
 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, go to [choice.samhealthplans.org/](http://choice.samhealthplans.org/) or call 1-800-832-4580. 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-800-832-4580 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$2,500/individual or \$7,500/family	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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Preventive care</u> , bariatric surgery/gastric banding services, value-based service <u>copays</u> , and panniculectomies 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="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	<b>Medical In-Network:</b> \$3,150/individual or \$6,300/family  <b>Medical Out-of-Network:</b> Unlimited  <b>Pharmacy:</b> \$4,200/individual or \$8,400/family	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> , the overall family <u>out-of-pocket limit</u> must be met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Copayments</u> for certain services (air ambulance, bariatric surgery/gastric banding, panniculectomy, and value based services ( <b>exception:</b> If a cancer diagnosis, the value based service applies to 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 <u>network provider</u> ?	Yes. See <a href="http://choice.samhealthplans.org/">choice.samhealthplans.org/</a> or call 1-800-832-4580 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>provider's office or clinic</u>	Primary care visit to treat an injury or illness	\$20/visit	30% <u>coinsurance</u>	-----None----- Refer to the Member Handbook as the official document for all <u>plan</u> provisions.
	<u>Specialist</u> visit	<u>Specialist</u> : \$35/visit	30% <u>coinsurance</u>	
		Acupuncture: \$35/visit	35% <u>coinsurance</u>	
<u>Preventive care/screening/immunization</u>	No Charge	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for. <u>Deductible</u> does not apply. Refer to the Member Handbook as the official document for all <u>plan</u> provisions.	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	30% <u>coinsurance</u>	-----None----- Refer to the Member Handbook as the official document for all <u>plan</u> provisions.
	Imaging (CT/PET scans, MRIs)	CT/PET scan: No Charge	30% <u>coinsurance</u>	Requires authorization; Failure to obtain prior authorization can result in a requested service being denied. Refer to the Member Handbook as the official document for all <u>plan</u> provisions.
MRI: \$150/visit				

\* For more information about limitations and exceptions, see the plan or policy document at [choice.samhealthplans.org](http://choice.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 <b>prescription drug coverage</b> is available at <a href="http://choice.samhealthplans.org/">choice.samhealthplans.org/</a>	Tier 2- Generic drugs	\$7 <u>copay</u> or 20% <u>coinsurance</u> /prescription, whichever is greater	Not Covered	Some prescriptions require authorization; Failure to obtain prior authorization can result in a requested service being denied. Tier 1-Therapeutic and Preventive drugs are offered with \$0 <u>cost share</u> and include: specified generic drugs, selected Asthma medications, and Tobacco Cessations drugs/supplies. Refer to the Member Handbook as the official document for all <u>plan</u> provisions.
	Tier 3- Preferred brand drugs	\$25 <u>copay</u> or 25% <u>coinsurance</u> /prescription, whichever is greater.		
	Tier 4- Non-preferred brand drugs	50% <u>coinsurance</u> /prescription		
	Tier 5- <u>Specialty</u> drugs	10% <u>coinsurance</u> /prescription		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$150/visit	30% <u>coinsurance</u>	Some services require authorization; Failure to obtain prior authorization can result in a requested service being denied. Refer to the Member Handbook as the official document for all <u>plan</u> provisions.
	Physician/surgeon fees	\$50/visit	30% <u>coinsurance</u>	-----None----- Refer to the Member Handbook as the official document for all <u>plan</u> provisions.
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$100/visit	\$100/visit	If admitted, services are subject to Inpatient benefits and the Emergency Room <u>copay</u> is waived. Refer to the Member Handbook as the official document for all <u>plan</u> provisions.
	<u>Emergency medical transportation</u>	Ground: 30% <u>coinsurance</u> after \$100 <u>copay</u>	30% <u>coinsurance</u> after \$100 <u>copay</u>	Air Ambulance will be reimbursed up to 250% of the Medicare Allowable amount for non-participating providers. Air Ambulance does not apply to the <u>out-of-pocket limit</u> . Refer to the Member Handbook as the official document for all <u>plan</u> provisions.
		Air: 30% <u>coinsurance</u>	30% <u>coinsurance</u>	
<u>Urgent care</u>	\$20/visit	\$20/visit	-----None----- Refer to the Member Handbook as the official document for all <u>plan</u> provisions.	

