare-covered podiatry services: \$30 copay per service.</p> <p>Silver Tier Providers: Outpatient hospital services: \$450 copay per service. Medicare-covered podiatry services: \$40 copay per service.</p>	<p>Outpatient hospital services: \$300 copay per services. Medicare-covered podiatry services: \$35 copay per service.</p>
<p>Ambulatory Surgical Center <i>Prior Authorization is required for elective/planned surgeries performed in an Ambulatory Surgery Center (ASC).</i></p> <p><i>Prior Authorization is required for spinal injections for pain management.</i></p>	<p>Gold Tier Providers: \$275 copay per services.</p> <p>Silver Tier Providers: \$325 copay per service.</p>	<p>\$250 copay per service.</p>
<p>Doctor's Office Visits <i>Prior Authorization is required for spinal injections for pain management.</i></p>	<p>Gold Tier Providers: Primary care physician visit: \$5 copay. Specialist visit: \$30 copay.</p> <p>Silver Tier Providers: Primary care physician visit: \$15 copay. Specialist visit: \$40 copay.</p> <p>Supplemental Benefit: \$0 copay for telehealth visits with a primary care physician.</p>	<p>Primary care physician visit: \$0 copay. Specialist visit: \$30 copay.</p> <p>Supplemental Benefit: \$0 copay for telehealth visits with a primary care physician.</p>

	Samaritan Advantage Premier Plan (HMO)	Samaritan Advantage Premier Plan Plus (HMO)
<p>Preventive Care (See the Evidence of Coverage for benefit details.)</p>	<p>You pay nothing for all preventive services covered under Original Medicare. Any additional preventive services approved by Medicare during the contract year will be covered.</p>	<p>You pay nothing for all preventive services covered under Original Medicare. Any additional preventive services approved by Medicare during the contract year will be covered.</p>
<p>Emergency Care</p>	<p>Nationwide coverage: \$100 copay per visit.</p> <p>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.</p> <p>Worldwide coverage: \$100 copay per visit.</p>	<p>Nationwide coverage: \$90 copay per visit.</p> <p>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.</p> <p>Worldwide coverage: \$90 copay per visit.</p>
<p>Urgently Needed Services</p>	<p>Nationwide coverage: \$35 copay per Medicare-covered visit.</p> <p>Worldwide coverage: Not covered.</p>	<p>Nationwide coverage: \$35 copay per Medicare-covered visit.</p> <p>Worldwide coverage: Not covered.</p>
<p>Diagnostic Services / Labs / Imaging</p> <p><i>Prior Authorization is required for:</i></p> <ul style="list-style-type: none"> ● <i>MRA and MRI of the breast, cervical, lumbar, and thoracic regions only.</i> ● <i>PET, CTA coronary and virtual colonoscopies;</i> ● <i>Capsule/wireless endoscopies and motility monitoring studies; and</i> ● <i>Genetic testing services, except standard prenatal testing.</i> 	<p>Diagnostic tests and procedures: \$0 copay.</p> <p>Lab services: \$0 copay.</p> <p>Diagnostic Radiology Services (such as MRI, CAT Scan): 20% coinsurance.</p> <p>X-rays: \$15 copay.</p> <p>Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance.</p>	<p>Diagnostic tests and procedures: \$0 copay.</p> <p>Lab services: \$0 copay.</p> <p>Diagnostic Radiology Services (such as MRI, CAT Scan): 20% coinsurance.</p> <p>X-rays: \$15 copay.</p> <p>Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance.</p>

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Samaritan Advantage Premier Plan Plus

	Samaritan Advantage Premier Plan (HMO)	Samaritan Advantage Premier Plan Plus (HMO)
Hearing Services	<p>Medicare-covered: \$25 copay.</p> <p>Supplemental Benefits: Routine hearing exam (up to 1 exam every calendar year): \$10 copay. Hearing aids and supplies: \$500 benefit limit every calendar year. Easily pay for your hearing aids with our benefits MasterCard.</p>	<p>Medicare-covered: \$25 copay.</p> <p>Supplemental Benefits: Routine hearing exam (up to 1 exam every calendar year): \$10 copay. Hearing aids and supplies: \$1,000 benefit limit every calendar year. Easily pay for your hearing aids with our benefits MasterCard.</p>
<p>Dental Services <i>Prior Authorization is required for Medicare-covered dental.</i></p>	<p>Medicare-covered: \$20 copay.</p> <p>Supplemental Benefits: \$1,000 combined benefit limit for preventive and comprehensive dental services. Easily pay for these services with our benefits MasterCard. (Orthodontia is not covered.)</p>	<p>Medicare-covered: \$20 copay.</p> <p>Supplemental Benefits: \$2,000 combined benefit limit for preventive and comprehensive dental services. Easily pay for these services with our benefits MasterCard. (Orthodontia is not covered.)</p>
Vision Services	<p>Exam to diagnose and treat diseases and conditions of the eye: \$30 copay. Eyeglasses or contact lenses after cataract surgery: \$0 copay.</p> <p>Supplemental Benefits: Routine eye exam (up to 1 visit every calendar year): \$10 copay. Eye wear: \$225 benefit limit every calendar year for contact lenses, or eyeglasses (frames, lenses and upgrades). Easily pay for these services with our benefits MasterCard.</p>	<p>Exam to diagnose and treat diseases and conditions of the eye: \$30 copay. Eyeglasses or contact lenses after cataract surgery: \$0 copay.</p> <p>Supplemental Benefits: Routine eye exam (up to 1 visit every calendar year): \$5 copay. Eye wear: \$225 benefit limit every calendar year for contact lenses, or eyeglasses (frames, lenses and upgrades). Easily pay for these services with our benefits MasterCard.</p>

