




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 <a href="#">deductible</a> ?                                | <p><b>In-network:</b><br/>                     \$2,850/individual; \$5,700/family</p> <p><b>Out-of-network:</b><br/>                     \$5,700/individual; \$11,400/family</p>                            | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | <b>Yes.</b> In-Network services for Office Visits, In-Network Pharmacy, <a href="#">Preventive services</a> , and <a href="#">Urgent Care</a> are covered before you meet your <a href="#">deductible</a> . | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| Are there other <a href="#">deductibles</a> for specific services?              | <b>No</b>   | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | <p><b>In-Network:</b><br/>                     \$7,900/individual; \$15,800/family</p> <p><b>Out-of-Network:</b><br/>                     Unlimited</p>   | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.  | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |

|  |  |  |
|--|--|--|
| 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<br>(You will pay the least)  | Out-of-Network Provider<br>(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       | \$40 <a href="#">copay</a> /visit   | 70% <a href="#">coinsurance</a>                    | <a href="#">Deductible</a> does not apply to <a href="#">in-network providers</a> .<br>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                       | \$80 <a href="#">copay</a> /visit   | 70% <a href="#">coinsurance</a>                    |  |
|  | <a href="#">Preventive Care/screening/immunization</a> | \$0 <a href="#">copay</a> /visit  | 70% <a href="#">coinsurance</a>                    |  |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | Radiology:<br>30% <a href="#">coinsurance</a><br><br>Labs:<br>30% <a href="#">coinsurance</a> | 70% <a href="#">coinsurance</a>                    | For Radiology services, <a href="#">deductible</a> applies.<br>For Lab services, <a href="#">deductible</a> applies.<br>Some services require authorization. Failure to obtain authorization can result in a requested service being denied.                                     |
|  | Imaging (CT/PET scans, MRIs)                           | 30% <a href="#">coinsurance</a>   | 70% <a href="#">coinsurance</a>                    | For Imaging services, <a href="#">deductible</a> applies.<br>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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="#">samhealthplans.org</a> | Preventive drugs (Tier 1)                        | 0% <a href="#">coinsurance</a>               | 70% <a href="#">coinsurance</a>                    | <a href="#">Deductible</a> does not apply to <a href="#">in-network providers</a> .<br>Out-of-Network drugs are not covered unless urgent or emergent.<br>Some prescriptions require authorization. Failure to obtain authorization can result in a requested service being denied. |
|   | Generic drugs (Tier 2)                           | \$15 <a href="#">copay</a> /prescription     | 70% <a href="#">coinsurance</a>                    |   |
|   | Preferred brand drugs (Tier 3)                   | \$60 <a href="#">copay</a> /prescription     | 70% <a href="#">coinsurance</a>                    |   |
|   | Non-preferred brand drugs (Tier 4)               | 50% <a href="#">coinsurance</a>              | 70% <a href="#">coinsurance</a>                    |   |
|   | <a href="#">Specialty drugs</a> (Tier 5)         | 50% <a href="#">coinsurance</a>              | 70% <a href="#">coinsurance</a>                    |   |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)   | 30% <a href="#">coinsurance</a>              | 70% <a href="#">coinsurance</a>                    | <a href="#">Deductible</a> applies.<br>Some services require authorization. Failure to obtain authorization can result in a requested service being denied.   |
|   | Physician/surgeon fees                           | 30% <a href="#">coinsurance</a>              | 70% <a href="#">coinsurance</a>                    |   |
| <b>If you need immediate medical attention</b>  | <a href="#">Emergency room care</a>              | 30% <a href="#">coinsurance</a>              | 30% <a href="#">coinsurance</a>                    | <a href="#">Deductible</a> applies.<br>If admitted, services are subject to Inpatient benefits and Emergency room <a href="#">cost share</a> is waived.   |
|   | <a href="#">Emergency medical transportation</a> | 30% <a href="#">coinsurance</a>              | 30% <a href="#">coinsurance</a>                    |   |
|   | <a href="#">Urgent Care</a>                      | \$70 <a href="#">copay</a> /visit            | \$70 <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<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)        | 30% <a href="#">coinsurance</a>   | 70% <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                    | 30% <a href="#">coinsurance</a>   | 70% <a href="#">coinsurance</a>                    |   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$40 <a href="#">copay</a> /visit   | 70% <a href="#">coinsurance</a>                    | <a href="#">Deductible</a> does not apply to <a href="#">in-network providers</a> .   |
|   | Inpatient services                        | 30% <a href="#">coinsurance</a>   | 70% <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:<br>\$40 <a href="#">copay</a> /visit<br><br><a href="#">Specialist</a> :<br>\$80 <a href="#">copay</a> /visit | 70% <a href="#">coinsurance</a>                    | <a href="#">Deductible</a> does not apply to <a href="#">in-network providers</a> .<br><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 | 30% <a href="#">coinsurance</a>   | 70% <a href="#">coinsurance</a>                    | <a href="#">Deductible</a> applies.   |
|   | Childbirth/delivery facility services     | 30% <a href="#">coinsurance</a>   | 70% <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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 30% <a href="#">coinsurance</a>              | 70% <a href="#">coinsurance</a>                    | <a href="#">Deductible</a> applies.   |
|  | <a href="#">Rehabilitation services</a>   | \$40 <a href="#">copay</a> /visit            | 70% <a href="#">coinsurance</a>                    | <a href="#">Deductible</a> does not apply to <a href="#">in-network providers</a> . 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>     | \$40 <a href="#">copay</a> /visit            | 70% <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>      | 30% <a href="#">coinsurance</a>              | 70% <a href="#">coinsurance</a>                    | <a href="#">Deductible</a> applies. 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> | 30% <a href="#">coinsurance</a>              | 70% <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>          | 30% <a href="#">coinsurance</a>              | 70% <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<br>(You will pay the least)   | Out-of-Network Provider<br>(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 | 70% <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> .<br>Coverage is limited to one exam per benefit year for children only.<br>Call health plan for specific coverage information.   |
|  | Children's glasses         | \$0 <a href="#">copay</a> , for specific codes | 70% <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> .<br>Coverage is limited to once per benefit year for children only. Contacts and frames are each covered up to \$150 per calendar year.<br>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](#).)

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- 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.)

- 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, kwijijigo 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,850 |
| ■ <a href="#">Specialist copayment</a>                          | \$80    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

#### 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> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$2,850        |
| Copayments                        | \$200          |
| Coinsurance                       | \$2,100        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$5,210</b> |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,850 |
| ■ <a href="#">Specialist copayment</a>                          | \$80    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

#### 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> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$100          |
| Copayments                        | \$900          |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Joe would pay is</b> | <b>\$1,060</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,850 |
| ■ <a href="#">Specialist copayment</a>                          | \$80    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

#### 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> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,400        |
| Copayments                        | \$400          |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,800</b> |