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. 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/ or call 1-800-832-4580 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In-network:** $2,500/individual; $5,000/family **Out-of-network:** $5,000/individual; $10,000/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**Yes.** In-Network services for Office Visits, some Pharmacy, Preventive Services, and Urgent Care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**In-Network:** $7,350/individual; $14,700/family **Out-of-Network:** Unlimited	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

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

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 provider's office or clinic	Primary care visit to treat an injury or illness	$50 not subject to deductible	70% after deductible	Deductible does not apply to in-network providers. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Specialist visit	$100 not subject to deductible		
	Preventive care/screening/ immunization	$0 not subject to deductible		
If you have a test	Diagnostic test (x-ray, blood work)	30% not subject to deductible	70% after deductible	Deductible does not apply to in-network providers. Some services require authorization. Failure to obtain authorization can result in a requested service being denied.
	Imaging (CT/PET scans, MRIs)	30% after deductible		Coinsurance applies after deductible has been met. Some services require authorization. Failure to obtain authorization can result in a requested service being denied.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at samhealthplans.org	Preventive drugs (Tier 1)	$0 not subject to deductible	70% after deductible, not covered unless urgent or emergent.	Deductible does not apply to in-network providers. Some prescriptions require authorization. Failure to obtain authorization can result in a requested service being denied.
	Generic drugs (Tier 2)	$20 not subject to deductible		
	Preferred brand drugs (Tier 3)	$60 not subject to deductible		
	Non-preferred brand drugs (Tier 4)	50% after deductible		Coinsurance applies after deductible has been met. Some prescriptions require authorization. Failure to obtain authorization can result in a requested service being denied.
	Specialty drugs (Tier 5)			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% after deductible	70% after deductible	Coinsurance applies after deductible has been met. Some services require authorization. Failure to obtain authorization can result in a requested service being denied.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	30% after deductible	30% after deductible	Coinsurance applies after deductible has been met. If admitted, services are subject to Inpatient benefits and Emergency Room coinsurance is waived.
	Emergency medical transportation			Coinsurance applies after deductible has been met.
	Urgent care	$100 not subject to deductible	$100 not subject to deductible	Deductible does not apply.

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)	30% after deductible	70% after deductible	Coinsurance applies after deductible has been met. Requires authorization. Failure to obtain authorization can result in a requested service being denied.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 not subject to deductible	70% after deductible	Deductible does not apply to in-network providers.
	Inpatient services	30% after deductible		Coinsurance applies after deductible has been met. 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: $50 not subject to deductible Specialist: $100 not subject to deductible	70% after deductible	Deductible does not apply to in-network providers. Cost sharing does not apply for in-network preventive services. Cost share will depend on how the provider bills the service. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services			
	Childbirth/delivery facility services	30% after deductible		Coinsurance applies after deductible has been met.

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	Home health care	30% after deductible	70% after deductible	Coinsurance applies after deductible has been met.
	Rehabilitation services	$100 after deductible		Cost share applies after deductible has been met. Coverage is limited to 30 visits per year for Physical, Occupational, and Speech therapy. An additional 30 visits may be approved for certain conditions. Services in Urgent Care or Emergency Room will apply applicable cost share.
	Habilitation services			
	Skilled nursing care	30% after deductible		Coinsurance applies after deductible has been met. Requires authorization. Failure to obtain authorization can result in a requested service being denied. Coverage is limited to 60 days per year.
	Durable medical equipment			Coinsurance applies after deductible has been met. Authorization required for rental or purchase over $800 or rentals over 3 months. Failure to obtain authorization can result in a requested service being denied.
	Hospice services			Coinsurance applies after deductible has been met. Coverage is limited to max of 5 consecutive days and lifetime max of 30 days for respite care.

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 not subject to deductible	70% after deductible	Deductible does not apply to in-network providers. Coverage is limited to one exam per benefit year for children only.
	Children's glasses			Deductible does not apply to in-network providers. Coverage is limited to once per benefit year for children only. 1 set of standard hardware (frames/lenses) every year. Contacts will have 40% coinsurance with no unit limit.
	Children's dental check-up	Not Covered	Not Covered	Please check with your dental plan.

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
- 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
- Cosmetic surgery (with authorization)
- 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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 or 1-800-832-4580. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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.

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, kwiijigo 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	$2,500
Specialist	$100
Hospital (facility)	30%
Other	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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$200
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,660**

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

The plan's overall deductible	$2,500
Specialist	$100
Hospital (facility)	30%
Other	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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$900**

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

The plan's overall deductible	$2,500
Specialist	$100
Hospital (facility)	30%
Other	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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

The plan would be responsible for the other costs of these EXAMPLE covered services.