

Iverson Memorial Hospital Standard Plan -PPO 0 DED/1500 DED



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, contact 800-207-1018. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 800-207-1018 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Tier 1: Deductible Waived Tier 2: \$1,500 per person / \$2,500 per family per calendar. Tier 3: \$3,000 per person / \$6,000 per family per calendar. Does not apply to most services provided by Iverson Memorial Hospital, preventive care received by an In- Network provider, or generic and brand name drugs purchased through the Prescription Drug Program. Prescription drug copayments do not count toward the deductible.	Generally, you must pay all 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> ?	No.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or co-insurance 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 <u>deductibles</u> for specific	No.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Tier 1 and Tier 2: \$3,250 per person / \$6,500 per family per calendar year for In-network and Out-of-network providers Tier 3: \$6,500 per person / \$13,000 per family per calendar.	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> ?	Penalties for failure to obtain precertification for services, amounts over Maximum Allowable Charges, premiums, balance-billed charges and other health care not covered by this plan.	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, this plan accesses two different networks depending on your location. For a list of preferred providers for First Choice of the Midwest visit www.1choicem.com or call 1-888-246-9949. For a list of preferred providers for PHCS-HD visit www.multiplan.com or call 1-800-678-7427.	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 provider 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 provider before you get services.
Do you need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u>.



All copayment and co-insurance 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
		Tier 1 Iverson Hospital	Tier 2 Network and Wyoming First Choice of the Midwest	UCH Tier 3 Multiplan / PHCS Non- Network Providers	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness (PCP)	10% co-insurance	20% co-insurance after deductible	50% co-insurance after deductible	Deductible does not apply to services performed at Iverson Memorial Hospital.
	<u>Specialist</u> visit (SCP)	10% co-insurance	20% co-insurance after deductible	50% co-insurance after deductible	Deductible does not apply to services performed at Iverson Memorial Hospital.
	<u>Preventive</u> care / <u>screening</u> / immunization	0% co-insurance	0% co-insurance	50% co-insurance after deductible	Deductible does not apply to Iverson Memorial Hospital or other In-Network providers. Covered Expenses include items and services rated A or B in the United States Preventive Services Task Force recommendations including but not limited to: office visits, well woman care, well child care, mammogram, prostate screening, routine physical examination, x-rays, laboratory blood tests, immunizations, and other preventive care services required by applicable law. Subject to age and frequency limits.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% co-insurance	20% co-insurance after deductible	50% co-insurance after deductible	Deductible does not apply to services performed at Iverson Memorial Hospital. Deductible does apply to Physician/surgeon fees. Imaging services performed in a hospital or imaging center must be reported to the plan 48 hours in advance of the procedure or you may be assessed a penalty.
	Imaging (CT/PET scans, MRIs)	10% co-insurance	20% co-insurance after deductible	50% co-insurance after deductible	

		Tier 1 Ivinson Hospital	Tier 2 Network and Wyoming First Choice of the Midwest	UCH Tier 3 Multiplan / PHCS Non- Network Providers	What You Will Pay Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.serveyourx.com or by calling 800-759-3203.	Standard Tier 1 (generic drugs)	Retail & Mail Order: \$5 co-pay per prescription			Deductible does not apply. Covers up to a 34-day supply at a retail pharmacy and up to a 90-day supply through mail order. However, birth control will be covered for up to a 90-day supply at a retail pharmacy. Drugs required as part of evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force are covered at 100% not subject to any copayment, co-insurance or deductible. Including certain contraceptive, certain preventive drugs and certain smoking cessation products.
	Standard Tier 2 (preferred brand drugs)	Retail & Mail Order: \$15 co-pay per prescription plus 20% co-insurance			
	Standard Tier 3 (non- preferred brand drugs)	Retail & Mail Order: \$25 co-pay per prescription plus 25% co-insurance			
	Maintenance Tier 1 (generic drugs)	Retail & Mail Order: \$5 co-pay per prescription			
	Maintenance Tier 2 (preferred brand drugs)	Retail & Mail Order: \$15 co-pay per prescription plus 20% co-insurance			
	Maintenance Tier 3 (non- preferred brand drugs)	Retail & Mail Order: \$25 co-pay per prescription plus 25% co-insurance			
	<u>Specialty drugs</u>	10% co-insurance			All specialty pharmacy medications that are administered at home or as a scheduled visit in your Physician's office or other facility should be obtained through the Specialty Pharmacy. All specialty drugs should have prior authorization

