SUMMARY OF BENEFITS

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

Samaritan Health Plans

2020

INTRODUCTION TO 2020 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), which we will send you after you enroll. If you would like to see the EOC before you enroll, you can go to https://medicare.samhealthplans.org.

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 managed directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as Samaritan Advantage Health Plans).

Tips for comparing your Medicare choices

This booklet will give you a summary of what Samaritan Advantage Health Plans covers 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 http://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 http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About Samaritan Advantage Health Plans (HMO)
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1-800-832-4580 (TTY: 1-800-735-2900).

INTRODUCTION TO 2020 SUMMARY OF BENEFITS

SECTION I – THINGS TO KNOW ABOUT SAMARITAN ADVANTAGE HEALTH PLANS (HMO)

Hours of Operation & Contact Information

- From October 1 to March 31 we are open from 8:00 a.m. – 8:00 p.m. local time, 7 days a week.
- From April 1 to September 30, we are open from 8:00 a.m. – 8:00 p.m. local time, Monday through Friday.

Samaritan Advantage Health Plans Phone Numbers and Website

- Call us at: 541-768-4550, or toll-free at 1-800-832-4580, TTY: 1-800-735-2900.
- Visit our website: https://medicare.samhealthplans.org.

Who can join?

To join Samaritan Advantage Premier Plan Plus, Samaritan Advantage Premier Plan, or Samaritan Advantage Conventional Plan, you must be enrolled in Medicare Part A and Medicare Part B and 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 Health Plans has an extensive network of doctors, hospitals, pharmacies, and other providers. If you use 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 https://medicare.samhealthplans.org, 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 plans' benefits or costs, please contact Samaritan Advantage Health Plans 1-800-832-4580, (TTY: 1-800-735-2900) for details.

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SECTION II - MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES			
Monthly Plan Premium	$129 per month. In addition, you must keep paying your Medicare Part B premium.	$55 per month. In addition, you must keep paying your Medicare Part B premium.	$70 per month. In addition, you must keep paying your Medicare Part B premiums.
Deductible	Medical deductible: Not applicable. Prescription drug deductible: Not applicable.	Medical deductible: Not applicable. Prescription drug deductible: $200 on tiers 3, 4 and 5.	Medical deductible: Not applicable. Prescription drug deductible: Not applicable.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $3,750 for services you receive from in-network providers. Does not include Medicare Part D drug costs.	Your yearly limit(s) in this plan: • $3,750 for services you receive from in-network providers. Does not include Medicare Part D drug costs.	Your yearly limit(s) in this plan: • $3,750 for services you receive from in-network providers. This plan does not cover Medicare Part D drugs.
SECTION II - COVERED MEDICAL AND HOSPITAL BENEFITS			
Inpatient Hospital *Prior Authorization is required for inpatient hospital care (including inpatient rehabilitation care).* *Prior Authorization requirements for childbirth are in accordance with the Newborns' and Mothers' Health Protection Act.*	Days 1-6: $300 copay per day. Days 7-90: $0 copay per day.	Days 1-6: $300 copay per day. Days 7-90: $0 copay per day.	Days 1-5: $200 copay per day. Days 6-90: $0 copay per day. **Supplemental Benefit:** Days 91 and beyond: $0 copay per day.

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Ambulatory Surgical Center *Prior Authorization is required.*	Medicare-covered: 15% coinsurance per surgery.	Medicare-covered: $200 copay per surgery.	Medicare-covered: $100 copay per surgery.
Outpatient Hospital *Prior Authorization is required.*	Outpatient hospital surgery: 15% coinsurance per surgery.	Outpatient hospital surgery: $200 copay per surgery.	Outpatient hospital surgery: $150 copay per surgery.
Doctor's Office Visits	Primary care physician visit: $5 copay. Specialist visit: $30 copay.	Primary care physician visit: $5 copay. Specialist visit: $30 copay.	Primary care physician visit: $5 copay. Specialist visit: $20 copay.
Preventive Care (See the Evidence of Coverage for benefit details.)	$0 copay for all preventive services covered under Original Medicare. Any additional preventive services approved by Medicare during the contract year will be covered.	$0 copay for all preventive services covered under Original Medicare. Any additional preventive services approved by Medicare during the contract year will be covered.	$0 copay for all preventive services covered under Original Medicare. Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	Nationwide coverage: $90 copay per Medicare-covered visit. Worldwide supplemental coverage: $90 copay per visit. If you are admitted to the hospital within 12 hours, you do not have to pay your copay for emergency care.	Nationwide coverage: $90 copay per Medicare-covered visit. Worldwide supplemental coverage: $90 copay per visit. If you are admitted to the hospital within 12 hours, you do not have to pay your copay for emergency care.	Nationwide coverage: $90 copay per Medicare-covered visit. Worldwide supplemental coverage: $90 copay per visit. If you are admitted to the hospital within 12 hours, you do not have to pay your copay for emergency care.

