

 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 SIMNSA at 1-800-424-4652. 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 <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf> or call 1-800-424-4652 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. There is no <a href="#">deductible</a> .	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>For participating providers \$6,350 individual / \$12,700 family</b>	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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billed charges 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> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.simnsa.com">www.simnsa.com</a> or call 1-800-424-4652 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a provider in the <a href="#">plan's 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 <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (a balance bill). 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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a referral before you see the <a href="#">specialist</a> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$5 <u>copay</u> /visit	Not covered	None
	<a href="#">Specialist</a> visit	\$5 <u>copay</u> /visit	Not covered	<u>Preauthorization</u> for services other than OB/GYN required or the service may not be covered. Chiropractic is not covered.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	Not covered	<u>Preauthorization</u> is required for certain services. Failure to obtain <u>preauthorization</u> for non-emergency or non-urgent procedures may result in non-payment of benefits.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	<u>Preauthorization</u> is required for certain services. Failure to obtain <u>preauthorization</u> for non-emergency or non-urgent procedures may result in non-payment of benefits.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.simnsa.com">www.simnsa.com</a>	Generic drugs	\$5 <u>copay</u> /prescription	Not covered	Drugs, supplies, and supplements are covered when prescribed by a Participating Provider and in accordance with <u>plan</u> guidelines. Certain drugs are covered only for a 30-day supply in a 30-day period. No charge for contraceptives required under the Health Resources and Services Administration (HRSA) guidelines. Select drugs require <u>preauthorization</u> . Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
	Preferred brand drugs	\$5 <u>copay</u> /prescription	Not covered	
	Non-preferred brand drugs	\$5 <u>copay</u> /prescription	Not covered	
	<a href="#">Specialty drugs</a>	\$5 <u>copay</u> /prescription	Not covered	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	<u>Preauthorization</u> is required for certain services. Failure to obtain <u>preauthorization</u> for non-emergency procedures may result in non-payment of benefits.
	Physician/surgeon fees	No charge	Not covered	<u>Preauthorization</u> is required for certain services. Failure to obtain <u>preauthorization</u> for non-emergency procedures may result in non-payment of benefits.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$250 <u>copay</u> /visit	\$250 <u>copay</u> /visit	<u>Copay</u> is waived if you are admitted to the hospital.
	<a href="#">Emergency medical transportation</a>	No charge	No charge	None
	<a href="#">Urgent care</a>	\$25 <u>copay</u> /visit	\$50 <u>copay</u> /visit outside Mexico; \$25 <u>copay</u> /visit in Mexico	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	<u>Preauthorization</u> is required for certain services. Failure to obtain <u>preauthorization</u> for non-emergency procedures may result in non-payment of benefits.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$5 <u>copay</u> /visit	Not covered	No charge for “Other Items and Services” – See Summary of Benefits and Schedule of Copayments.
	Inpatient services	No charge	Not covered	None
<b>If you are pregnant</b>	Office visits	\$5 <u>copay</u> /visit	Not covered	<u>Cost sharing</u> does not apply to certain <u>preventative services</u> . Depending on the type of services, <u>copay</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	None

[\* For more information about limitations and exceptions, see the plan or policy document at [www.simnsa.com].]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	Not covered	Since the <u>plan</u> service area is in Mexico, Home Health, Rehabilitation, Habilitation, and Skilled Nursing services are only available in limited situations and <u>preauthorization</u> is required. Please consult your <u>plan</u> document (available at <a href="http://www.simnsa.com">www.simnsa.com</a> ). Skilled Nursing Facilities are not available in the <u>plan</u> service area.
	<a href="#">Rehabilitation services</a>	\$10 <u>copay</u> /visit	Not covered	
	<a href="#">Habilitation services</a>	\$10 <u>copay</u> /visit	Not covered	
	<a href="#">Skilled nursing care</a>	No charge	Not covered	
	<a href="#">Durable medical equipment</a>	No charge	Not covered	
	<a href="#">Hospice services</a>	No charge	Not covered	Since the <u>plan</u> service area is in Mexico, Hospice Services are only available in limited situations. Please consult your <u>plan</u> document (available at <a href="http://www.simnsa.com">www.simnsa.com</a> ).
<b>If your child needs dental or eye care</b>	Children's eye exam	\$5 <u>copay</u> /visit	Not covered	Eye exams for the purpose of obtaining or maintaining contact lenses are not covered.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	May be covered if dental policy is purchased by your employer. For more information, please contact your employer or call the <u>plan</u> at 619-407-4082 (U.S.) or 683-29-02 (Mexico).

### 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.)

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|--|--|--|
| <ul style="list-style-type: none"> <li>• Chiropractic Care</li> <li>• Cosmetic Surgery</li> <li>• Dental Care</li> <li>• Hearing Aids</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility Treatment</li> <li>• Long Term Care</li> <li>• Non-Emergency care when traveling outside the Plan's Service Area in Mexico</li> </ul> | <ul style="list-style-type: none"> <li>• Non-Medically Necessary Services/Treatment</li> <li>• Private-Duty Nursing</li> <li>• Weight Loss Programs</li> </ul> |
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#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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|--|--|---|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric Surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Routine Eye Care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Routine Foot Care</li> </ul> |
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**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](http://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](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 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 Managed Health Care at 1-888-HMO-HELP (466-2219) or [www.dmhc.com](http://www.dmhc.com).

**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 619-407-4082 (Estados Unidos) o al 683-29-02 (Mexico).

\_\_\_\_\_ *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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$0
■ Hospital (facility) [ <i>cost sharing</i> ]	\$0
■ Other [ <i>cost sharing</i> ]	\$60

#### 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>\$4,600</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$60
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$60</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$10
■ Hospital (facility) [ <i>cost sharing</i> ]	\$0
■ Other [ <i>cost sharing</i> ]	\$590

#### 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>\$4,400</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$600</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$15
■ Hospital (facility) [ <i>cost sharing</i> ]	\$250
■ Other [ <i>cost sharing</i> ]	\$20

#### 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>\$1,700</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$285
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$285</b>