
 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](https://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](https://www.healthcare.gov/sbc-glossary) or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	Montrose Regional Health Network: \$500/person/\$1,000/family; First Health Network and Simplified Benefits Administrators: \$850/person, \$1,450/family; Non-participating <a href="#">providers</a> : \$1,450/person, \$2,650/family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. The following participating <a href="#">provider</a> services: <a href="#">primary care physician's</a> office visits, <a href="#">urgent care physician</a> , <a href="#">preventive care</a> , and <a href="#">prescription drugs</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	Montrose Regional Health Network: \$2,500/person, \$5,000/family; First Health Network and Simplified Benefits Administrators: \$3,550/person, \$6,250/family; Non-participating <a href="#">providers</a> : \$6,850/person, \$11,250/family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Prescription drug discounts or coupons on a brand name drug when a medically appropriate generic equivalent is available,, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges (unless balanced billing is prohibited), and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="https://simplifiedbenefitsadministrators.org">simplifiedbenefitsadministrators.org</a> or call 1-800-207-1018 for a list of participating <a href="#">providers</a> .	You pay the least if you use a <a href="#">provider</a> in the Montrose Regional Health <a href="#">provider network</a> . You pay more if you use a <a href="#">provider</a> in the Simplified Benefits Administrators and First Health <a href="#">provider network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a provider for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 Network and Simplified Benefits Administrators (You will pay more)	Non-Participating Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$35 <a href="#">copayment per visit</a> , <a href="#">deductible</a> does not apply	\$35 <a href="#">copayment per visit</a> , <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	<a href="#">Diagnostic tests</a> (lab and x-ray services), and chemotherapy and radiation treatment are not included in the office visit <a href="#">copayment</a> .
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.magellanrx.com">www.magellanrx.com</a>	Generic drugs	20% <a href="#">copayment</a> (up to a 90-day supply/retail or mail order); <a href="#">deductible</a> does not apply			<a href="#">Prescription drugs</a> are payable subject to a <a href="#">prescription drug</a> maximum copayment amount of \$150 per prescription for a 30-day supply, and \$350 per prescription for a 90-day supply.  <a href="#">Specialty drugs</a> must be obtained through the Magellan Specialty Pharmacy and are limited to a 30-day supply per prescription.
	Preferred brand drugs	40% <a href="#">copayment</a> (up to a 90-day supply/retail or mail order); <a href="#">deductible</a> does not apply			
	Non-preferred brand drugs	40% <a href="#">copayment</a> (up to a 90-day supply/retail or mail order); <a href="#">deductible</a> does not apply			
	<a href="#">Specialty drugs</a>	Subject to the above retail copayment amounts; <a href="#">deductible</a> does not apply.			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a> after \$100 <a href="#">copayment</a>			The emergency room <a href="#">copayment</a> will be waived if admitted to the hospital through the emergency room or is life/limb threatening or otherwise is a medical emergency.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [simplifiedbenefitsadministrators.org](http://simplifiedbenefitsadministrators.org)

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)	
	<a href="#">Emergency medical transportation</a>	10% <u>coinsurance</u>			None
	<a href="#">Urgent Care</a>				<u>Diagnostic tests</u> (lab and x-ray services), and chemotherapy and radiation treatment are not included in the <u>urgent care</u> office visit <u>copayment</u> .
	Facility	10% <u>coinsurance</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Physician / Office Visit	\$35 <u>copayment</u> per visit, <u>deductible</u> does not apply	\$35 <u>copayment</u> per visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to the facility's semi-private room rate.
	Physician/surgeon fees	10% <u>coinsurance</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	10% <u>coinsurance</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Inpatient services	10% <u>coinsurance</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you are pregnant	<a href="#">Office visits</a>			50% <u>coinsurance</u>	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, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound).
	Primary Care Physician	\$35 <u>copayment</u> per visit, <u>deductible</u> does not apply	\$35 <u>copayment</u> per visit, <u>deductible</u> does not apply		
	Specialist	10% <u>coinsurance</u>	10% <u>coinsurance</u>		
	Childbirth/delivery professional services	10% <u>coinsurance</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<a href="#">Rehabilitation services</a>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Outpatient rehabilitation is limited to 30 visits per therapy type per calendar year and includes occupational, physical and speech

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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)	
	<a href="#">Habilitation services</a>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	therapy. Additional visits in increments of 5 (not to exceed 20) may be available when deemed medically necessary.
	<a href="#">Skilled nursing care</a>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to the semi-private room rate.
	<a href="#">Durable medical equipment</a>				None
	<a href="#">New Purchase:</a>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<a href="#">Replacement:</a>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<a href="#">Hospice services</a>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
<b>If your child needs dental or eye care</b>	Children's eye exam	100% covered -1 per calendar year			Vision benefits may be available through a separate <u>enrollment</u> .
	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Chiropractic care</li> <li>• Dental Care (adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Long term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (adult)</li> <li>• Routine foot care</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> </ul>

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [simplifiedbenefitsadministrators.org](http://simplifiedbenefitsadministrators.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: [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](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 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, kwijigo holne' 1 (800) 207-1018.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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](#) \$500
- [Specialist \[cost sharing\]](#) 10%
- Hospital (facility) [\[cost sharing\]](#) 10%
- Other [\[cost sharing\]](#) 10%

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>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,440
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,940</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist \[cost sharing\]](#) 10%
- Hospital (facility) [\[cost sharing\]](#) 10%
- Other [\[cost sharing\]](#) 10%

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>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,020
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,520</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist \[cost sharing\]](#) 10%
- Hospital (facility) [\[cost sharing\]](#) 10%
- Other [\[cost sharing\]](#) 10%

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>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$460
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$960</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.