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/ 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:
What is the overall deductible?	$300/individual or $900/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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care, bariatric surgery/gastric banding services, value-based service copays, and panniculectomies 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 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?	Medical In-Network: $3,000/individual or $6,000/family Medical Out-of-Network: Unlimited Pharmacy: $4,200/individual or $8,400/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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Copayments for certain services (air ambulance, bariatric surgery/gastric banding, panniculectomy, value based services (exception: If a cancer diagnosis, the value based service applies to 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. See choice.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/visit	30% coinsurance	----------None---------- Refer to the Member Handbook as the official document for all plan provisions.
	Specialist visit	Specialist: $40/visit	30% coinsurance	Chiropractic is covered up to $850 per year. Refer to the Member Handbook as the official document for all plan provisions.
		Chiropractic: $25/visit		
		Acupuncture: $35/visit	35% coinsurance	
	Preventive care/screening/ immunization	No Charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Deductible does not apply. Refer to the Member Handbook as the official document for all plan provisions.
If you have a test	Diagnostic test (x-ray, blood work)	Blood Work: No Charge	30% coinsurance	----------None---------- Refer to the Member Handbook as the official document for all plan provisions.
		X-rays: $25/visit		
	Imaging (CT/PET scans, MRIs)	$200/visit	30% coinsurance	Requires authorization; Failure to obtain prior authorization can result in a requested service being denied. Deductible does not apply. Value Based services: CT, MRI, and PET. These services do not count towards the out-of- pocket limit. Refer to the Member Handbook as the official document for all plan provisions.

* For more information about limitations and exceptions, see the plan or policy document at 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 need drugs to treat your illness or condition More information about prescription drug coverage is available at choice.samhealthplans.org/	Tier 2- Preferred Generic drugs	$7 copay or 20% coinsurance/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 cost share and include: specified generic drugs, selected Asthma medications, and Tobacco Cessations drugs/supplies. Refer to the Member Handbook as the official document for all plan provisions.
	Tier 3- Preferred brand drugs	$25 copay or 25% coinsurance/prescription, whichever is greater		
	Tier 4- Non-preferred brand drugs	50% coinsurance/prescription		
	Tier 5- Specialty drugs	10% coinsurance/prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	SHS facility: $150/visit plus any other cost share if a Value Based service	Not Covered	Some services require authorization; Failure to obtain prior authorization can result in a requested service being denied. Value Based services: $400 copay for spine surgery for pain, arthroscopies, and shoulder surgery for osteoarthritis. $200 copay for MRI, CT, and PET scans. Bariatric Surgery/Gastric Banding, Panniculectomies, and Value Based surgery/ services do not count towards the deductible or out-of-pocket limit. Refer to the Member Handbook as the official document for all plan provisions.
		Non-SHS facility: $250/visit plus any other cost share if a Value Based service	30% coinsurance	
	Physician/surgeon fees	$60/visit	30% coinsurance	----------None---------- Refer to the Member Handbook as the official document for all plan provisions.

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 immediate medical attention	Emergency room care	$150/visit	$150/visit	If admitted, services are subject to Inpatient benefits and the Emergency Room copay is waived. Refer to the Member Handbook as the official document for all plan provisions.
	Emergency medical transportation	Ground: 30% coinsurance after $100 copay	30% coinsurance after $100 copay	Air Ambulance will be reimbursed up to 250% of the Medicare Allowable amount for non-participating providers. Air Ambulance does not apply to the out-of-pocket limit. Refer to the Member Handbook as the official document for all plan provisions.
		Air: 30% coinsurance	30% coinsurance	
	Urgent care	$40/visit	$40/visit	----------None---------- Refer to the Member Handbook as the official document for all plan provisions.
If you have a hospital stay	Facility fee (e.g., hospital room)	SHS facility: $175/day up to 5 days plus any other cost share if a Value Based service	Not Covered	Requires authorization. Failure to obtain prior authorization can result in a requested service being denied. Bariatric Surgery/Gastric Banding: $5,000 copay Value Based services: $400 copay for spine surgery for pain, arthroscopies, and shoulder surgery for osteoarthritis. $200 copay for MRI, CT, and PET scans Value Based surgery/services do no not count towards the deductible or out-of-pocket limit. Refer to the Member Handbook as the official document for all plan provisions.
		Non-SHS facility: $300/day up to 5 days plus any other cost share if a Value Based service	30% coinsurance	
	Physician/surgeon fees	$60/visit	30% coinsurance	----------None---------- Refer to the Member Handbook as the official document for all plan provisions.

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 mental health, behavioral health, or substance abuse services	Outpatient services	Mental Health: $25/visit	30% coinsurance	----------None---------- Refer to the Member Handbook as the official document for all plan provisions.
		Chemical Dependency: $40/visit		
	Inpatient services	SHS facility: $175/day up to 5 days	Not Covered	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 plan provisions.
		Non-SHS facility: $300/day up to 5 days	30% coinsurance	
		Residential: 30% coinsurance		
If you are pregnant	Office visits	$25 global fee	30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, a copayment 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 plan provisions.
	Childbirth/delivery professional services	$60/visit	30% coinsurance	
	Childbirth/delivery facility services	SHS facility: $175/day up to 5 days	Not Covered	
		Non-SHS facility: $300/day up to 5 days	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	$30/visit	30% coinsurance	----------None---------- Refer to the Member Handbook as the official document for all plan provisions.
	Rehabilitation services	$35/visit	30% coinsurance	Physical, Occupational, Speech Therapy. SHS Physical therapy $30/visit Refer to the Member Handbook as the official document for all plan provisions.
	Habilitation services	$35/visit	30% coinsurance	

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)	
	Skilled nursing care	No Charge	30% coinsurance	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 plan provisions.
	Durable medical equipment	30% coinsurance	50% coinsurance	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 plan provisions.
	Hospice services	No Charge	30% coinsurance	----------None---------- Refer to the Member Handbook as the official document for all plan provisions.
If your child needs dental or eye care	Children's eye exam	$25/visit	30% coinsurance after $25 copay	Please verify eligibility on SCP Vision Plan. Refer to the Member Handbook as the official document for all plan 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 plan. Refer to the Member Handbook as the official document for all plan provisions.

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.)

- 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)
- Chiropractic care (limits apply)
- 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 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 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 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, 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 choice.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	$300
Specialist *copayment*	$40
Hospital (facility) *copayment*	$300
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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$400
Coinsurance	$50
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,010

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

The plan's overall deductible	$300
Specialist *copayment*	$40
Hospital (facility) *copayment*	$300
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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$800

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

The plan's overall deductible	$300
Specialist *copayment*	$40
Hospital (facility) *copayment*	$300
Other *copayment*	$25

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	$2,500

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$500
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$900

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