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Mental Health Care <i>Prior Authorization is required for day treatment and electroconvulsive therapy.</i>	Outpatient group therapy visit: \$5 copay. Individual therapy visit: \$5 copay. Inpatient Mental Health Care: \$500 copay per stay.	Outpatient group therapy visit: \$0 copay. Individual therapy visit: \$0 copay. Inpatient Mental Health Care: \$500 copay per stay.
Skilled Nursing Facility (SNF) <i>Prior Authorization is required.</i>	Days 1-20: \$0 copay per day. Days 21-45: \$165 copay per day. Days 46-100: \$0 copay per day.	Days 1-20: \$0 copay per day. Days 21-45: \$165 copay per day. Days 46-100: \$0 copay per day.
Physical Therapy	\$30 copay per visit.	\$25 copay per visit.
Ambulance	Ground Ambulance: \$250 copay. Air Ambulance: 20% coinsurance. Cost-sharing applies for one-way trips.	Ground Ambulance: \$250 copay. Air Ambulance: 20% coinsurance. Cost-sharing applies for one-way trips.
Transportation	Unlimited trips to any health-related location.	Unlimited trips to any health-related location.
Medicare Part B Drugs <i>Prior authorization is required for some high cost infused/injected drugs. Please see the Provider Administered Drugs Prior Authorization List to determine which Part B drugs require prior authorization. The list is located on our website at samhealthplans.org/find-a-drug.</i>	For Part B drugs such as chemotherapy drugs: 20% coinsurance. Other Part B drugs: 20% coinsurance. Some Part B drugs may have a less than 20% coinsurance. CMS will release a list of these drugs quarterly. You won't pay more than \$35 for a one-month supply of insulin product covered under the Part B drug benefit.	For Part B drugs such as chemotherapy drugs: 20% coinsurance. Other Part B drugs: 20% coinsurance. Some Part B drugs may have a less than 20% coinsurance. CMS will release a list of these drugs quarterly. You won't pay more than \$35 for a one-month supply of insulin product covered under the Part B drug benefit.
Acupuncture	Medicare-covered acupuncture: \$20 copay per visit. Routine acupuncture: \$20 copay per visit. (We cover up to 30 supplemental visits per calendar year.)	Medicare-covered acupuncture: \$20 copay per visit. Routine acupuncture: \$20 copay per visit. (We cover up to 30 supplemental visits per calendar year.)

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Samaritan Advantage Premier Plan Plus

	Samaritan Advantage Premier Plan (HMO)	Samaritan Advantage Premier Plan Plus (HMO)
Annual Physical Exam	\$0 copay for a supplemental annual physical exam.	\$0 copay for a supplemental annual physical exam.
Cardiac and Pulmonary Rehabilitation Services	Cardiac rehabilitation services: \$0 copay per visit. Pulmonary rehabilitation services: \$0 copay per visit. Supervised exercise therapy: \$0 copay per visit.	Cardiac rehabilitation services: \$0 copay per visit. Pulmonary rehabilitation services: \$0 copay per visit. Supervised exercise therapy: \$0 copay per visit.
Chiropractic Services	Medicare-covered (manual manipulation to correct subluxation): \$20 copay per visit. Supplemental Benefit: Routine services: \$25 copay per visit. (We cover up to 5 routine visits per calendar year.)	Medicare-covered (manual manipulation to correct subluxation): \$20 copay per visit. Supplemental Benefit: Routine services: \$25 copay per visit. (We cover up to 5 routine visits per calendar year.)
Diabetes Self-Management Training, Diabetic Services and Supplies <i>Prior Authorization is required for insulin pumps (with purchase or rental billed amount greater than \$500 or rental length greater than 3 months).</i>	Diabetes monitoring supplies: \$0 copay. Diabetes self-management training: \$0 copay. Therapeutic shoes or inserts: \$0 copay.	Diabetes monitoring supplies: \$0 copay. Diabetes self-management training: \$0 copay. Therapeutic shoes or inserts: \$0 copay.

