**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, call 1-800-207-1018 or visit simplifiedbenefitsadministrators.org. 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 call1-866-487-2365 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Participating Providers:<br>Montrose Regional Health: $1,500/person, $3,000/family<br>First Health Network and Simplified Benefits Administrators: $2,150/person, $4,050/family<br>Non-participating providers:<br>$4,050/person, $7,850/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. The following participating provider services: primary care physician's office visits, urgent care physician, preventive care, and prescription drugs 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 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?** | Participating providers:<br>Montrose Regional Health Network: $5,000/person, $10,000/family<br>First Health Network and Simplified Benefits Administrators: $7,000/person, $11,250/family<br>Non-participating providers:<br>$13,750/person, $19,250/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, 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?** | Prescription drug discounts or coupons on a brand name drug when a medically appropriate generic equivalent is available,, premiums, balance billing charges (unless balanced billing is prohibited), 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 simplifiedbenefitsadministrators.org or call 1-800-207-1018 for a list of participating providers. | You pay the least if you use a provider in the Montrose Regional Health provider network. You pay more if you use a provider in the Simplified Benefits Administrators or First Health provider 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 |
|---|---|---|---|---|---|
| | | Montrose Regional Health Network (You will pay the least) | First Health and Simplified Benefits Administrators (You will pay more) | Non-Participating 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 | $50 copayment per visit, deductible does not apply | $50 copayment per visit, deductible does not apply | 50% coinsurance | Diagnostic tests (lab and x-ray services), and chemotherapy and radiation treatment are not included in the office visit copayment. |
| | Specialist visit | 30% coinsurance | 30% coinsurance | 50% coinsurance | None |
| | Preventive care/screening/ immunization | No charge | No charge | 50% coinsurance | 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) | 30% coinsurance | 30% coinsurance | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | 30% coinsurance | 50% coinsurance | None |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.magellanrx.com | Generic drugs | 40% copayment (up to a 90-day supply/retail or mail order); deductible does not apply | | | Prescription drugs are payable subject to a prescription drug maximum copayment amount of $250 per prescription for a 30- day supply, and $500 per prescription for a 90-day supply.<br><br>Specialty drugs must be obtained through the Magellan Specialty Pharmacy and are limited to a 30-day supply per prescription. |
| | Preferred brand drugs | 60% copayment (up to a 90-day supply/retail or mail order); deductible does not apply | | | |
| | Non-preferred brand drugs | 60% copayment (up to a 90-day supply/retail or mail order); deductible does not apply | | | |
| | Specialty drugs | Subject to the above retail copayment amounts; deductible does not apply. | | | |
| **If you have outpatient surgery** | Facility Fee (e.g. Ambulatory surgery center) | 30% coinsurance | 30% coinsurance | 50% coinsurance | None |
| | Physician/surgeon fees | 30% coinsurance | 30% coinsurance | 50% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | 30% coinsurance after $100 copayment | | | The emergency room copayment will be waived if admitted to the hospital through the emergency room or is life/limb threatening or otherwise is a medical emergency. |

| | | | | |
|---|---|---|---|---|
| | Emergency medical transportation | 30% coinsurance | | None |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Montrose Regional Health Network (You will pay the least) | First Health Network and Simplified Benefits Administrators (You will pay more) | Non-Participating Provider (You will pay the most) | |
| | Urgent Care | | | | Diagnostic tests (lab and x-ray services), and chemotherapy and radiation treatment are not included in the urgent care office visit copayment. |
| | Facility | 30% coinsurance | 30% coinsurance | 50% coinsurance | |
| | Physician / Office Visit | $50 copayment per visit, deductible does not apply | $50 copayment per visit, deductible does not apply | 50% coinsurance | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance | 30% coinsurance | 50% coinsurance | Limited to the facility's semi-private room rate. |
| | Physician/surgeon fees | 30% coinsurance | 30% coinsurance | 50% coinsurance | None |
| **If you need mental health, behavioral health, or substance use disorder services** | Outpatient services | 30% coinsurance | 30% coinsurance | 50% coinsurance | None |
| | Inpatient services | 30% coinsurance | 30% coinsurance | 50% coinsurance | None |
| **If you are pregnant** | Office visits | | | 50% coinsurance | Maternity services are limited to the covered Employee or Spouse only. Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound). |
| | Primary Care Physician | $50 copayment per visit , deductible does not apply | $50 copayment per visit, deductible does not apply | | |
| | Specialist | 30% coinsurance | 30% coinsurance | | |
| | Childbirth/delivery professional services | 30% coinsurance | 30% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 30% coinsurance | 30% coinsurance | 50% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Montrose Regional Health Network (You will pay the least) | First Health Network and Simplified Benefits Administrators (You will pay more) | Non-Participating Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | 30% coinsurance | 30% coinsurance | 50% coinsurance | None |
| | Rehabilitation services | 30% coinsurance | 30% coinsurance | 50% coinsurance | Outpatient rehabilitation is limited to 30 visits per therapy type per calendar year and includes occupational, physical and speech therapy. Additional visits in increments of 5 (not to exceed 20) may be available when deemed medical necessary. |
| | Habilitation services | 30% coinsurance | 30% coinsurance | 50% coinsurance | |
| | Skilled nursing care | 30% coinsurance | 30% coinsurance | 50% coinsurance | Coverage is limited to the semi-private room rate. |
| | Hospice services | 30% coinsurance | 30% coinsurance | 50% coinsurance | None |
| | Durable medical equipment | | | | None |
| | New Purchase: | 30% coinsurance | 30% coinsurance | 50% coinsurance | |
| | Replacement: | 50% coinsurance | 30% coinsurance | 50% coinsurance | |
| | | | | | None |
| If your child needs dental or eye care | Children's eye exam | 100% covered -1 per calendar year | | | Vision benefits may be available through a separate enrollment. |
| | Children's glasses | 100% covered - 1 per calendar year - $150 calendar maximum | | | |
| | Children's dental check-up | Not Covered | | | Dental benefits may be available through a separate enrollment. |

**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.)**

- Acupuncture
- Cosmetic surgery
- Chiropractic care
- Dental Care (adult)
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (adult)
- Routine foot care

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Bariatric surgery | • Hearing Aids | • Infertility Treatment |

**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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 on how 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: 800-207-1018.

**Does this plan provide Minimum Essential Coverage? Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**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) 207-1018.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1 (800) 207-1018.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1 (800) 207-1018.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1 (800) 207-1018.

***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 | $1,500 |
| Specialist *[cost sharing]* | 30% |
| Hospital (facility) *[cost sharing]* | 30% |
| Other *[cost sharing]* | 30% |

**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** | **$12,700** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,500 |
| Coinsurance | $3,360 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$4,860** |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Specialist *[cost sharing]* | 30% |
| Hospital (facility) *[cost sharing]* | 30% |
| Other *[cost sharing]* | 30% |

**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** | **$5,600** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,500 |
| Coinsurance | $1,230 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$2,730** |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Specialist *[cost sharing]* | 30% |
| Hospital (facility) *[cost sharing]* | 30% |
| Other *[cost sharing]* | 30% |

**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** | **$2,800** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,500 |
| Coinsurance | $390 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,890** |

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