



# High-Deductible Health Plan with HSA Schedule of Benefits

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
<b>Deductible</b> <ul style="list-style-type: none"> <li>Per Calendar Year.</li> <li>Medical and pharmacy.</li> <li>Some services do not apply to the Deductible, as indicated below.</li> </ul>	Individual: \$3,200 Family: \$6,400	There is no separate deductible for Out-of-Network services
<b>Out-of-Pocket Maximum</b> <ul style="list-style-type: none"> <li>Per Calendar Year.</li> <li>Medical and Pharmacy.</li> </ul>	Individual: \$5,000 Family: \$10,000	Individual: Unlimited Family: Unlimited

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

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

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

Benefit	In-Network	Out-of-Network
<b>Diagnostic Services</b>		
<b>Diagnostic radiology</b> Includes diagnostic and therapeutic Services, electrocardiograms, fluoroscopy, ultrasounds and X-rays.	\$25, deductible applies	30%, deductible applies
<b>High-tech imaging</b> Includes CT scans, MRIs, PET scans and SPECT scans.	20%, deductible applies	30%, deductible applies
<b>Laboratory</b>	No charge, deductible applies	30%, deductible applies
<b>Mental Health and Substance Use Disorder Services</b>		
<b>Office visits</b>	\$40, deductible applies	30%, deductible applies
<b>Inpatient care</b> SHS Facility  Non-SHS Facility	\$175/day, up to \$875 maximum pers stay, deductible applies  \$300/day, up to \$1,500 maximum per stay, deductible applies	30%, deductible applies  30%, deductible applies
<b>Residential programs</b> Includes detoxification and partial hospitalization	30%, deductible applies	30%, deductible applies
<b>Other Services</b>		
<b>Injectables and other drugs administered in the office (other than oral medications)<sup>4</sup></b>	20%, deductible applies	20%, deductible applies
<b>Panniculectomy<sup>5</sup></b>	50%, deductible applies	Not covered
<b>Diabetes education</b>	No charge, deductible applies	30%, deductible applies
<b>Diabetic Supplies; including Continuous Glucose Monitors.</b> 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
<b>Durable Medical Equipment (DME), prosthetics, orthotics and Medical Supplies</b> Includes artificial limbs and eyes, diabetic equipment, enteral and parenteral formula	30%, deductible applies	50%, deductible applies
<b>Hearing aids</b>	Hearing aids are limited up to \$3000 every 3 years, deductible applies No limit for dependents 20 years old and younger	Hearing aids are limited up to \$3000 every 3 years, deductible applies No limit for dependents 20 years old and younger
<b>Home Health Care</b>	\$30, deductible applies	30%, deductible applies
<b>Hospice</b> 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
<b>Bariatric surgery</b> <sup>2,6</sup>	\$5,000, deductible applies	Not covered
<b>Wigs</b> See Member Handbook for additional benefit information	20%, deductible applies	20%, deductible applies
<b>Acupuncture</b>	\$35, deductible applies	30%, deductible applies
<b>Chiropractic care</b> <sup>3</sup> 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](http://samhealthplans.org/Find-a-Drug) to view your Formulary or call Customer Service to request a copy.

Benefit	In-Network	Out-of-Network
<b>Tier 1:</b> Preventive drugs	<b>1 to 90-day supply:</b> No charge, deductible does not apply	Not covered
<b>Tier 2:</b> Low-cost therapeutic	<b>1 to 34-day supply:</b> \$3, deductible applies <b>35 to 90-day supply:</b> \$9, deductible applies	Not covered
<b>Tier 3:</b> Preferred	<b>1 to 34-day supply:</b> \$15, deductible applies <b>35 to 90-day supply:</b> \$45, deductible applies	Not covered
<b>Tier 4:</b> High-cost preferred	<b>1 to 34-day supply:</b> \$65 or 25% (whichever is less), deductible applies	Not covered
<b>Tier 5:</b> Non-preferred	<b>1 to 34-day supply:</b> \$250 or 50% (whichever is less), deductible applies	Not covered
<b>Tier 6:</b> High-cost specialty	<b>1 to 34-day supply:</b> 15%, deductible applies	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 apply to Out-of-Pocket Maximum.

# 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.

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



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**[samhealthplans.org](http://samhealthplans.org)**