# High-Deductible Health Plan with HSA Schedule of Benefits

This chart provides 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.

Below is the amount you pay after you have met your Calendar Year Deductible (unless noted that Deductible is waived).

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Deductible**<br>• Per Calendar Year.<br>• Medical and pharmacy.<br>• Some services do not apply to the Deductible, as indicated below. | Individual: $3,200<br>Family: $6,400 | There is no separate deductible for Out-of-Network services |
| **Out-of-Pocket Maximum**<br>• Per Calendar Year.<br>• Medical and Pharmacy. | Individual: $5,000<br>Family: $10,000 | Individual: Unlimited<br>Family: Unlimited |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Preventive Care** | | |
| **Annual gynecological exams** | No charge | 30%, deductible waived |
| **Breast pumps and breast pump Supplies** | No charge | 30%, deductible waived |
| **Colorectal screening** | No charge | 30%, deductible waived |
| **Immunizations** | No charge | 30%, deductible waived |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Routine exams and well-childcare** | No charge | 30%, deductible waived |
| **Routine mammograms** | No charge | 30%, deductible waived |
| **Tobacco Use cessation** | No charge | 30%, deductible waived |
| **Physician Services/Professional Services** | | |
| **Primary care[1]**<br>Services when rendered in office | $25 | 30% |
| **Specialty care**<br>Services when rendered in office | $40 | 30% |
| **Surgery professional**<br>(at hospital or Ambulatory Surgery Center) | $60 | 30% |
| **Allergy injections** | $15 | 30% |
| **Chronic Care visits**<br>Asthma, diabetes, congestive heart failure (CHF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD) | No charge | 30% |
| **Naturopath visits[1]** | $25 | 30% |
| **Telehealth visit** | No charge, deductible waived | 30% |
| **Specified surgical procedures**<br>(including surgery and anesthesia) | 20% | 30% |
| **Emergency Services** | | |
| **Ambulance, air** | 20% | 20% |
| **Ambulance, ground** | 20% | 20% |

| Benefit | In-Network | Out-of-Network |
| --- | --- | --- |
| **Emergency room**<br>ER professional or ancillary Services billed separately. Refer to the applicable benefit in this Document for additional Cost Share information.<br>Cost Share waived if admitted to the Hospital and all Services subject to inpatient benefits. | $150 | $150 |
| **Urgent care** | $40 | $40 |
| **Inpatient Care** | | |
| **Inpatient Hospital** | | |
| SHS Facility | $175/day, up to $875 maximum per stay | N/A |
| Non-SHS Facility | $300/day, up to $1,500 maximum per stay | 30% |
| **Inpatient Habilitative and Rehabilitative Services**<br>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 | N/A |
| Non-SHS Facility | $300/day, up to $1,500 maximum per stay | 30% |
| **Maternity Services and routine nursery care** | $40 | 30% |
| **Skilled Nursing Facility care** | No charge | 30% |
| **Outpatient Services** | | |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Outpatient Rehabilitative Services**<br>Includes occupational, physical and Speech Therapy.<br>Limited to 30-60 combined visits per Calendar Year depending on condition.<br>Limits do not apply for Mental Health and Substance Use Disorder Services. | | |
| SHS Facility | $30 | N/A |
| Non-SHS Facility | $35 | 30% |
| **Outpatient Services**<br>Includes surgery performed in an Ambulatory Surgery Center or outpatient Hospital facility, chemotherapy, dialysis, infusion, injections and radiation therapy. | | |
| SHS Facility | $150 | N/A |
| Non-SHS Facility | $250 | 30% |
| **Diagnostic Services** | | |
| **Diagnostic radiology**<br>Includes diagnostic and therapeutic Services, electrocardiograms, fluoroscopy, ultrasounds and X-rays. | $25 | 30% |
| **High-tech imaging**<br>Includes CT scans, MRIs, PET scans and SPECT scans. | 20% | 30% |
| **Laboratory** | No charge | 30% |
| **Mental Health and Substance Use Disorder Services** | | |
| **Office visits** | $40 | 30% |
| **Inpatient care** | | |
| SHS Facility | $175/day, up to $875 maximum pers stay | 30% |
| Non-SHS Facility | $300/day, up to $1,500 maximum per stay | |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Residential programs**<br>Includes detoxification and partial hospitalization | 30% | 30% |
| **Other Services** | | |
| **Injectables and other drugs administered in the office (other than oral medications)[4]** | 20% | 20% |
| **Panniculectomy[5]** | 50% | Not covered |
| **Diabetes education** | No charge | 30% |
| **Diabetic Supplies; including Continuous Glucose Monitors.**<br>Supplies purchased from a pharmacy will fall under Pharmacy benefit (please refer to formulary) | No charge | 50% |
| **Durable Medical Equipment (DME), prosthetics, orthotics and Medical Supplies**<br>Includes artificial limbs and eyes, diabetic equipment, enteral and parenteral formula | 30% | 50% |
| **Hearing aids** | Hearing aids are limited up to $3000 every 3 years.<br>No limit for dependents 20 years old and younger. | Hearing aids are limited up to $3000 every 3 years.<br>No limit for dependents 20 years old and younger. |
| **Home Health Care** | $30 | 30% |
| **Hospice**<br>Respite care is covered for up to a maximum of five consecutive days and a lifetime limit of 30 days. | No charge | 30% |
| **Bariatric surgery[2]** | $5,000 | Not covered |
| **Wigs**<br>See Member Handbook for additional benefit information | 20% | 20% |
| **Acupuncture** | $35 | 30% |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Chiropractic care[3]**<br>Coverage for up to 12 spinal manipulation visits per Calendar Year. | $25 | 30% |
| **Prescription Drugs** | | |

Deductible applies unless noted, for all pharmacy tiers.

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 waived | Not covered |
| **Tier 2: Low-cost therapeutic** | **1 to 34-day supply:** $3<br>**35 to 90-day supply:** $9 | Not covered |
| **Tier 3: Preferred** | **1 to 34-day supply:** $15<br>**35 to 90-day supply:** $45 | Not covered |
| **Tier 4: High-cost preferred** | **1 to 34-day supply:** $65 or 25% (whichever is less) | Not covered |
| **Tier 5: Non-preferred** | **1 to 34-day supply:** $250 or 50% (whichever is less) | Not covered |
| **Tier 6: High-cost specialty** | **1 to 34-day supply:** 15% | 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.

# Additional information

## In-Network

A Provider 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.

Thank you for the opportunity to serve you.

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