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Urgently Needed Services	Nationwide coverage: $35 copay per Medicare-covered visit. Worldwide coverage: Not covered.	Nationwide coverage: $35 copay per Medicare-covered visit. Worldwide coverage: Not covered.	Nationwide coverage: $25 copay per Medicare-covered visit. Worldwide coverage: Not covered.
Diagnostic Services/Labs/Imaging *Prior Authorization is required for:* • *MRI, PET, CTA coronary, and virtual colonoscopies;* • *Capsule/wireless endoscopies and motility monitoring studies;* • *Genetic testing services, except standard prenatal testing; and* • *Urine drug tests after 12 units per year.*	Diagnostic tests and procedures: $0 copay. Lab services: $0 copay. MRI, CAT Scan: 20% coinsurance. X-rays: $20 copay.	Diagnostic tests and procedures: $0 copay. Lab services: $0 copay. MRI, CAT Scan: 20% coinsurance. X-rays: $14 copay.	Diagnostic tests and procedures: $0 copay. Lab services: $0 copay. MRI, CAT Scan: 20% coinsurance. X-rays: $15 copay.
Hearing Services	Medicare-covered: $0 copay per diagnostic exam. **Supplemental Benefits:** Routine hearing exam: $10 copay. (We cover up to 1 exam every calendar year.) Hearing aids and supplies: $500 benefit limit every calendar year.	Medicare-covered: $0 copay per diagnostic exam. **Supplemental Benefit:** Routine hearing exam: $10 copay. (We cover up to 1 exam every calendar year.)	Medicare-covered: $0 copay per diagnostic exam. **Supplemental Benefit:** Routine hearing exam: $10 copay. (We cover up to 1 exam every calendar year.)

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Dental Services *Prior Authorization is required for Medicare-covered dental.*	Medicare-covered: $20 copay per service. **Supplemental Benefits:** Preventive oral exam (up to 2 every calendar year): $25 copay. Regular cleaning (prophylaxis) (up to 2 every calendar year): $25 copay. If prophylaxis occurs at the time of the oral exam, only one $25 copay will apply. Dental x-rays (up to 1 set every calendar year): $0 copay. Comprehensive dental: $1,000 benefit limit every calendar year.	Medicare-covered: $15 copay per service.	Medicare-covered: $15 copay per service. **Supplemental Benefits:** Preventive oral exam (up to 2 every calendar year): $20 copay. Regular cleaning (prophylaxis) (up to 2 every calendar year): $20 copay. If prophylaxis occurs at the time of the oral exam, only one $20 copay will apply. Dental x-rays (up to 1 set every calendar year): $0 copay.

