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 or call 541-768-4550 or toll free at 1-800-832-4580 (TTY 1-800-735-2900). 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:** $3,000/individual; $6,000/family **Out-of-network:** $6,000/individual; $12,000/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.** Urgent care and in-network services for: alternative care, biofeedback, diabetic education and supplies, diagnostic tests, office visits, pediatric vision routine exams and hardware, pharmacy, preventive services, skilled nursing care, and specified surgical procedures 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:** $7,900/individual; $15,800/family **Out-of-Network:** $15,800/individual; $31,600/family	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?	Transplant cost of facilities, 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**. See 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	$25 copay Deductible does not apply	50% coinsurance	Some in-office procedures require prior authorization. Failure to obtain prior authorization can result in a requested service being denied.
	Specialist visit	$45 copay Deductible does not apply	50% coinsurance	
	Preventive care/screening/ immunization	No charge Deductible does not apply	50% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance Deductible does not apply	50% coinsurance	Some services require authorization. Failure to obtain prior authorization can result in a requested service being denied.
	Imaging (CT/PET scans, MRIs)	20% coinsurance Deductible does not apply	50% coinsurance	Some services require prior authorization. Failure to obtain prior authorization can result in a requested service being denied. Imaging services include SPECT scans.

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)	No charge Deductible does not apply	Not covered	Out-of-Network drugs only covered if urgent or emergent at a 50% coinsurance. Some prescriptions require prior authorization. Failure to obtain prior authorization can result in a requested service being denied.
	Generic drugs (Tier 2)	$10 copay/prescription Deductible does not apply	Not covered	
	Preferred brand drugs (Tier 3)	$35 copay/prescription Deductible does not apply	Not covered	
	Non-preferred brand drugs (Tier 4)	$75 copay/prescription Deductible does not apply	Not covered	
	Specialty drugs (Tier 5)	50% coinsurance Deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Some services require prior authorization. Failure to obtain prior authorization can result in a requested service being denied.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$300 copay then 20% coinsurance	$300 copay then 20% coinsurance	If admitted, services are subject to inpatient benefits and emergency room cost share is waived.
	Emergency medical transportation	20% coinsurance	20% coinsurance	The cost of ground transportation is covered to or from the nearest hospital. Air transportation is also covered to the nearest hospital capable of treatment, when ground transportation is not medically appropriate, and when medically necessary.
	Urgent care	$60 copay Deductible does not apply	$60 copay Deductible does not apply	None.

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% coinsurance	50% coinsurance	Prior authorization is required. Failure to obtain prior authorization can result in a requested service being denied. Transplant cost of facilities does not accumulate toward this plan's out-of-pocket limit. Inpatient habilitative/rehabilitative services are covered with a maximum of 30 days per calendar year. Limits do not apply for mental health and chemical dependency/substance abuse related services.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Prior authorization is required. Failure to obtain prior authorization can result in a requested service being denied.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay Deductible does not apply	50% coinsurance	None.
	Inpatient services	20% coinsurance	50% coinsurance	Includes inpatient and residential. Prior authorization is required. Failure to obtain prior authorization can result in a requested service being denied.
If you are pregnant	Office visits	Primary care: $25 copay Deductible does not apply Specialist: $45 copay Deductible does not apply	50% coinsurance	Cost sharing does not apply for in-network preventive services. Depending on the type of services, a copay, coinsurance, or deductible may apply. 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	20% coinsurance	50% coinsurance	None.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Prior authorization is required for a newborn stay of less than 5 days. Failure to obtain prior 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 help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	None.
	Rehabilitation services	$45 copay	50% coinsurance	Limited to 30-60 visits per calendar year depending on condition. Limits do not apply for mental health and chemical dependency/ substance abuse related services.
	Habilitation services	$45 copay	50% coinsurance	
	Skilled nursing care	No charge Deductible does not apply	50% coinsurance	Prior authorization is required. Failure to obtain prior authorization can result in a requested service being denied. Services are covered for up to 60 days per calendar year. Custodial care is not a covered benefit. Limits do not apply for mental health and chemical dependency/ substance abuse related services.
	Durable medical equipment	20% coinsurance	50% coinsurance	All durable medical equipment (DME) items greater than $800 for purchase, rental items with rental fee greater than $800 per month or rental length greater than 3 months require prior authorization. Failure to obtain prior authorization can result in a requested service being denied. Vision hardware: Covered after cataract surgery or due to medical needs. Coverage is limited to one-time per eye, after cataract surgery.
	Hospice services	20% coinsurance	50% coinsurance	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	No charge Deductible does not apply	50% coinsurance	Coverage is limited to one exam per calendar year. Call health plan for specific coverage information.
	Children's glasses	No charge Deductible does not apply	50% coinsurance	Contacts and frames are each covered once per calendar year. Cost sharing may apply for specific lens codes. Call health plan for specific coverage information.
	Children's dental check-up	Not covered	Not covered	Please check with your dental plan for coverage.

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
- Dental care (Adult and Pediatric)
- Infertility treatment (Includes testing)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (Unless member has diabetes mellitus)
- Temporomandibular joint (TMJ) or myofascial pain treatment, advice or appliances
- Weight loss programs

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

- Acupuncture ($1,000 combined limit for massage, chiropractic, & massage)
- Chiropractic care ($1,000 combined limit for massage, chiropractic, & massage)
- Hearing aids (Only covered in accordance with state and federal law)

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, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa and Oregon Division of Financial Regulation at 1-866-814-9710 or https://dfr.oregon.gov/. 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: Samaritan Health Plans at 541-768-4550 or toll free at 1-800-832-4580 (TTY 1-800-735-2900). You may also contact the Department of Labor, EBSA 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

* For more information about limitations and exceptions, see the plan or policy document at samhealthplans.org.

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	$3,000
Specialist copayment	$45
Hospital (facility) coinsurance	20%
Other copayment	$25

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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$100
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,560**

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

The plan's overall deductible	$3,000
Specialist copayment	$45
Hospital (facility) coinsurance	20%
Other copayment	$25

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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$30
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$690**

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

The plan's overall deductible	$3,000
Specialist copayment	$45
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)*

Total Example Cost	**$1,970**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$100
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,710**

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