



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [samhealthplans.org](http://samhealthplans.org). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [healthcare.gov/sbc-glossary/](http://healthcare.gov/sbc-glossary/) or call 1-800-832-4580 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<p><b>In-network:</b> \$750/individual; \$1,500/family</p> <p><b>Out-of-network:</b> \$1,500/individual; \$3,000/family</p>	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	<b>Yes.</b> In-Network services for Office Visits, In-Network Pharmacy, <u>Preventive services</u> , and <u>Urgent Care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	<b>No</b>	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<p><b>In-Network:</b> \$3,000/individual; \$6,000/family</p> <p><b>Out-of-Network:</b> \$6,000/individual; \$12,000/family</p>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Will you pay less if you use a <a href="#">network provider</a> ?	Yes. Visit <a href="http://samhealthplans.org">samhealthplans.org</a> or call 1-800-832-4580 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$15 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	<a href="#">Deductible</a> does not apply to <a href="#">in-network providers</a> . You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
	<a href="#">Specialist</a> visit	\$30 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	
	<a href="#">Preventive Care/screening/immunization</a>	\$0 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Radiology: 20% <a href="#">coinsurance</a>  Labs: 20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	For Radiology services, <a href="#">deductible</a> does not apply to <a href="#">in-network providers</a> . For Lab services, <a href="#">deductible</a> does not apply to <a href="#">in-network providers</a> . Some services require authorization. Failure to obtain authorization can result in a requested service being denied.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	For Imaging services, <a href="#">deductible</a> does not apply to <a href="#">in-network providers</a> . Some services require authorization. Failure to obtain authorization can result in a requested service being denied. Imaging services include SPECT scans.

\* For more information about limitations and exceptions, see the plan or policy document at [samhealthplans.org](http://samhealthplans.org).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="#">samhealthplans.org</a>	Preventive drugs (Tier 1)	\$0 <a href="#">copay</a> /prescription	50% <a href="#">coinsurance</a>	<a href="#">Deductible</a> does not apply to <a href="#">in-network providers</a> . Some prescriptions require authorization. Failure to obtain authorization can result in a requested service being denied.
	Generic drugs (Tier 2)	\$10 <a href="#">copay</a> /prescription	50% <a href="#">coinsurance</a>	
	Preferred brand drugs (Tier 3)	\$35 <a href="#">copay</a> /prescription	50% <a href="#">coinsurance</a>	
	Non-preferred brand drugs (Tier 4)	\$75 <a href="#">copay</a> /prescription	50% <a href="#">coinsurance</a>	
	<a href="#">Specialty drugs</a> (Tier 5)	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies. Some services require authorization. Failure to obtain authorization can result in a requested service being denied.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$200 <a href="#">copay</a> , then 20% <a href="#">coinsurance</a>	\$200 <a href="#">copay</a> , then 20% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies. If admitted, services are subject to Inpatient benefits and Emergency room <a href="#">cost share</a> is waived.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies.
	<a href="#">Urgent Care</a>	\$45 <a href="#">copay</a> /visit	\$45 <a href="#">copay</a> /visit	<a href="#">Deductible</a> does not apply.

\* For more information about limitations and exceptions, see the plan or policy document at [samhealthplans.org](#).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies. Requires authorization. Failure to obtain authorization can result in a requested service being denied.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	<a href="#">Deductible</a> does not apply to <a href="#">in-network providers</a> .
	Inpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies. Includes Inpatient and Residential. Requires authorization. Failure to obtain authorization can result in a requested service being denied.
If you are pregnant	Office visits	Primary Care: \$15 <a href="#">copay</a> /visit  <a href="#">Specialist</a> : \$30 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	<a href="#">Deductible</a> does not apply to <a href="#">in-network providers</a> . <a href="#">Cost sharing</a> does not apply for in-network <a href="#">preventive services</a> . <a href="#">Cost share</a> will depend on how the <a href="#">provider</a> bills the service. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies.
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

\* For more information about limitations and exceptions, see the plan or policy document at [samhealthplans.org](http://samhealthplans.org).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies.
	<a href="#">Rehabilitation services</a>	\$30 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies. Coverage is limited to 30 visits per year for Physical, Occupational, and Speech therapy. An additional 30 visits may be approved for certain conditions.
	<a href="#">Habilitation services</a>	\$30 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	Services in <a href="#">Urgent Care</a> or Emergency room will apply applicable <a href="#">cost share</a> .
	<a href="#">Skilled nursing care</a>	\$0 <a href="#">copay</a>	50% <a href="#">coinsurance</a>	<a href="#">Deductible</a> does not apply to <a href="#">in-network providers</a> . Requires authorization. Failure to obtain authorization can result in a requested service being denied. Coverage is limited to 60 days per year.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies. Requires authorization with line items over \$800 in rental or purchase fees or rentals over three (3) months. Failure to obtain authorization can result in a requested service being denied.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies. Coverage is limited to max of 5 consecutive days and lifetime max of 30 days for respite care.

\* For more information about limitations and exceptions, see the plan or policy document at [samhealthplans.org](http://samhealthplans.org).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	\$0 <a href="#">copay</a> , for specific codes	50% <a href="#">coinsurance</a>	\$0 <a href="#">copay</a> , for specific codes for <a href="#">in-network providers</a> . <a href="#">Cost sharing</a> may apply for other codes. <a href="#">Deductible</a> does not apply to <a href="#">in-network providers</a> . Coverage is limited to one exam per benefit year for children only. Call health plan for specific coverage information.
	Children's glasses	\$0 <a href="#">copay</a> , for specific codes	50% <a href="#">coinsurance</a>	\$0 <a href="#">copay</a> , for specific codes for <a href="#">in-network providers</a> . <a href="#">Cost sharing</a> may apply for other codes. <a href="#">Deductible</a> does not apply to <a href="#">in-network providers</a> . Coverage is limited to once per benefit year for children only. Contacts and frames are each covered up to \$150 per calendar year. Call health plan for specific coverage information.
	Children's dental check-up	Not covered	Not covered	Please check with your dental plan.

\* For more information about limitations and exceptions, see the plan or policy document at [samhealthplans.org](http://samhealthplans.org).

### Excluded Services & Other Covered Services:

#### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Bariatric Surgery
- Cosmetic surgery (with authorization)
- Dental care
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture
- Chiropractic care
- Hearing aids (1 per side every 48 months)
- Routine foot care

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: [samhealthplans.org](http://samhealthplans.org) or 1-800-832-4580. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your [appeal](#). Contact Oregon Division of Insurance at 1-888-877-4894 or [www.insurance.oregon.gov/consumer/health-insurance/health.html](http://www.insurance.oregon.gov/consumer/health-insurance/health.html).

#### Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

#### Does this plan meet the Minimum Value Standards? **Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

#### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-832-4580.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-832-4580.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-832-4580.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne'1-800-832-4580.'

—————To see examples of how this plan might cover costs for a sample medical situation, see the next section—————

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$750
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**  
 Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,840</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$80
Coinsurance	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,790</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$750
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**  
 Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,460</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$590</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$750
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**  
 Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,970</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$600
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,450</b>