### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>In-network: $3,550/individual; $7,100/family</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Urgent care and in-network services for: biofeedback, cardiac rehab, diabetic education and supplies, office visits, outpatient habilitative/rehabilitative services, pediatric vision routine exam, pediatric vision hardware up to $150, pharmacy, and preventive services are covered before you meet your deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>In-network: $8,150/individual; $16,300/family</td>
<td>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.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
</tbody>
</table>
### Important Questions and Answers

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://samhealthplans.org">samhealthplans.org</a> or call 1-800-832-4580 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

---

**Note:** All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least): $40 copay/visit Deductible does not apply.</td>
<td>Out-of-Network Provider (You will pay the most): 70% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$80 copay/visit Deductible does not apply.</td>
<td>70% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge. Deductible does not apply.</td>
<td>70% coinsurance</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Labs: 30% coinsurance</td>
<td>Labs: 70% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>30% coinsurance</td>
<td>70% coinsurance</td>
</tr>
</tbody>
</table>

---

* For more information about limitations and exceptions, see the plan or policy document at [samhealthplans.org](http://samhealthplans.org).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier 1: Generic</td>
<td>$15 copay/prescription&lt;br&gt;Deductible does not apply.</td>
<td>Out-of-Network drugs only covered if urgent or emergent. Some prescriptions require prior authorization. Failure to obtain prior authorization can result in a requested prescription being denied.</td>
</tr>
<tr>
<td></td>
<td>Tier 2: Preferred</td>
<td>$60 copay/prescription&lt;br&gt;Deductible does not apply.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3: Non-Preferred</td>
<td>50% coinsurance&lt;br&gt;Deductible does not apply.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 4: Generic and Preferred Specialty</td>
<td>50% coinsurance&lt;br&gt;Deductible does not apply.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 5: Non-Preferred Specialty</td>
<td>50% coinsurance&lt;br&gt;Deductible does not apply.</td>
<td></td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>30% coinsurance</td>
<td>Some services require prior authorization. Failure to obtain prior authorization can result in a requested service being denied.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>30% coinsurance</td>
<td>If admitted, services are subject to inpatient benefits and the emergency room cost share is waived.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>30% coinsurance</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$70 copay/visit&lt;br&gt;Deductible does not apply.</td>
<td>None.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [samhealthplans.org](http://samhealthplans.org).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>30% coinsurance</td>
<td>70% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% coinsurance</td>
<td>70% coinsurance</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>$40 copay/visit Deductible does not apply.</td>
<td>70% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Residential: 30% coinsurance</td>
<td></td>
<td>70% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>30% coinsurance</td>
<td>70% coinsurance</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>Primary Care: $40 copay/visit Deductible does not apply.</td>
<td>Primary Care: 70% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist: $80 copay/visit Deductible does not apply.</td>
<td>Specialist: 70% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>30% coinsurance</td>
<td>70% coinsurance</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [samhealthplans.org](http://samhealthplans.org).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery facility services</td>
<td>30% coinsurance</td>
<td>70% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Prior authorization is required for a vaginal delivery that exceeds a 48 hour stay or cesarean delivery that exceeds a 96 hour stay. Failure to obtain prior authorization can result in a requested service being denied. Exception: Newborn stay less than 5 days does not require prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>30% coinsurance</td>
<td>70% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$40 copay/visit</td>
<td>70% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Forsake employment</td>
<td>Deductible does not</td>
<td>Limited to 30–60 visits per calendar year depending on condition. Limits do not apply for mental health and substance use disorder related services.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$40 copay/visit</td>
<td>70% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Deductible does not apply.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>30% coinsurance</td>
<td>70% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>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 of extended care. Custodial care is not a covered benefit.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>30% coinsurance</td>
<td>70% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>All durable medical equipment (DME) and supplies, prosthetics, and orthotics with billed amount greater than $800 for purchase, rental items with rental fee greater than $800 per month or rental length greater than 3 months, and continuous glucose monitors 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.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at samhealthplans.org.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Hospice services</td>
<td>Network Provider (You will pay the least): 30% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most): 70% coinsurance</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Children’s eye exam</td>
<td>No charge.</td>
<td>70% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>No deductible up to $150, then subject to deductible and 30% coinsurance</td>
<td>70% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered.</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see the plan or policy document at samhealthplans.org.*
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
<th>Excluded Services</th>
<th>Other Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
<td>• Dental care (Adult and Pediatric)</td>
<td>• Routine eye care (Adult)</td>
</tr>
<tr>
<td>• Bariatric Surgery</td>
<td>• Infertility treatment (Includes testing)</td>
<td>• Routine foot care (Unless member has diabetes mellitus)</td>
</tr>
<tr>
<td>• Chiropractic care</td>
<td>• Long-term care</td>
<td>• Treatment for Temporomandibular joint</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
<td>• Non-emergency care when traveling outside the U.S.</td>
<td>• Weight loss programs</td>
</tr>
<tr>
<td>• Custodial care</td>
<td>• Private-duty nursing</td>
<td></td>
</tr>
</tbody>
</table>

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

- 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://drf.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)

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>$3,550</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$80</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>30%</td>
</tr>
<tr>
<td>Other copayment</td>
<td>$40</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$3,550</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,900</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
<tr>
<td>The total Peg would pay is</td>
<td>$5,710</td>
</tr>
</tbody>
</table>

**What isn’t covered**:
- Limits or exclusions: $60

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

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>$3,550</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$80</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>30%</td>
</tr>
<tr>
<td>Other copayment</td>
<td>$40</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1600</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
<tr>
<td>The total Joe would pay is</td>
<td>$1,760</td>
</tr>
</tbody>
</table>

**What isn’t covered**:
- Limits or exclusions: $60

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

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>$3,550</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$80</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>30%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>30%</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,400</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
<tr>
<td>The total Mia would pay is</td>
<td>$1,800</td>
</tr>
</tbody>
</table>

**What isn’t covered**:
- Limits or exclusions: $0

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