
 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 800-832-4580 (TTY 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 www.healthcare.gov/sbc-glossary/ or call 800-832-4580 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	Medical only: \$2,800/individual or \$5,600/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> is 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 www.healthcare.gov/coverage/preventive-care-benefits/ .
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> ?	In-Network Medical/Pharmacy \$5,000/individual or \$10,000/family Out-of-Network Medical/Pharmacy 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>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 choice.samhealthplans.org or call 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</u> charge 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 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 <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>	Some services require prior authorization. Failure to obtain prior authorization can result in a requested service being denied.
	<u>Specialist</u> visit	<u>Specialist</u> : \$40 <u>copay</u> /visit	30% <u>coinsurance</u>	Some services require prior authorization. Failure to obtain prior authorization can result in a requested service being denied.
		Acupuncture: \$35 <u>copay</u> /visit	35% <u>coinsurance</u>	None.
		Chiropractic: \$25 <u>copay</u> /visit	30% <u>coinsurance</u>	Chiropractic is covered up to \$850/year.
<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)	Electrocardiogram (ECG/EKG): \$25 <u>copay</u> /visit	30% <u>coinsurance</u>	None.
		Labs: No charge.		Some services require prior authorization. Failure to obtain prior authorization can result in a requested service being denied.
		Radiology: \$25 <u>copay</u> /visit		None.
	Imaging (CT/PET scans, MRIs)	\$400 <u>copay</u> /visit	30% <u>coinsurance</u>	PET scans and MRIs require prior authorization. Failure to obtain prior authorization can result in a requested service being denied. CT/PET scans and MRIs are value-based high-tech imaging services.

* 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 <u>prescription drug coverage</u> is available at choice.samhealthplans.org .	Tier 1: Preventive	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. Covered for up to a 90-day supply. Exception: Birth control is covered up to a 180-day supply.
	Tier 2: Low-cost therapeutic	No charge.		
	Tier 3: Preferred	\$7 <u>copay</u> /prescription or 20% <u>coinsurance</u> , whichever is greater		
	Tier 4: High-cost preferred	\$25 <u>copay</u> /prescription or 25% <u>coinsurance</u> , whichever is greater		
	Tier 5: Non-preferred	50% <u>coinsurance</u>		
	Tier 6: High-cost specialty	10% <u>coinsurance</u>		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	SHS designated facility: \$150 <u>copay</u> /visit, plus additional <u>cost sharing</u> when value-based services are provided	Not covered.	Some services require prior authorization. Failure to obtain prior authorization can result in a requested service being denied. Value-based specified surgical procedures (spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis): \$400 <u>copay</u> /visit for in-network services Value-based high-tech imaging (CT/PET scans, MRI): \$400 <u>copay</u> /visit for in-network services
		Non-SHS facility: \$250 <u>copay</u> /visit, plus additional <u>cost sharing</u> when value-based services are provided	30% <u>coinsurance</u> , plus additional <u>cost sharing</u> when value-based services are provided	
	Physician/surgeon fees	\$60 <u>copay</u> /visit	30% <u>coinsurance</u>	Some services require prior authorization. Failure to obtain prior authorization can result in a requested service being denied.
If you need immediate medical attention	Emergency room care	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit	When admitted to the same facility, the emergency room <u>copay</u> is waived. Inpatient benefits will apply.
	<u>Emergency medical transportation</u>	Air: 30% <u>coinsurance</u>	30% <u>coinsurance</u> , plus any <u>balance billing</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 will be