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Vision Services	Exam to diagnose and treat diseases and conditions of the eye: $30 copay per exam. **Supplemental Benefits:** Routine eye exam (up to 1 every calendar year): $30 copay. Eyeglasses or contact lenses after cataract surgery: $0 copay. Eye wear: $125 benefit limit every calendar year for contact lenses (up to 12 pairs), or eyeglasses (frames, lenses and upgrades).	Exam to diagnose and treat diseases and conditions of the eye: $30 copay per exam. **Supplemental Benefits:** Routine eye exam (up to 1 every calendar year): $0 copay. Eyeglasses or contact lenses after cataract surgery: $0 copay. Eye wear: $125 benefit limit every calendar year for contact lenses (up to 12 pairs), or eyeglasses (frames, lenses and upgrades).	Exam to diagnose and treat diseases and conditions of the eye: $20 copay per exam. **Supplemental Benefits:** Routine eye exam (up to 1 every calendar year): $20 copay. Eyeglasses or contact lenses after cataract surgery: $0 copay. Eye wear: $125 benefit limit every calendar year for contact lenses (up to 12 pairs), or eyeglasses (frames, lenses and upgrades).
Mental Health Care *Prior Authorization is required.*	Individual or group therapy: $30 copay per session. Inpatient mental health facility: $500 copay per stay.	Individual or group therapy: $30 copay per session. Inpatient mental health facility: $500 copay per stay.	Individual or group therapy: $20 copay per session. Inpatient mental health facility: $500 copay per stay.
Skilled Nursing Facility (SNF) *Prior Authorization is required for stays greater than 7 days.*	Days 1-20: $0 copay per day. Days 21-60: $160 copay per day. Days 61-100: $0 copay per day. **Supplemental Benefit:** Days 101-120: $0 copay per day.	Days 1-20: $0 copay per day. Days 21-60: $160 copay per day. Days 61-100: $0 copay per day. **Supplemental Benefit:** Days 101-120: $0 copay per day.	Days 1-20: $0 copay per day. Days 21-60: $160 copay per day. Days 61-100: $0 copay per day. **Supplemental Benefit:** Days 101-120: $0 copay per day.

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Physical Therapy	Medicare-covered services: $25 copay per visit.	Medicare-covered services: $25 copay per visit.	Medicare-covered services: $15 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.	Ground Ambulance: $250 copay. Air Ambulance: 20% coinsurance. Cost-sharing applies for one-way trips.
Transportation	Not covered.	Not covered.	Not covered.
Medicare Part B Drugs *Prior Authorization is required for 40 specific high cost infused/injected drugs (including any brand name equivalents), as listed on the 2020 Prior Authorization List.*	Part B chemotherapy drugs: 20% coinsurance. Other Part B drugs: 20% coinsurance.	Part B chemotherapy drugs: 20% coinsurance. Other Part B drugs: 20% coinsurance.	Part B chemotherapy drugs: 20% coinsurance. Other Part B drugs: 20% coinsurance.
Acupuncture	$20 copay per visit. (We cover up to 30 supplemental visits per calendar year.)	$20 copay per visit. (We cover up to 30 supplemental visits per calendar year.)	$20 copay per visit. (We cover up to 30 supplemental visits per calendar year.)
Annual Physical Exam	$0 copay for a supplemental annual physical exam.	$0 copay for a supplemental annual physical exam.	$0 copay for a supplemental annual physical exam.
Cardiac and Pulmonary Rehabilitation Services	Medicare-covered: $0 copay.	Medicare-covered: $0 copay.	Medicare-covered: $0 copay.

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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.)	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 *Prior Authorization is required for insulin pumps (with purchase or rental billed amount greater than $500 or rental length greater than 3 months), therapeutic and diabetic shoes/inserts.*	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.	Diabetes monitoring supplies: $0 copay. Diabetes self-management training: $0 copay. Therapeutic shoes or inserts: $0 copay.
Durable Medical Equipment *(DME and related supplies)* *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.*	Medicare-covered: 20% coinsurance.	Medicare-covered: 20% coinsurance.	Medicare-covered: 20% coinsurance.

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Gym membership and fitness programs	$0 for a SamFit gym membership as a supplemental benefit.	Fitness Benefit: Not covered.	$0 for a SamFit gym membership as a supplemental benefit.
Home Health Services	Medicare-covered: $0 copay.	Medicare-covered: $0 copay.	Medicare-covered: $0 copay.
Podiatry Services	Medicare-covered: $35 copay per visit.	Medicare-covered: $35 copay per visit.	Medicare-covered: $15 copay per visit.
Prosthetic Devices and Related Supplies *(braces, artificial limbs, etc.)* *Prior Authorization is required for prosthetics/orthotics with billed amount greater than $500 for purchase.*	Medicare-covered: 20% coinsurance.	Medicare-covered: 20% coinsurance.	Medicare-covered: 20% coinsurance.