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Ivins Hospital	Tier 2 Network and Wyoming First Choice of the Midwest	UCH Multiplan / PHCS Non- Network Providers	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance	20% co-insurance after deductible	50% co-insurance after deductible	Deductible does not apply to services performed at Ivins Memorial Hospital. Deductible does apply to Physician/surgeon fees. Outpatient surgical procedures performed in a hospital or surgical center must be reported to the plan 48 hours in advance of the procedure
	Physician/surgeon fees	10% co-insurance	20% co-insurance after deductible	50% co-insurance after deductible	
If you need immediate medical attention	<u>Emergency room services</u>	10% co-insurance	20% co-insurance after deductible	20% co-insurance after deductible	Deductible does not apply to services performed at Ivins Memorial Hospital. Deductible does apply to Physician/surgeon fees. Emergency admissions must be reported within 1 business days after the admission or you may be assessed a penalty.
	<u>Emergency medical transportation</u>	Not Available	20% co-insurance after deductible	20% co-insurance after deductible	Deductible does not apply to services performed at Ivins Memorial Hospital.
	<u>Urgent care</u>	Not Available	20% co-insurance after deductible	50% co-insurance after deductible	Deductible applies
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance	20% co-insurance after deductible	Not Covered	Deductible does not apply to services performed at Ivins Memorial Hospital. Deductible does apply to Physician/surgeon fees. Non-emergency hospital admissions must be reported at least 48 hours in advance of the admission or you may be assessed a penalty.
	Physician/surgeon fee	10% co-insurance	20% co-insurance after deductible	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% co-insurance	20% co-insurance after deductible	50% co-insurance after deductible	Deductible does not apply to services performed at Ivins Memorial Hospital. Deductible does apply to Physician fees.
	Inpatient services	10% co-insurance	20% co-insurance after deductible	Not Covered	Deductible does not apply to services performed at Ivins Memorial Hospital. Deductible does apply to Physician fees. Emergency admissions must be reported within 1 business day after the admission and non-emergency hospital admissions must be reported at least 48 hours in advance of the admission or you may be assessed a penalty.
If you are pregnant	Office visits	10% co-insurance	20% co-insurance after deductible	50% co-insurance after deductible	Deductible does not apply to services performed at Ivins Memorial Hospital. Deductible does apply to Physician fees. The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery. The pregnancy of a dependent child is not covered.
	Childbirth/delivery professional services	10% co-insurance	20% co-insurance after deductible	50% co-insurance after deductible	
	Childbirth/delivery facility services	10% co-insurance	20% co-insurance after deductible	50% co-insurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Iverson Hospital	Tier 2 Network and Wyoming First Choice of the Midwest	Tier 3 Multiplan / PHCS Non- Network Providers	
If you need help recovering or have other special health needs	<u>Home health care</u>	Not Available	20% co-insurance after deductible	50% co-insurance after deductible	Deductible applies. Services must be received within 14 days of discharge from a hospital or skilled nursing facility.
	<u>Rehabilitation services</u>	10% co-insurance	20% co-insurance after deductible	50% co-insurance after deductible	Deductible does not apply to services performed at Iverson Memorial Hospital. Speech therapy, physical therapy and occupational therapy have a combined 40 visit maximum per calendar year. Rehabilitation services must be reported to the plan 48 hours in advance of the procedure or you may be assessed a penalty.
	<u>Habilitation services</u>	10% co-insurance	20% co-insurance after deductible	50% co-insurance after deductible	Deductible does not apply to services performed at Iverson Memorial Hospital. Coverage is only provided for speech therapy when needed to correct a congenital anomaly (e.g. cleft lip or cleft palate). Benefits are combined with the calendar year maximum for rehabilitation services. Habilitation services must be reported to the plan 48 hours in advance of the procedure or you may be assessed a penalty.
	<u>Skilled nursing care</u>	10% co-insurance	20% co-insurance after deductible	50% co-insurance after deductible	Deductible does not apply to services performed at Iverson Memorial Hospital. Skilled Nursing Facility stays must be reported to the plan at least 48 hours in advance of the stay or you may be assessed a penalty. Coverage is limited to a 30-day calendar year maximum.
	<u>Durable medical equipment (DME)</u>	10% co-insurance	20% co-insurance after deductible	Not Covered	Deductible does not apply to services performed at Iverson Memorial Hospital.
	<u>Hospice service</u>	10% co-insurance	20% co-insurance after deductible	Not Covered	Deductible does not apply to services performed at Iverson Memorial Hospital. Hospice care must be reported to the plan at least 48 hours in advance of services rendered or you may be assessed a penalty.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Dental and Vision benefits are covered under a separate plan, if elected.
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
• Acupuncture • Bariatric Surgery • Cosmetic Surgery except for reconstructive surgery due to a congenital condition or reconstructive mammoplasties	• Habilitative Services, except for Speech Therapy • Hearing Aids • Infertility Treatment • Long-term Care • Dental Care - separate coverage available	• Non-emergency Care when traveling outside of the U.S. • Routine Eye Care - separate coverage available • Routine Foot Care • Weight Loss Programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
• Chiropractic Care		