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<p>Durable Medical Equipment (DME and related supplies)</p> <p><i>Prior Authorization is required for items with billed amount greater than \$500 for purchase. Rental items with rental fee greater than \$500 per month or rental length greater than 3 months.</i></p> <p><i>Prior Authorization is required for all miscellaneous DME codes.</i></p> <p><i>Prior Authorization is required for enteral and parenteral nutrition.</i></p>	20% coinsurance.	20% coinsurance.
<p>Gym Membership and Fitness Programs</p>	<p>\$25 copay per year for the Silver&Fit® Fitness Center Program.</p> <p>\$10 copay per year for the Silver&Fit® Home Fitness Program.</p>	<p>\$0 copay per year for the Silver&Fit® Healthy Aging and Exercise Program®. (Includes the Fitness Center Program and Home Fitness Program.)</p>
<p>Home Health Services</p>	\$0 copay.	\$0 copay.
<p>Over-The-Counter (OTC) Benefit</p>	<p>\$100 supplemental benefit limit every quarter for eligible over-the-counter items. Pay for eligible OTC items with our benefits MasterCard. Any unused amount does not carry over to the next quarter.</p>	<p>\$100 supplemental benefit limit every quarter for eligible over-the-counter items. Pay for eligible OTC items with our benefits MasterCard. Any unused amount does not carry over to the next quarter.</p>
<p>Personal Emergency Response System (PERS)</p>	\$0 copay for a PERS.	\$0 copay for a PERS.
<p>Podiatry Services</p>	\$35 copay per visit.	\$35 copay per visit.

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Samaritan Advantage Premier Plan Plus

	Samaritan Advantage Premier Plan (HMO)	Samaritan Advantage Premier Plan Plus (HMO)
<p>Prosthetic Devices and Related Supplies (braces, artificial limbs, etc.)</p> <p><i>Prior Authorization is required for prosthetics/orthotics with billed amount greater than \$500 for purchase.</i></p>	20% coinsurance.	20% coinsurance.
<p>Part D prescription drug benefits</p>		
<p>Deductible Phase</p> <p>You are in this phase until you have paid the plan deductible amount. While in this phase you will pay 100% of the cost for drugs in tiers that are subject to the deductible.</p>	<p>Prescription Drug Deductible: \$175 for Tiers 3, 4 and 5.</p>	<p>Prescription Drug Deductible: Not Applicable.</p>

	Samaritan Advantage Premier Plan (HMO)	Samaritan Advantage Premier Plan Plus (HMO)		
<p>Initial Coverage Phase</p> <p>You are in this phase until your total yearly drug costs reach \$5,030. Total yearly drug costs are the drug costs paid by both you and our plan.</p> <p>You will pay these cost shares until you leave the initial coverage phase.</p> <p>Your cost sharing may be different if you use a Long-Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days or 100 days for drugs on Tier 6) of a drug.</p> <p>Please call us or see the plan’s Evidence of Coverage on our website at samhealthplans.org/Medicare for complete information about your costs for covered drugs.</p>	Standard Retail Cost-Sharing			
	Tier	One-month supply	Tier	One-month supply
	Tier 1 Preferred Generic	\$3 copay	Tier 1 Preferred Generic	\$3 copay
	Tier 2 Generic	\$9 copay	Tier 2 Generic	\$9 copay
	Tier 3 Preferred Brand	\$47 copay	Tier 3 Preferred Brand	\$47 copay
	Tier 4 Non-Preferred	\$100 copay	Tier 4 Non-Preferred	\$100 copay
	Tier 5 Specialty	29% coinsurance	Tier 5 Specialty	33% coinsurance
Tier 6 Select Care	\$0 copay	Tier 6 Select Care	\$0 copay	

Samaritan Advantage Premier Plan
Samaritan Advantage Premier Plan Plus

	Samaritan Advantage Premier Plan (HMO)	Samaritan Advantage Premier Plan Plus (HMO)		
<p>Initial Coverage Phase, cont'd.</p> <p>Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible.</p> <p>You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.</p>	Standard Retail Cost-Sharing			
	Tier	Three-month supply	Tier	Three-month supply
	Tier 1 Preferred Generic	\$6 copay	Tier 1 Preferred Generic	\$6 copay
	Tier 2 Generic	\$18 copay	Tier 2 Generic	\$18 copay
	Tier 3 Preferred Brand	\$94 copay	Tier 3 Preferred Brand	\$94 copay
	Tier 4 Non-Preferred	\$200 copay	Tier 4 Non-Preferred	\$200 copay
	Tier 5 Specialty	Not Applicable	Tier 5 Specialty	Not Applicable
	Tier 6 Select Care	\$0 copay	Tier 6 Select Care	\$0 copay

