



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 <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> and services listed in your complete terms of coverage.	This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at healthcare.gov/coverage/preventive-care-benefits .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For participating providers \$6,350 individual / \$12,700 family	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> ?	Premiums, <u>balance-billing</u> charges and health care this <u>plan</u> doesn't cover.	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. See www.simnsa.com or call 1-800-424-4652 for a list of <u>network providers</u> .	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 <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (a <u>balance bill</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 <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 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
		Network Provider (You will pay the least)	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	\$5 copay /visit	Not covered	Applicable copays may apply to telehealth services.
	Specialist visit	\$5 copay /visit	Not covered	Preauthorization for services other than OB/GYN required or the service may not be covered. Chiropractic is not covered
	Preventive care/screening /immunization	No charge	Not covered	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)	No charge	Not covered	Preauthorization is required for certain services. Failure to obtain preauthorization for non-emergency or non-urgent procedures may result in non-payment of benefits.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Preauthorization is required for certain services. Failure to obtain preauthorization for non-emergency or non-urgent procedures may result in non-payment of benefits. Coverage and authorization for screening and testing for COVID-19 will be determined based on the applicable state and federal regulations in place at the time of the subject screening and testing.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.simnsa.com	Generic drugs	\$5 copay/prescription	Not covered	Drugs, supplies, and supplements are covered when prescribed by a Participating Provider and in accordance with plan 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

[* 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				drugs require <u>preauthorization</u> . Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
	Preferred brand drugs	\$5 <u>copay/prescription</u>	Not covered	
	Non-preferred brand drugs	\$5 <u>copay/prescription</u>	Not covered	
	Specialty drugs	\$5 <u>copay/prescription</u>	Not covered	
If you have outpatient surgery	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 nonpayment 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 nonpayment of benefits.
If you need immediate medical attention	Emergency room care	\$250 <u>copay/visit</u>	\$250 <u>copay/visit</u>	<u>Copay</u> is waived if you are admitted to the hospital.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	\$25 <u>copay/visit</u>	\$50 <u>copay/visit</u> outside Mexico; \$25 <u>copay/visit</u> in Mexico	None
If you have a hospital stay	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 nonpayment of benefits.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$5 <u>copay/visit</u>	Not covered	*See Summary of Benefits and Schedule of Copayments.
	Inpatient services	No charge	Not covered	None
If you are pregnant	Office visits	\$5 <u>copay/visit</u>	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Since the <u>plan</u> service area is in Mexico, Home Health, <u>Rehabilitation</u> , <u>Habilitation</u> , 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 www.simnsa.com). Skilled Nursing Facilities are not available in the <u>plan</u> service area.
	Rehabilitation services	\$10 <u>copay</u> /visit	Not covered	
	Habilitation services	\$10 <u>copay</u> /visit	Not covered	
	Skilled nursing care	No charge	Not covered	
	Durable medical equipment	No charge	Not covered	Must be in accordance with <u>durable medical equipment formulary</u> guidelines. Certain equipment requires <u>preauthorization</u> . Since the plan service area is in Mexico, <u>Hospice Services</u> are only available in limited situations. Please consult your plan document. Available at www.simnsa.com . Skilled Nursing Facilities are not available in the <u>plan</u> service area.
	Hospice services	No charge	Not covered	
If your child needs dental or eye care	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](#).)

- Chiropractic Care
- Cosmetic Surgery
- Dental Care (Adult & Child)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-Emergency care when traveling outside the Plan's Service Area in Mexico
- Non-Medically Necessary Services/Treatment
- Private-Duty Nursing
- Weight Loss Program

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture
- Bariatric Surgery
- Routine Eye Care (Adult)
- Routine Foot Care

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 Managed Health Care at 1-888-466-2219 or www.dmhc.com. 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: Department of Managed Health Care at 1-888-466-2219 or www.dmhc.com.

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 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 plan's overall deductible	\$0
■ Specialist [copayment]	\$0
■ Hospital (facility) [copayment]	\$0
■ Other [copayment]	\$0

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	\$0
Copayments	\$0
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$0
The total Peg would pay is	\$0

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ Specialist [copayment]	\$5
■ Hospital (facility) [copayment]	\$0
■ Other [copayment]	\$120

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	\$0
Copayments	\$125
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$0
The total Joe would pay is	\$125

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist [copayment]	\$5
■ Hospital (facility) [copayment]	\$250
■ Other [copayment]	\$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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$265
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$265

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