\* For more information about limitations and exceptions, see the plan or policy document at [choice.samhealthplans.org](http://choice.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)	\$100/day up to 5 days	30% <u>coinsurance</u>	Requires authorization. Failure to obtain prior authorization can result in a requested service being denied. Bariatric Surgery/Gastric Banding: \$5,000 <u>copay</u> Refer to the Member Handbook as the official document for all <u>plan</u> provisions.
	Physician/surgeon fees	\$50/visit	30% <u>coinsurance</u>	-----None----- Refer to the Member Handbook as the official document for all <u>plan</u> provisions.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35/visit	30% <u>coinsurance</u>	-----None----- Refer to the Member Handbook as the official document for all <u>plan</u> provisions.
	Inpatient services	Inpatient: \$100/day up to 5 days	30% <u>coinsurance</u>	Requires authorization; Failure to obtain prior authorization can result in a requested service being denied. You only pay up to \$500 for in-network Inpatient services. Refer to the Member Handbook as the official document for all <u>plan</u> provisions.
Residential: 30% <u>coinsurance</u>				
If you are pregnant	Office visits	\$20 global fee	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Newborn Inpatient care in excess of 4 days requires prior authorization. Failure to obtain prior authorization can result in a requested service being denied. Refer to the Member Handbook as the official document for all <u>plan</u> provisions.
	Childbirth/delivery professional services	\$50/visit	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$100/day up to 5 days	30% <u>coinsurance</u>	

\* For more information about limitations and exceptions, see the plan or policy document at [choice.samhealthplans.org](http://choice.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 help recovering or have other special health needs</b>	<u>Home health care</u>	\$15/visit	30% <u>coinsurance</u>	-----None----- Refer to the Member Handbook as the official document for all <u>plan</u> provisions.
	<u>Rehabilitation services</u>	\$25/visit	30% <u>coinsurance</u>	Physical, Occupational, Speech Therapy SHS Physical therapy \$20/visit Refer to the Member Handbook as the official document for all <u>plan</u> provisions.
	<u>Habilitation services</u>	\$25/visit	30% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	No Charge	30% <u>coinsurance</u>	Requires authorization; Failure to obtain prior authorization can result in a requested service being denied. Coverage is limited to 60 days per calendar year of extended care. Refer to the Member Handbook as the official document for all <u>plan</u> provisions.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Requires authorization with line items over \$1,000 in rental/purchase fees or rentals over 3 months. Failure to obtain prior authorization can result in a requested service being denied. Includes prosthesis, oxygen, and oxygen supplies. Exceptions are diabetic, incontinence, and CPAP supplies. Ages 18 and over: Coverage is limited to \$500 lifetime max for orthotics. Refer to the Member Handbook as the official document for all <u>plan</u> provisions.
	<u>Hospice services</u>	No Charge	30% <u>coinsurance</u>	-----None----- Refer to the Member Handbook as the official document for all <u>plan</u> provisions.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$25/visit	30% <u>coinsurance</u> after \$25 <u>copay</u>	Please verify eligibility on SCP Vision <u>Plan</u> . Refer to the Member Handbook as the official document for all <u>plan</u> provisions.
	Children's glasses	Covered up to \$250/year	Covered up to \$250/year	
	Children's dental check-up	Not Covered	Not Covered	Please check with your dental <u>plan</u> . Refer to the Member Handbook as the official document for all <u>plan</u> provisions.

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

- Chiropractic care (limits apply)
- Cosmetic surgery
- Dental care (Adult)
- 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
- Bariatric surgery (with authorization)
- Hearing aids (limits apply to adults)
- Routine foot care (only if the patient has diabetes, peripheral vascular disease, or recurrent infections)

**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](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: 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).

### 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, kwijigo 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 <u>plan's</u> overall <u>deductible</u>	\$2500
■ <u>Specialist copayment</u>	\$35
■ Hospital (facility) <u>copayment</u>	\$100
■ Other <u>copayment</u>	\$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>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,700
Copayments	\$200
Coinsurance	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,010</b>

### Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2500
■ <u>Specialist copayment</u>	\$35
■ Hospital (facility) <u>copayment</u>	\$100
■ Other <u>copayment</u>	\$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>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,900</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2500
■ <u>Specialist copayment</u>	\$35
■ Hospital (facility) <u>copayment</u>	\$100
■ Other <u>copayment</u>	\$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>\$2,500</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,300</b>

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