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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)	
				reimbursed up to 250% of the Medicare allowable amount for <u>out-of-network providers</u> .
		Ground: 30% <u>coinsurance</u> after \$100 <u>copay</u> /service	30% <u>coinsurance</u> after \$100 <u>copay</u> /service	None.
	<u>Urgent care</u>	\$40 <u>copay</u> /visit	\$40 <u>copay</u> /visit	None.
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 additional <u>cost sharing</u> when value-based services are provided	Not covered.	Requires prior authorization. Failure to obtain prior authorization can result in a requested service being denied. Bariatric surgery (in-network/designated facilities only): \$5,000 <u>copay</u> .
		Non-SHS facility: \$300 <u>copay</u> /day up to \$1,500 maximum per stay, plus additional <u>cost sharing</u> when value-based services are provided	30% <u>coinsurance</u>	Bariatric surgery (out-of-network): Not covered. Value-based specified surgical procedures (spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis): \$400 <u>copay</u> /visit Value-based high-tech imaging (CT/PET scans, MRI): \$400 <u>copay</u> /visit
	Physician/surgeon fees	\$60 <u>copay</u> /visit	30% <u>coinsurance</u>	Requires prior authorization. Failure to obtain prior authorization can result in a requested service being denied.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental health: \$40 <u>copay</u> /visit	30% <u>coinsurance</u>	None.
		Partial hospitalization for mental health: 30% <u>coinsurance</u>		
		Substance use disorder: \$40 <u>copay</u> /visit		

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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)		
		Outpatient intensive services and programs (including partial hospitalization) for substance use disorder: 30% <u>coinsurance</u>	Not covered.		
		Residential: 30% <u>coinsurance</u>	30% <u>coinsurance</u>		
	Inpatient services	SHS facility: \$175 <u>copay/day</u> 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/day</u> up to \$1,500 maximum per stay	30% <u>coinsurance</u>		
		Residential: 30% <u>coinsurance</u>	30% <u>coinsurance</u>		
If you are pregnant	Office visits	Primary care visit: \$25 <u>copay/visit</u>	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>copay</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).	
		<u>Specialist</u> : \$40 <u>copay/visit</u>			
	Childbirth/delivery professional services	No charge.	30% <u>coinsurance</u>		
	Childbirth/delivery facility services	SHS facility: \$175 <u>copay/day</u> up to \$875 maximum per stay	Not covered.		Prior authorization is required for labor and delivery stays that exceed 96 hours and newborn stays that exceed 5 days. Failure to obtain prior authorization can result in a requested service being denied.
		Non-SHS facility: \$300 <u>copay/day</u> up to \$1,500 maximum per stay	30% <u>coinsurance</u>		
	If you need help recovering or have other	<u>Home health care</u>	\$30 <u>copay/visit</u>		30% <u>coinsurance</u>
<u>Rehabilitation services</u>		\$35 <u>copay/visit</u>	30% <u>coinsurance</u>	Includes physical, occupational, and speech	

* 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)	
special health needs	<u>Habilitation services</u>	\$35 <u>copay</u> /visit	30% <u>coinsurance</u>	therapy. SHS physical therapy <u>providers</u> : \$30 <u>copay</u> /visit
	<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.
	<u>Durable medical equipment</u>	DME: 30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Durable medical equipment (DME)</u> , <u>prosthetics</u> , <u>orthotics</u> and medical supplies with billed amount greater than \$1,000 for purchase or rental items with rental fee greater than \$1,000 per month or rental length greater than 3 months require prior authorization. Failure to obtain prior authorization can result in a requested service being denied. <u>Orthotics</u> (ages 18 and over): Coverage is limited to a \$500 lifetime limit. Vision hardware: Hardware needed after cataract surgery is a one-time per eye benefit.
		Continuous glucose monitors: 0% <u>coinsurance</u>		
<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.	Please check with your vision <u>plan</u> for coverage.
	Children's dental check-up	Not covered.	Not covered.	Please check with your dental <u>plan</u> 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 <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (adult and pediatric) • Infertility treatment 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing • Routine eye care (adult and pediatric) • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery (with authorization; at in-network/designated facilities only) 	<ul style="list-style-type: none"> • Chiropractic care (limits apply) • Hearing aids (limits apply to adults) 	<ul style="list-style-type: none"> • Routine foot care (unless the member has diabetes, peripheral vascular disease, or recurrent infections)

* For more information about limitations and exceptions, see the plan or policy document at choice.samhealthplans.org.

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 866-444-EBSA (3272) or 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 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, toll-free 800-832-4580 (TTY 800-735-2900). You may also contact the Department of Labor, Employee Benefits Security Administration at 866-444-EBSA (3272) or 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 800-832-4580.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-832-4580.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 800-832-4580.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 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 \$2,800
- 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,360

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

- The plan's overall deductible \$2,800
- 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$70
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,870

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

- The plan's overall deductible \$2,800
- 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
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In this example, Mia would pay:

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