
 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](http://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 <u>deductible</u> ?	<b>Medical only:</b> \$350/individual or \$1,050/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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> , bariatric surgery/gastric banding, HHWB, panniculectomy, PCH, and value-based services 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="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<b>In-Network Medical/Pharmacy:</b> \$7,200/individual or \$14,400/family <b>Out-of-Network Medical/Pharmacy:</b> Unlimited	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> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Copays</u> on certain services (air ambulance, bariatric surgery/gastric banding, panniculectomy, value-based), <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</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit	30% <u>coinsurance</u>	None.
	<u>Specialist</u> visit	<u>Specialist</u> : \$40 <u>copay</u> /visit	30% <u>coinsurance</u>	None.
		Chiropractic: \$25 <u>copay</u> /visit	30% <u>coinsurance</u>	Chiropractic is covered up to \$850 per year.
		Acupuncture: \$35 <u>copay</u> /visit	35% <u>coinsurance</u>	None.
<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u> ; <u>deductible</u> does not apply	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Blood Work: No charge X-rays: \$25 <u>copay</u> /visit	30% <u>coinsurance</u>	None.
	Imaging (CT/PET scans, MRIs)	\$200 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	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. Does not apply to the <u>out-of-pocket limit</u> . Exception: Value-based services with a cancer diagnosis apply to the <u>out-of-pocket limit</u> .
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://choice.samhealthplans.org">choice.samhealthplans.org</a>	Preventive (Tier 1)	No charge; <u>deductible</u> does not apply	Not covered	Some prescriptions require prior authorization. Failure to obtain prior authorization can result in a requested <u>prescription drug</u> being denied.
	Preferred Generic drugs (Tier 2)	\$7 <u>copay</u> or 20% <u>coinsurance</u> per prescription, whichever is greater; <u>deductible</u> does not apply		
	Preferred brand drugs (Tier 3)	\$25 <u>copay</u> or 25% <u>coinsurance</u> per prescription, whichever is greater; <u>deductible</u> does not apply		
	Non-preferred brand drugs (Tier 4)	50% <u>coinsurance</u> per prescription; <u>deductible</u> does not apply		
	<u>Specialty drugs</u> (Tier 5)	10% <u>coinsurance</u> per prescription; <u>deductible</u> does not apply		

\* 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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	SHS designated facility: \$150 <u>copay</u> /visit, plus any other <u>cost-sharing</u> 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 <u>copay</u> for spine surgery for pain, arthroscopies, and shoulder surgery for osteoarthritis. Value-based radiology: \$200 <u>copay</u> for MRI and CT/PET scans. Value-based procedures/services do not apply to the <u>deductible</u> or <u>out-of-pocket limit</u> . Exception: Value-based services with a cancer diagnosis apply to the <u>out-of-pocket limit</u> .
		Non-SHS facility: \$250 <u>copay</u> /visit, plus any other <u>cost-sharing</u> if a value-based service.	30% <u>coinsurance</u>	
	Physician/surgeon fees	\$60 <u>copay</u> /visit	30% <u>coinsurance</u>	None.
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit	If admitted, services are subject to inpatient benefits, and the emergency room <u>copay</u> is waived.
	<u>Emergency medical transportation</u>	Ground: 30% <u>coinsurance</u> after \$100 <u>copay</u>	30% <u>coinsurance</u> after \$100 <u>copay</u>	Covered for up to 300 miles each year to or from the nearest hospital.
		Air: 30% <u>coinsurance</u>	30% <u>coinsurance</u>	Air ambulance will be reimbursed up to 250% of the Medicare allowable amount for <u>out-of-network providers</u> . Air transportation is covered to the nearest hospital capable of treatment, when ground transportation is inappropriate, and when <u>medically necessary</u> . Air ambulance does not apply to the <u>out-of-pocket limit</u> .
<u>Urgent care</u>	\$40 <u>copay</u> /visit	\$40 <u>copay</u> /visit	None.	