	Samaritan Advantage Premier Plan (HMO)	Samaritan Advantage Premier Plan Plus (HMO)
Initial Coverage Phase, cont'd.	Standard Mail Order	
	Tier	Three-month supply
	Tier 1 Preferred Generic	\$6 copay
	Tier 2 Generic	\$18 copay
	Tier 3 Preferred Brand	\$94 copay
	Tier 4 Non-Preferred	\$200 copay
	Tier 5 Specialty	Not Applicable
	Tier 6 Select Care	\$0 copay
	<p>Your cost-sharing may be different if you use a Long-Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days or 100 days for drugs on Tier 6) of a drug.</p> <p>Please call us or see the plan's Evidence of Coverage on our website (medicare.samhealthplans.org) for complete information about your costs for covered drugs.</p>	<p>Your cost-sharing may be different if you use a Long-Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days or 100 days for drugs on Tier 6) of a drug.</p> <p>Please call us or see the plan's Evidence of Coverage on our website (medicare.samhealthplans.org) for complete information about your costs for covered drugs.</p>

Samaritan Advantage Premier Plan
Samaritan Advantage Premier Plan Plus

	Samaritan Advantage Premier Plan (HMO)	Samaritan Advantage Premier Plan Plus (HMO)												
<p>Coverage Gap</p> <p>You enter this phase once you and the plan pay a combined total of \$5,030. Not everyone will enter the coverage gap.</p> <p>After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total \$8,000, which is the end of the coverage gap.</p> <p>You will pay these cost shares until you leave the coverage gap phase.</p> <p>For generic drugs, only the amount you pay counts and moves you through the coverage gap. For brand drugs, the amount you pay, and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.</p>	<p>You pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs.</p> <p>Our plan provides additional coverage for Tier 6 Select Care Drugs in the coverage gap as a supplemental benefit.</p> <p>Standard Retail Cost-Sharing</p> <table border="1"> <thead> <tr> <th>Tier</th> <th>One-month supply</th> </tr> </thead> <tbody> <tr> <td>Tier 6 Select Care</td> <td>\$0 copay</td> </tr> </tbody> </table>	Tier	One-month supply	Tier 6 Select Care	\$0 copay	<p>You pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs.</p> <p>Our plan provides additional coverage for Tier 1 Preferred Generics, Tier 2 Generic and Tier 6 Select Care Drugs in the coverage gap as a supplemental benefit.</p> <p>Standard Retail Cost-Sharing</p> <table border="1"> <thead> <tr> <th>Tier</th> <th>One-month supply</th> </tr> </thead> <tbody> <tr> <td>Tier 1 Preferred Generic</td> <td>\$3 copay</td> </tr> <tr> <td>Tier 2 Generic</td> <td>\$9 copay</td> </tr> <tr> <td>Tier 6 Select Care</td> <td>\$0 copay</td> </tr> </tbody> </table>	Tier	One-month supply	Tier 1 Preferred Generic	\$3 copay	Tier 2 Generic	\$9 copay	Tier 6 Select Care	\$0 copay
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<p>Catastrophic Amount</p> <p>You enter this phase once your yearly out-of-pocket drug costs total \$8,000.</p> <p>You will remain in this phase and pay these cost shares until the end of the calendar year.</p>	<p>You pay nothing.</p>	<p>You pay nothing.</p>

Pre-enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative toll free at **866-747-5267** (TTY **800-735-2900**) or **541-768-4550**.

Understanding the benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit samhealthplans.org/Medicare or call us toll free at **866-747-5267** (TTY **800-735-2900**) or **541-768-4550** to request a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the formulary to make sure your drugs are covered.

Understanding important rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copays/coinsurance may change on Jan. 1, 2025.
- Except in emergency or urgent situations, we do not generally cover services by out-of-network providers (doctors who are not listed in the provider directory).
- Our plan allows you to see some providers outside of our network (non-contracted providers). However, while we will pay for certain covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. Our plan may require you to obtain prior approval before seeking services with an out-of-network provider.



2300 NW Walnut Blvd., Corvallis, OR 97330
866-747-5267 (TTY 800-735-2900)

samhealthplans.org

Samaritan Advantage Health Plans is an HMO with a Medicare contract. Enrollment in Samaritan Advantage Health Plans depends on contract renewal. Samaritan Health Plans complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.