simplified benefits ADMINISTRATORS

Montrose County School district Re-1J Employee Benefit Plan: Basic Plan

Coverage for: Individual + Family| **Plan Type:** PPO

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 simplifiedbenefitsadministrators.org or call 800-207-1018. 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: Montrose Regional Health: $2,500/person, $4,000/family First Health Network and Simplified Benefits Administrators: $3,000/person, $5,000/family Non-participating providers: $5,000/person, $8,000/family	Generally, you must pay all 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, for in-network **providers**: **preventive** care, office visits, prescription drugs, and chiropractic 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 **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: Montrose Regional Health Network: $6,500/person, $11,000/family First Health Network and Simplified Benefits Administrators: $8,000/person, $12,000/family Non-participating providers: $14,000/person, $20,000/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 does not 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. To find an in-network **provider** visit **simplifiedbenefitsadministrators.org** or call Member Services at 800-207-1018..	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the Montrose Regional health provider network. You will pay the most if you use a provider in the Simplified Benefits Administrators or First Health network. You will pay more 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**.

* For more information about limitations and exceptions, see the plan or policy document at selecthealth.org/materials.

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 and River Landing Surgical Center Network (You will pay the least)	First health and Simplified Benefits Administrators (You will pay more)	Out-of-Network 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 (PCP)	$60 copayment per visit, deductible does not apply	$60 copayment per visit, deductible does not apply	50% **co-insurance**	Diagnostic tests (lab and x-ray services), and chemotherapy and radiation treatment are not included in the office visit copayment.
	Specialist visit (SCP)	30% **co-insurance**	30% **co-insurance**	40% **co-insurance**	----------None----------
	Preventive care / **screening** / immunization	No Charge	No charge	50% **co-insurance**	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% **co-insurance**	30% **co-insurance**	50% **co-insurance**	----------None----------
	Imaging (CT/PET scans, MRIs)	30% **co-insurance**	30% **co-insurance**	50% **co-insurance**	----------None----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.magellanrx.com**	Standard Tier 1 (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 $350 per prescription for a 30- day supply, and $700 per prescription for a 90-day supply. Specialty drugs must be obtained through the Magellan Specialty Pharmacy and are limited to a 30-day supply per prescription
	Standard Tier 2 (preferred brand drugs)	60% copayment (up to a 90-day supply/retail or mail order); deductible does not apply			
	Standard Tier 3 (non-preferred brand drugs)	60% copayment (up to a 90-day supply/retail or mail order); deductible does not apply			
	Maintenance Tier 1 (generic drugs)	40% copayment (up to a 90-day supply/retail or mail order); deductible does not apply			
	Maintenance Tier 2 (preferred brand drugs)	60% copayment (up to a 90-day supply/retail or mail order); deductible does not apply			
	Maintenance Tier 3 (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.			

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Montrose Regional Health Network and River Landing Surgical Center Network (You will pay the least)	First health and Simplified Benefits Administrators (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% **co-insurance**	30% **co-insurance**	50% **co-insurance**	----------None----------
	Physician/surgeon fees	30% **co-insurance**	30% **co-insurance**	50% **co-insurance**	----------None----------
If you need immediate medical attention	**Emergency room services**	**30% coinsurance** after $100 copayment			The emergency room copayment will be waived if admitted to the hospital through the Emergencies only. **Emergency medical transportation** applies to in-network benefits.
	Emergency medical transportation	**30% coinsurance**			
	Urgent care				Applies to **urgent care** facilities only.
	Urgent Care Facility	30% **co-insurance**	30% **co-insurance**	50% **co-insurance**	Diagnostic tests (lab and x-ray services), and chemotherapy and radiation treatment are not included in the urgetn care office visit copayment.
	Physician / Office Visit	$60 copayment per visit, deductible does not apply	$60 copayment per visit, deductible does not apply	50% **co-insurance**	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% **co-insurance**	30% **co-insurance**	50% **co-insurance**	Limited to facility's semi-private room rate.
	Physician/surgeon fee	30% **co-insurance**	30% **co-insurance**	50% **co-insurance**	----------None----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% **co-insurance**	30% **co-insurance**	50% **co-insurance**	----------None----------
	Inpatient services	30% **co-insurance**	30% **co-insurance**	50% **co-insurance**	
If you are pregnant	Office visits - Primary Care Physician	$60 copayment per visit , deductible does not apply	$60 copayment per visit , deductible does not apply	50% **co-insurance**	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). .
	Office Visits - Specialist	30% **co-insurance**	30% **co-insurance**	50% **co-insurance**	
	Childbirth/delivery professional services	30% **co-insurance**	30% **co-insurance**	50% **co-insurance**	
	Childbirth/delivery facility services	30% **co-insurance**	30% **co-insurance**	50% **co-insurance**	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Montrose Regional Health Network and River Landing Surgical Center Network (You will pay the least)	First health and Simplified Benefits Administrators (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	**Home health care**	30% **co-insurance**	30% **co-insurance**	50% **co-insurance**	----------None----------
	Rehabilitation services	30% **co-insurance**	30% **co-insurance**	50% **co-insurance**	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% **co-insurance**	30% **co-insurance**	50% **co-insurance**	Benefits may be denied or reduced by 50% for failure to obtain **preauthorization** for certain services.
	Skilled nursing care	30% **co-insurance**	30% **co-insurance**	50% **co-insurance**	Coverage is limited to the semi-private room rate.
	Durable medical equipment (DME)				----------None----------
	New Purchase	30% **co-insurance**	30% **co-insurance**	50% **co-insurance**	
	Replacement	50% **co-insurance**	50% **co-insurance**	50% **co-insurance**	
	Hospice service	30% **co-insurance**	30% **co-insurance**	50% **co-insurance**	----------None----------
If your child needs dental or eye care	Children's eye exam	100% covered - 1 per calendar year			----------None----------
	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.

