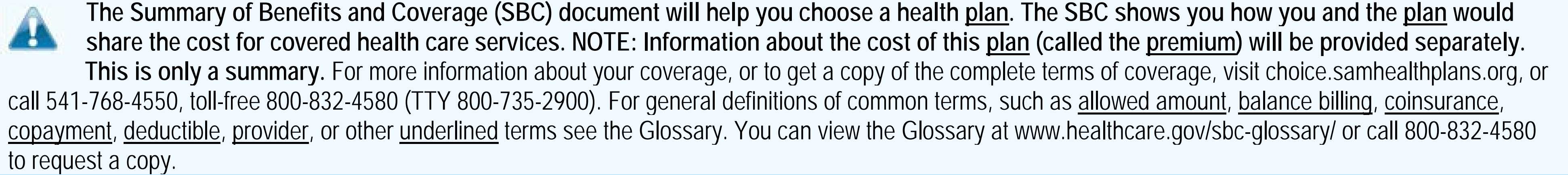
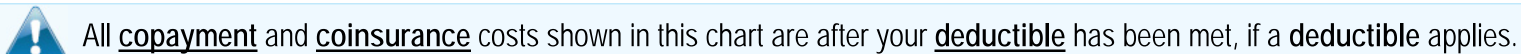

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. 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 deductible?	**Medical only**: $400/individual or $1,200/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, bariatric surgery, panniculectomy, and value-based services 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?	**In-Network Medical/Pharmacy** $7,200/individual or $14,400/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 (air ambulance, bariatric surgery, panniculectomy, value-based 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 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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
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	Some services require prior authorization. Failure to obtain prior authorization can result in a requested service being denied.
	Specialist visit	Specialist: $40 copay/visit	30% coinsurance	Some services require prior authorization. Failure to obtain prior authorization can result in a requested service being denied.
		Acupuncture: $35 copay/visit	35% coinsurance	None.
		Chiropractic: $25 copay/visit	30% coinsurance	Chiropractic is covered up to $850/year.
	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)	Electrocardiogram (ECG/EKG): $25 copay/visit	30% coinsurance	None.
		Labs: No charge.		Some services require prior authorization. Failure to obtain prior authorization can result in a requested service being denied.
		Radiology: $25 copay/visit		None.
	Imaging (CT/PET scans, MRIs)	$200 copay/visit Deductible does not apply.	30% coinsurance Deductible does not apply.	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. These services do not apply to the out-of-pocket limit, **except** when billed with a cancer diagnosis.

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 1: Preventive	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. 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. Deductible does not apply.		
	Tier 3: Preferred	$7 copay/prescription or 20% coinsurance, whichever is greater Deductible does not apply.		
	Tier 4: High-cost preferred	$25 copay/prescription or 25% coinsurance, whichever is greater Deductible does not apply.		
	Tier 5: Non-preferred	50% coinsurance Deductible does not apply.		
	Tier 6: High-cost specialty	10% coinsurance Deductible does not apply.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	SHS designated facility: $150 copay/visit, plus additional cost sharing 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 copay/visit for in-network services Value-based high-tech imaging (CT/PET scans, MRI): $200 copay/visit for in-network services Value-based services do not apply to the deductible or out-of-pocket limit. **Exception:** Value-based services with a cancer diagnosis apply to the out-of-pocket limit.
		Non-SHS facility: $250 copay/visit, plus additional cost sharing when value-based services are provided	30% coinsurance, plus additional cost sharing when value-based services are provided	
	Physician/surgeon fees	$60 copay/visit	30% coinsurance	Some services require prior authorization. Failure to obtain prior authorization can result in a requested service being denied.

* 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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	When admitted to the same facility, the emergency room copay is waived. Inpatient benefits will apply.
	Emergency medical transportation	Air: 30% coinsurance	30% coinsurance, plus any balance billing	Air transportation is covered to the nearest hospital capable of treatment, when ground transportation is inappropriate, and when medically necessary. Air ambulance will be reimbursed up to 250% of the Medicare allowable amount for out-of-network providers. Air ambulance does not apply to the out-of-pocket limit.
		Ground: 30% coinsurance after $100 copay/service	30% coinsurance after $100 copay/service	None.
	Urgent care	$40 copay/visit	$40 copay/visit	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	SHS facility: $175 copay/day up to $875 maximum per stay, plus additional cost sharing 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 copay, does not apply to the deductible or out-of-pocket limit. Bariatric surgery (out-of-network): Not covered. Value-based specified surgical procedures (spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis): $400 copay/visit for in-network services. Value-based high-tech imaging (CT/PET scans, MRI): $200 copay/visit for in-network services. Value-based services do not apply to the deductible or out-of-pocket limit. **Exception:** Value-based services with a cancer diagnosis apply to the out-of-pocket limit.
		Non-SHS facility: $300 copay/day up to $1,500 maximum per stay, plus additional cost sharing when value-based services are provided	30% coinsurance, plus additional cost sharing when value-based services are provided	
	Physician/surgeon fees	$60 copay/visit	30% coinsurance	Requires prior authorization. Failure to obtain prior authorization can result in a requested service being denied.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental health: $25 copay/visit	30% coinsurance	None.
		Partial hospitalization for mental health: 30% coinsurance		
		Substance use disorder: $40 copay/visit		
		Outpatient intensive services and programs (including partial hospitalization) for substance use disorder: 30% coinsurance	Not covered.	
		Residential: 30% coinsurance	30% coinsurance	Requires prior authorization. Failure to obtain prior authorization can result in a requested service being denied.
	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		
If you are pregnant	Office visits	Primary care 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: $40 copay/visit		
	Childbirth/delivery professional services	No charge.	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)	
	Childbirth/delivery facility services	SHS facility: $175 copay/day 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 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	Includes physical, occupational, and 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.
	Durable medical equipment	DME: 30% coinsurance	50% coinsurance	Durable medical equipment (DME), prosthetics, orthotics 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. Orthotics (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% coinsurance		
	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.	Please check with your vision plan for coverage.
	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 and pediatric) • Infertility treatment	• Long-term care • Non-emergency care when traveling outside the U.S.	• 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.)		
• Acupuncture • Bariatric surgery (with authorization; at in-network/designated facilities only)	• Chiropractic care (limits apply) • Hearing aids (limits apply to adults)	• Routine foot care (unless the member 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 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, kwiijigo 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	$400
■ 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	$600
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$960**

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

■ The plan's overall deductible	$400
■ 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	$400
Copayments	$400
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	$400
■ 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	$400
Copayments	$500
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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