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

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.ccoio.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:

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: Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or dol.gov/ebsa/healthreform.

To contact Simplified Benefits Administrators Member Services, please call 800-207-1018 weekdays, TTY users should call 711, or visit us at simplifiedbenefitsadministrators.org.

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.—————

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 co-insurance) 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	Waived
■ Specialist	10%
■ Hospital (SRMC)	10%
■ Other	\$3,250

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles - Waived at Iverson	\$0
Copayments	\$0
co-insurance	\$1,154
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$1,154

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

■ The plan's overall deductible	Waived
■ Specialist	10%
■ Hospital (SRMC)	10%
■ Other	\$3,250

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles - Waived at Iverson	\$0
Copayments	\$0
co-insurance	\$540
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$540

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

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

■ The plan's overall deductible	Waived
■ Specialist	10%
■ Hospital (facility)	10%
■ Other	\$3,250

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles - Waived at Iverson	\$0
Copayments	\$0
co-insurance	\$280
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$280

IVINSON MEMORIAL HOSPITAL

10/13/2026

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Non-Discrimination Notice

Simplified Benefits Administrators 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 other languages.

If you need these services, please call Simplified Benefits Administrators Member Services at 800-538-5038 or Simplified Benefits Administrators 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 Simplified Benefits Administrators 504/Civil Rights Coordinator at 844-208-9012 or the Compliance Hotline at 800-442-4845 (TTY Users: 711). You may also call the Office for Civil Rights at 1-800-368-1019 (TTY Users: 800-537-7697).

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: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। Select Health मा फोन गर्नुहुनुहोस्।

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 Health.

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

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Serb-Croatian

ПАЖИМА: Ако говорите Српски, бесплатне услуге помоћи за језик, биће вам доступне. Контактирајте Select Health.

Arabic

تامدخ كل رفوتتسف ،بیرع تّدحتت تنك اذّا :هيبنت اب .تسامش رايتخا رد ناگيار .تروصب ،يناز كمك Select Health. ب لصتا .أناجم قيو غلا قدعاسملا

Persian

تامدخ ،دینکیم تبحص ینک دراو ار نابز هب رگا :هجوت اب .تسامش رايتخا رد ناگيار .تروصب ،يناز كمك .ديريگب سامت. Select Health

Thai

หมายเหตุ: หากคุณพูด ใ้ภาษาไทย, การบริการภาษา โดยไม่มีค่าใช้จ่าย มีพร้อมบริการให้กับคุณ ติดต่อ Select Health

Simplified Benefits Administrators: 1-800-207-1018

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