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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 <u>copay</u> /day up to \$875 maximum per stay, plus any other <u>cost-sharing</u> 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 <u>copay</u> (not covered out-of-network); does not apply to the <u>deductible</u> or <u>out-of-pocket limit</u> . Value-based procedures: \$400 <u>copay</u> for spine surgery for pain, arthroscopies, and shoulder surgery for osteoarthritis. Value-based radiology services: \$200 <u>copay</u> for MRI, CT/PET scans. Value-based procedures/services do not apply to the <u>deductible</u> or the <u>out-of-pocket limit</u> . <b>Exception:</b> Value-based services with a cancer diagnosis apply to the <u>out-of-pocket limit</u> .
		Non-SHS facility: \$300 <u>copay</u> /day up to \$1,500 maximum per stay, plus any other <u>cost-sharing</u> if a value-based service	30% <u>coinsurance</u>	
	Physician/surgeon fees	\$60 <u>copay</u> /visit	30% <u>coinsurance</u>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental health: \$25 <u>copay</u> /visit	30% <u>coinsurance</u>	None.
		Chemical dependency: \$40 <u>copay</u> /visit		
		Outpatient intensive services and programs (including partial hospitalization) for substance use: 30% <u>coinsurance</u>	Not covered	
		Partial hospitalization for mental health: 30% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Inpatient services	SHS facility: \$175 <u>copay</u> /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 <u>copay</u> /day up to \$1,500 maximum per stay		30% <u>coinsurance</u>		
Residential: 30% <u>coinsurance</u>				

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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 <u>copay</u> /visit	30% <u>coinsurance</u>	<p><u>Cost-sharing</u> does not apply to certain <u>preventive services</u>.</p> <p>Depending on the type of services, a <u>copay</u>, <u>coinsurance</u>, or <u>deductible</u> may apply.</p> <p>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</p> <p>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.</p> <p>Exception: Newborn stay less than 5 days does not require prior authorization.</p>
		Specialist visit: \$40 <u>copay</u> /visit		
	Childbirth/delivery professional services	No charge	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	SHS facility: \$175 <u>copay</u> /day, up to \$875 maximum per stay	Not covered	
Non-SHS facility: \$300 <u>copay</u> /day, up to \$1,500 maximum per stay		30% <u>coinsurance</u>		
If you need help recovering or have other special health needs	<u>Home health care</u>	\$30 <u>copay</u> /visit	30% <u>coinsurance</u>	None.
	<u>Rehabilitation services</u>	\$35 <u>copay</u> /visit	30% <u>coinsurance</u>	Physical, occupational, speech therapy. SHS physical therapy <u>providers</u> : \$30 <u>copay</u> /visit.
	<u>Habilitation services</u>	\$35 <u>copay</u> /visit	30% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	No charge	30% <u>coinsurance</u>	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.

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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	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<p><u>Durable Medical Equipment (DME)</u> and supplies, <u>prosthetics</u>, and <u>orthotics</u> 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.</p> <p>Continuous glucose monitors: 10% <u>coinsurance</u> in-network</p> <p><u>Orthotics</u> (ages 18 and over): Coverage is limited to a \$500 lifetime limit.</p> <p>Vision hardware: Coverage is limited to one-time per eye, after cataract surgery or due to medical need.</p>
	<u>Hospice services</u>	No Charge	30% <u>coinsurance</u>	None.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Please check with your vision <u>plan</u> for coverage.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Please check with your dental <u>plan</u> for coverage.

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## 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        | • Long-term care                                     | • Routine eye care (Adult)     |
| • Dental care (Adult)     | • Non-emergency care when traveling outside the U.S. | • Routine eye care (Pediatric) |
| • Dental care (Pediatric) | • Private-duty nursing                               | • Weight loss programs         |
| • Infertility treatment   |  |                                |

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

- |  |   |  |
|--|---|--|
| • Acupuncture  | • Chiropractic care (limits apply)      | • Routine foot care (only if the patient has diabetes, peripheral vascular disease, or recurrent infections) |
| • Bariatric Surgery (with authorization; at in-network/designated facilities only) | • Hearing aids (limits apply to adults) |  |

**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](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: 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, 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 plan's overall deductible \$350
- 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$550
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$910</b>

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

- The plan's overall deductible \$350
- 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$350
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$750</b>

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

- The plan's overall deductible \$350
- 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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$350
Copayments	\$500
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$950</b>