

## Samaritan Momentum HDHP 2800

[Employer Group Name]

# 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
<b>Deductible:</b> - Per Calendar Year - Medical and Pharmacy - Some services do not apply to the deductible, as indicated below.	Individual: \$2,800 Family: \$5,600	Individual: \$5,600 Family: \$11,200
<b>Out-of-Pocket Maximum:</b> - Per Calendar Year - Medical and Pharmacy	Individual: \$6,850 Family: \$13,700	Individual: \$13,700 Family: \$27,400

Benefit	In-Network	Out-of-Network
<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 Care</b> Cost share waived if admitted.	20%, deductible applies	20%, deductible applies
<b>Urgent Care</b>	20%, deductible applies	20%, deductible applies
<b>Inpatient Care</b>		
<b>Inpatient Habilitative and Rehabilitative Care†</b> Limited to 30 days per Calendar Year. Limits do not apply for Mental Health and Substance Use Disorder Services.	20%, deductible applies	50%, deductible applies
<b>Inpatient Hospital (Professional and Facility)†</b>	20%, deductible applies	50%, deductible applies
<b>Skilled Nursing Facility Care†</b> Up to 60 days per calendar year	20%, deductible applies	50%, deductible applies

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<b>Benefit</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Mental Health and Substance Use Disorder Services</b>		
<b>Inpatient Care</b> <sup>†</sup>	20%, deductible applies	50%, deductible applies
<b>Office Visits</b>	20%, deductible applies	50%, deductible applies
<b>Partial Hospitalization and Intensive Outpatient Services for Mental Health</b>	20%, deductible applies	50%, deductible applies
<b>Partial Hospitalization and Intensive Outpatient Services for Substance Use Disorder</b>	20%, deductible applies	Not Covered
<b>Residential Programs</b> <sup>†</sup> Includes detoxification.	20%, deductible applies	50%, deductible applies
<b>Office Visits</b>		
<b>Allergy Injections</b>	20%, deductible applies	50%, deductible applies
<b>Injectable Drugs and Other Drugs Administered Other Than Orally</b> <sup>†</sup> Services when rendered in-office.	20%, deductible applies	50%, deductible applies
<b>Primary Care</b> Services when rendered in-office.	20%, deductible applies	50%, deductible applies
<b>Specialty Care</b> Services when rendered in-office.	20%, deductible applies	50%, deductible applies
<b>Outpatient Care</b>		
<b>High-Tech Imaging</b> <sup>†</sup> Includes CT scans, MRIs, and PET scans.	20%, deductible applies	50%, deductible applies
<b>Laboratory</b> <sup>†</sup>	20%, deductible applies	50%, deductible applies
<b>Outpatient Habilitative Care</b> Includes occupational and speech therapy.	20%, deductible applies	50%, deductible applies
<b>Outpatient Rehabilitative Care</b> Includes occupational and speech therapy.	20%, deductible applies	50%, deductible applies
<b>Outpatient Services (Facility and Professional)</b> <sup>†</sup> Includes surgery performed in an ambulatory surgery center (ASC) or outpatient hospital facility, chemotherapy, dialysis, infusion, injections, and radiation therapy.	20%, deductible applies	50%, deductible applies
<b>Physical Therapy</b>	20%, deductible applies	50%, deductible applies

<b>Benefit</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Radiology</b> Includes diagnostic and therapeutic services, electrocardiograms, fluoroscopy, SPECT scans, and ultrasounds.	20%, deductible applies	50%, deductible applies
<b>X-Rays</b> Includes professional readings.	20%, deductible applies	50%, deductible applies
<b>Preventive Care</b>		
<b>Annual Gynecological Exams</b>	No charge, deductible does not apply	50%, deductible applies
<b>Breast Pumps and Breast Pump Supplies</b>	No charge, deductible does not apply	50%, deductible applies
<b>Colorectal Screening</b>	No charge, deductible does not apply	50%, deductible applies
<b>Immunizations</b>	No charge, deductible does not apply	50%, deductible applies
<b>Nutritional Therapy and/or Counseling</b>	No charge, deductible does not apply	50%, deductible applies
<b>Routine Exams and Well Child Care</b>	No charge, deductible does not apply	50%, deductible applies
<b>Routine Mammograms</b>	No charge, deductible does not apply	50%, deductible applies
<b>Tobacco Use Cessation</b>	No charge, deductible does not apply	50%, deductible applies
<b>Other Services</b>		
<b>Cardiac Rehab</b>	20%, deductible applies	50%, deductible applies
<b>Diabetes Education</b>	20%, deductible applies	50%, deductible applies
<b>Diabetic Supplies<sup>†</sup></b>	20%, deductible applies	50%, deductible applies
<b>Durable Medical Equipment (DME), Prosthetics, Orthotics, and Medical Supplies<sup>†</sup></b> Includes artificial limbs and eyes, diabetic equipment, enteral and parenteral formula, hearing aids and cochlear implants, and wigs.	20%, deductible applies	50%, deductible applies
<b>Home Health Care<sup>†</sup></b>	20%, deductible applies	50%, deductible applies
<b>Hospice</b>	20%, deductible applies	50%, deductible applies
<b>Transplants<sup>†</sup></b> See your Group Certificate for additional benefit information.	50%, deductible applies	50%, deductible applies

Benefit	In-Network	Out-of-Network
<p><b>Prescription Drugs</b></p> <p><i>Certain drugs require Prior Authorization.</i></p> <p>Please visit <a href="http://samhealthplans.org">samhealthplans.org</a> to view your Formulary or call our Customer Service Department to request a copy.</p> <p>Preventive Drugs have coverage at a \$0 Copayment when health care reform requirements are met.</p>		
<b>Tier 1: Low Cost Therapeutic<sup>†</sup></b>	20%, deductible applies	50%, deductible applies
<b>Tier 2: Preferred<sup>†</sup></b>	20%, deductible applies	50%, deductible applies
<b>Tier 3: High Cost Preferred<sup>†</sup></b>	20%, deductible applies	50%, deductible applies
<b>Tier 4: Non-preferred<sup>†</sup></b>	20%, deductible applies	50%, deductible applies
<b>Tier 5: High Cost Specialty<sup>†</sup></b>	50%, deductible applies	50%, 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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