Samaritan Health Plans

Samaritan Oregon Standard Bronze Plan

Schedule of Benefits

This chart provides a summary of key services offered by your plan and how much you will pay. See your Group Certificate for a full description of your plan's benefits and provisions.

Note about Prior Authorization:
Some services may require Prior Authorization. These services are marked with † in the chart. In some cases, if you fail to ask for Prior Authorization, the service will not be covered.

	In-Network	Out-of-Network
Deductible - Per Calendar Year - Medical and Pharmacy - Some services do not apply to the deductible, as indicated below.	$7,900/individual; $15,800/family	$15,800/individual; $31,600/family
Out-of-Pocket Maximum - Per Calendar Year - Medical and Pharmacy	$7,900/individual; $15,800/family	Unlimited

Benefit	In-Network	Out-of-Network
Emergency Services		
Ambulance, Air	0%, deductible applies	0%, deductible applies
Ambulance, Ground	0%, deductible applies	0%, deductible applies
Emergency Care Cost share waived if admitted.	0%, deductible applies	0%, deductible applies
Urgent Care	0%, deductible applies	0%, deductible applies
Inpatient Care		
Inpatient Habilitative and Rehabilitative Care† Limited to 30 days per Calendar Year. Limits do not apply for Mental Health and Substance Use Disorder Services.	0%, deductible applies	70%, deductible applies
Inpatient Hospital (Professional and Facility)†	0%, deductible applies	70%, deductible applies
Skilled Nursing Facility Care† Limited to 60 days per Calendar Year.	0%, deductible applies	70%, deductible applies

Benefit	In-Network	Out-of-Network
Mental Health and Substance Use Disorder Services		
Inpatient Care†	0%, deductible applies	70%, deductible applies
Office Visits	$45, deductible does not apply	70%, deductible applies
Residential Programs† Includes detoxification.	0%, deductible applies	70%, deductible applies
Office Visits		
Allergy Injections	0%, deductible applies	70%, deductible applies
Injectable Drugs and Other Drugs Administered Other Than Orally† Services when rendered in-office.	0%, deductible applies	70%, deductible applies
Primary Care Services when rendered in-office.	$45, deductible does not apply	70%, deductible applies
Specialty Care Services when rendered in-office.	$90, deductible does not apply	70%, deductible applies
Outpatient Care		
High-Tech Imaging† Includes CT scans, MRIs, and PET scans.	0%, deductible applies	70%, deductible applies
Laboratory†	0%, deductible applies	70%, deductible applies
Outpatient Habilitative Care Includes occupational, physical and speech therapy. Limited to 30-60 combined visits per Calendar Year depending on condition. Limits do not apply for Mental Health and Substance Use Disorder Services.	$45, deductible does not apply	70%, deductible applies
Outpatient Rehabilitative Care Includes occupational, physical and speech therapy. Limited to 30-60 combined visits per Calendar Year depending on condition. Limits do not apply for Mental Health and Substance Use Disorder Services.	$45, deductible does not apply	70%, deductible applies

Benefit	In-Network	Out-of-Network
Outpatient Services (Facility and Professional)† Includes surgery performed in an ambulatory surgery center (ASC) or outpatient hospital facility, chemotherapy, dialysis, infusion, injections, and radiation therapy.	0%, deductible applies	70%, deductible applies
Radiology Includes diagnostic and therapeutic services, electrocardiograms, fluoroscopy, SPECT scans, and ultrasounds.	0%, deductible applies	70%, deductible applies
X-Rays Includes professional readings.	0%, deductible applies	70%, deductible applies
Preventive Care		
Annual Gynecological Exams	No charge, deductible does not apply	70%, deductible applies
Breast Pumps and Breast Pump Supplies	No charge, deductible does not apply	70%, deductible applies
Colorectal Screening	No charge, deductible does not apply	70%, deductible applies
Immunizations	No charge, deductible does not apply	70%, deductible applies
Nutritional Therapy and/or Counseling	No charge, deductible does not apply	70%, deductible applies
Routine Exams and Well Child Care	No charge, deductible does not apply	70%, deductible applies
Routine Mammograms	No charge, deductible does not apply	70%, deductible applies
Tobacco Use Cessation	No charge, deductible does not apply	70%, deductible applies
Other Services		
Biofeedback Limited to 10 lifetime visits for migraines and urinary incontinence. Limit does not apply for Mental Health and Substance Use Disorder Services.	0%, deductible applies	70%, deductible applies
Cardiac Rehab	$45, deductible does not apply	70%, deductible applies
Diabetes Education	0%, deductible applies	70%, deductible applies
Diabetic Supplies†	0%, deductible applies	70%, 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, hearing aids and cochlear implants, and wigs	0%, deductible applies	70%, deductible applies
Home Health Care	0%, deductible applies	70%, deductible applies
Hospice Respite care is covered for up to a maximum of 5 consecutive days and a lifetime limit of 30 days.	0%, deductible applies	70%, deductible applies
Transplants† See your Group Certificate for additional benefit information.	0%, deductible applies	70%, deductible applies
Partial Hospitalization	0%, deductible applies	70%, deductible applies
Pediatric Vision Routine Exam (Ages 0-19)	No charge, deductible does not apply	70%, deductible applies
Pediatric Vision Hardware (Ages 0-19) Limited to one pair of glasses (standard frame and lenses) or contacts (lenses and fitting) once per Calendar Year.	No deductible up to $150, then subject to deductible and 0% coinsurance	70%, deductible applies

Benefit	In-Network	Out-of-Network
Prescription Drugs *Certain drugs require Prior Authorization.* Please visit samhealthplans.org to view your Formulary or call our Customer Service Department to request a copy. Preventive Drugs have coverage at a $0 Copayment when health care reform requirements are met. Out-of-Network drugs not covered unless urgent or emergent.		
Tier 1: Generic Drugs†	$15, deductible does not apply	70%, deductible applies
Tier 2: Preferred†	0%, deductible applies	70%, deductible applies
Tier 3: Non-Preferred†	0%, deductible applies	70%, deductible applies
Tier 4: Generic and Preferred Specialty†	0%, deductible applies	70%, deductible applies
Tier 5: Non-Preferred Specialty†	0%, deductible applies	70%, deductible applies

Additional Information

In-Network
A provider or facility who has a contract with Samaritan Health Plans and who has agreed to provide Services to Members of a plan. You generally will 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 will 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, we 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, for 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 (IRS). 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 usual, customary, and reasonable amounts
- 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 us at 541-768-4550, toll-free 1-800-832-4580 or TTY 1-800-735-2900. Our Customer Service Department hours are 8 a.m. to 8 p.m., Monday through Friday.

We look forward to serving you.

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