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SECTION IV - PRESCRIPTION DRUG BENEFITS			
Deductible Phase You are in this phase until you have paid the plan deductible amount. While in this is phase you will pay 100% of the cost for drugs in tiers that are subject to the deducible.	**There is no deductible stage for this plan.**	This plan has a $200 deductible. You pay the full cost for drugs in the following tiers until you have reached the deductible amount: • Preferred Brand (Tier 3) • Non-Preferred Drug (Tier 4) • Specialty Tier (Tier 5) For drugs in tiers 1, 2, and 6, you pay the cost-shares listed below in the “Initial Coverage Phase”.	**This plan does not cover Medicare Part D drugs.**

	Samaritan Advantage Premier Plan Plus (HMO)	Samaritan Advantage Premier Plan (HMO)	Samaritan Advantage Conventional Plan (HMO)
Initial Coverage Phase You are in this phase until your total yearly drug costs reach $4,020. Total yearly drug costs are the drug costs paid by both you and our plan. You will pay these cost shares until you leave the initial coverage phase. 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) of a drug. Please call us or see the plan's **"Evidence of Coverage"** on our website (https://medicare.samhealthplans.org) for complete information about your costs for covered drugs.	**Standard Retail Cost-Sharing**	**Standard Retail Cost-Sharing**	

Tier	One-month supply
Tier 1 (Preferred Generic)	$3 copay
Tier 2 (Generic)	$9 copay
Tier 3 (Preferred Brand)	$47 copay
Tier 4 (Non-Preferred Drug)	50% coinsurance
Tier 5 (Specialty Tier)	33% coinsurance
Tier 6 (Select Care Drugs)	$0 copay

Tier	One-month supply
Tier 1 (Preferred Generic)	$3 copay
Tier 2 (Generic)	$9 copay
Tier 3 (Preferred Brand)	$47 copay
Tier 4 (Non-Preferred Drug)	46% coinsurance
Tier 5 (Specialty Tier)	29% coinsurance
Tier 6 (Select Care Drugs)	$0 copay

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Initial Coverage Phase (Continued)	**Standard Mail Order**	**Standard Mail Order**	

Tier	Three-month supply
Tier 1 (Preferred Generic)	$9 copay
Tier 2 (Generic)	$27 copay
Tier 3 (Preferred Brand)	$141 copay
Tier 4 (Non-Preferred Drug)	50% coinsurance
Tier 5 (Specialty Tier)	Not Applicable
Tier 6 (Select Care Drugs)	$0 copay

Tier	Three-month supply
Tier 1 (Preferred Generic)	$9 copay
Tier 2 (Generic)	$27 copay
Tier 3 (Preferred Brand)	$141 copay
Tier 4 (Non-Preferred Drug)	46% coinsurance
Tier 5 (Specialty Tier)	Not Applicable
Tier 6 (Select Care Drugs)	$0 copay

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Coverage Gap Phase You enter this phase once you and the plan pay a combined total of $4,020. Not everyone will enter the coverage gap. 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 $6,350, which is the end of the coverage gap. You will pay these cost shares until you leave the coverage gap phase. 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.	Samaritan Advantage Premier Plan Plus offers supplemental gap coverage for drugs in tiers 1, 2, and 6.		

Tier	One-month supply
Tier 1 (Preferred Generic)	$3 copay or 25% coinsurance, whichever is lower
Tier 2 (Generic)	$9 copay or 25% coinsurance, whichever is lower
Tier 3 (Preferred Brand)	25% coinsurance
Tier 4 (Non-Preferred Drug)	25% coinsurance
Tier 5 (Specialty Tier)	25% coinsurance
Tier 6 (Select Care Drugs)	$0 copay

Tier	One-month supply
Tier 1 (Preferred Generic)	25% coinsurance
Tier 2 (Generic)	25% coinsurance
Tier 3 (Preferred Brand)	25% coinsurance
Tier 4 (Non-Preferred Drug)	25% coinsurance
Tier 5 (Specialty Tier)	25% coinsurance
Tier 6 (Select Care Drugs)	25% coinsurance

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Catastrophic Coverage Phase You enter this phase once your yearly out-of-pocket drug costs total $6,350. You will remain in this phase and pay these cost shares until the end of the calendar year.	You pay the greater of: • $3.60 copay for generic (including brand drugs treated as generic) and a $8.95 copay for all other drugs, or • 5% coinsurance.	You pay the greater of: • $3.60 copay for generic (including brand drugs treated as generic) and a $8.95 copay for all other drugs, or • 5% coinsurance.	

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