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 choice.samhealthplans.org, or call 541-768-4550, toll-free 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 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?	Medical/Pharmacy: $2,700/individual or $5,400/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. Preventive care is 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 Medical/Pharmacy: $5,000/individual or $10,000/family Out-of-Network Medical/Pharmacy: 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?	Copays on certain services, 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 copay/visit	30% coinsurance	None.
	Specialist visit	Specialist: $40 copay/visit	30% coinsurance	None.
		Chiropractic: $25 copay/visit	30% coinsurance	Chiropractic is covered up to $850 per year.
		Acupuncture: $35 copay/visit	35% coinsurance	None.
	Preventive care/screening/ immunization	No Charge; deductible does not apply	30% coinsurance; deductible does not apply	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)	Blood Work: No charge	30% coinsurance	None.
		X-rays: $25 copay/visit		
	Imaging (CT/PET scans, MRIs)	$400 copay/visit	30% coinsurance	MRIs & PET scans require prior authorization. Failure to obtain prior authorization can result in a requested service being denied. Value-based radiology: MRI, CT/PET scans.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at choice.samhealthplans.org	Preventive (Tier 1)	No charge; deductible does not apply	Not covered	Some prescriptions require prior authorization. Failure to obtain prior authorization can result in a requested prescription drug being denied.
	Preferred Generic drugs (Tier 2)	$7 copay or 20% coinsurance per prescription, whichever is greater		
	Preferred brand drugs (Tier 3)	$25 copay or 25% coinsurance per prescription, whichever is greater		
	Non-preferred brand drugs (Tier 4)	50% coinsurance per prescription		
	Specialty drugs (Tier 5)	10% coinsurance per prescription		

* 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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	SHS designated facility: $150 copay/visit, plus any other cost-sharing if a value-based service.	Not covered	Some services require prior authorization. Failure to obtain prior authorization can result in a requested service being denied. Value-based procedures: $400 copay for spine surgery for pain, arthroscopies, and shoulder surgery for osteoarthritis. Value-based radiology: $400 copay for MRI and CT/PET scans.
		Non-SHS facility: $250 copay/visit, plus any other cost-sharing if a value-based service.	30% coinsurance	
	Physician/surgeon fees	$60 copay/visit	30% coinsurance	None.
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	If admitted, services are subject to inpatient benefits, and the emergency room copay is waived.
	Emergency medical transportation	Ground: 30% coinsurance after $100 copay	30% coinsurance after $100 copay	Covered for up to 300 miles each year to or from the nearest hospital.
		Air: 30% coinsurance	30% coinsurance	Air ambulance will be reimbursed up to 250% of the Medicare allowable amount for out-of-network providers. Air transportation is covered to the nearest hospital capable of treatment, when ground transportation is inappropriate, and when medically necessary.
	Urgent care	$40 copay/visit	$40 copay/visit	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)	SHS facility: $175 copay/day up to $875 maximum per stay, plus any other cost-sharing if a value-based service	Not covered	Requires prior authorization. Failure to obtain prior authorization can result in a requested service being denied. Bariatric surgery/gastric banding: $5,000 copay; not covered out-of-network. Value-based procedures: $400 copay for spine surgery for pain, arthroscopies, and shoulder surgery for osteoarthritis. Value-based radiology services: $400 copay for MRI, CT/PET scans.
		Non-SHS facility: $300 copay/day up to $1,500 maximum per stay, plus any other cost-sharing if a value-based service	30% coinsurance	
	Physician/surgeon fees	$60 copay/visit	30% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental health: $40 copay/visit	30% coinsurance	None.
		Chemical dependency: $40 copay/visit		
		Outpatient intensive services and programs (including partial hospitalization) for substance use: 30% coinsurance	Not covered	
		Partial hospitalization for mental health: 30% coinsurance	30% coinsurance	
	Inpatient services	SHS facility: $175 copay/day up to $875 maximum per stay	Not covered	Requires prior authorization. Failure to obtain prior authorization can result in a requested service being denied.
		Non-SHS facility: $300 copay/day up to $1,500 maximum per stay	30% coinsurance	
		Residential: 30% coinsurance		

* 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 are pregnant	Office visits	Office visit: $25 copay/visit	30% coinsurance	Cost-sharing does not apply to certain preventive services. Depending on the type of services, a copay, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
		Specialist visit: $40 copay/visit		
	Childbirth/delivery professional services	No charge	30% coinsurance	
	Childbirth/delivery facility services	SHS facility: $175 copay/day, up to $875 maximum per stay	Not covered	Requires prior authorization for extended stays as described on page 25 of the 2019 SCP SMM. 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.
		Non-SHS facility: $300 copay/day, up to $1,500 maximum per stay	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	$30 copay/visit	30% coinsurance	None.
	Rehabilitation services	$35 copay/visit	30% coinsurance	Physical, occupational, speech therapy. SHS physical therapy providers: $30 copay/visit.
	Habilitation services	$35 copay/visit	30% coinsurance	
	Skilled nursing care	No charge	30% coinsurance	Requires prior 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.

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	Durable medical equipment	30% coinsurance	50% coinsurance	Durable Medical Equipment (DME) and supplies, prosthetics, and orthotics with billed amount greater than $1,000 for purchase requires prior authorization. Rental items with rental fee greater than $1,000 per month or rental length greater than 3 months requires prior authorization. Failure to obtain prior authorization can result in a requested service being denied. Continuous glucose monitors: 0% coinsurance in-network. Orthotics (ages 18 and over): Coverage is limited to a $500 lifetime limit. Vision hardware: Coverage is limited to one-time per eye, after cataract surgery or due to medical need.
	Hospice services	No Charge	30% coinsurance	None.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Please check with your vision plan for coverage.
	Children's glasses	Not covered	Not covered	
	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.)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Pediatric)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Pediatric)
- 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; at in-network/designated facilities only)
- 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, 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: Samaritan Choice Plans at 541-768-4550, toll-free 1-800-832-4580 (TTY: 1-800-735-2900). You may also contact the Department of Labor, 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，□□打□个号□ 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	$2,700
Specialist *copayment*	$40
Hospital (facility) *copayment*	$175
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	$2,900
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,260

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

The plan's overall deductible	$2,700
Specialist *copayment*	$40
Hospital (facility) *copayment*	$175
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	$2,700
Copayments	$70
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$2,770

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

The plan's overall deductible	$2,700
Specialist *copayment*	$40
Hospital (facility) *copayment*	$175
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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
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.