* For more information about limitations and exceptions, see the plan or policy document at selecthealth.org/materials.

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 and reconstructive • 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

* For more information about limitations and exceptions, see the plan or policy document at selecthealth.org/materials.

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's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov; or contact the **Plan**. 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:

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**.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

* For more information about limitations and exceptions, see the plan or policy document at selecthealth.org/materials.

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	**$2,500**
Specialist	**30%**
Hospital (facility)	**30%**
Other	**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	$2,500
Coinsurance	$3,360
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$5,860**

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

The plan's overall deductible	**$2,500**
Specialist	**30%**
Hospital (facility)	**30%**
Other	**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	$2,500
Coinsurance	$1,230
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,730**

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

The plan's overall deductible	**$2,500**
Specialist	**30%**
Hospital (facility)	**30%**
Other	**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	$2,500
Coinsurance	$390
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,890**

The other costs of these EXAMPLE covered services.

SBA EXAMPLE OPTION 1
8/14/2024

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Non-Discrimination Notice

Select Health obeys Federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

We provide free aid and services to people with disabilities to help them communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). We also provide free language services to people whose primary language is not English, such as qualified interpreters and member materials written in

If you need these services, please call Select Health Member Services at 800-538-5038 or Select Health Advantage Member Service at 855-442-9900. Any member or other person who believes he/she may have been subject to discrimination may file a complaint or grievance by calling the SelectHealth 504/Civil Rights Coordinator at 844-208-9012 or the Compliance Hotline at 800-442-4845 (TTY Users: 711).

Language Access Services

Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Select Health.

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 Select Health

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Select Health.

Korean
통지: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Select Health. 번호로 전화해 주십시오.

Nepali
ध्यान दिनुहोस्: तपाईले नेपाली बोल्ननुहुन्छ भने तपाईको नि म्ति भाषा सहायता सेवाहरू नि ःशुल्क रूपमा उपलब्ध छ। Select Health मा फोन गर्ननुहोस्।

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Select Health.

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: Select

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните Select Health.

French
ATTENTION: si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez Select Health.

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。Select Health. まで、お電話にてご連絡ください。

Amharic
ማሳሰቢያ፡ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎቶች ያለክፍያ ለእርስዎ ይገኛሉ። Select Health ን ያናግሩ።

Serb-Croatian
ПАЖЊА: Ако говорите Српски, бесплатне услуге пмоћи за језик, биће вам доступне. Контактирајте Select Health.

Arabic
تامدخ كل رفوتتسف ،ىبرع ثدحتت تنك اذإ :هيبنت
ب لصتا .أناجم قيوغللا ةدعاسملا Select Health.

Persian
تامدخ ،دينكيم تبحص ينک دراو ار نابز هب رگا :هجوت
اب .تسامش رايتخا رد ناگيار تروصب ،ينابز کمک
.ديريگب سامت Select Health

Thai
หมายเหตุ: หากคุณพูด ใส่ภาษา, การบริการภาษา โดยไม่มีค่าใช้จ่าย มีพร้อมบริการให้กับคุณ ติดต่อ Select Health

Select Health: 1-800-538-5038

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