



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. <a href="#">Preventive care</a> and services listed in your complete terms of coverage.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the deductible amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://healthcare.gov/coverage/preventive-care-benefits">healthcare.gov/coverage/preventive-care-benefits</a> .
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</b> \$6,350 individual / \$12,700 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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, <a href="#">balance billing</a> 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 <a href="#">provider</a> 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 <a href="#">referral</a> before you see the <a href="#">specialist</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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$7 <a href="#">copay</a> /visit	Not covered	Applicable copays may apply to telehealth services.
	<a href="#">Specialist</a> visit	\$7 <a href="#">copay</a> /visit	Not covered	<a href="#">Preauthorization</a> 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 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)	No charge	Not covered	<a href="#">Preauthorization</a> is required for certain services. Failure to obtain <a href="#">preauthorization</a> for non-emergency or non-urgent procedures may result in non-payment of benefits.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	<a href="#">Preauthorization</a> is required for certain services. Failure to obtain <a href="#">preauthorization</a> for non-emergency or non-urgent procedures may result in non-payment of benefits. Coverage and authorization for <a href="#">screening</a> and testing for COVID-19 will be determined based on the applicable state and federal regulations in place at the time of the subject <a href="#">screening</a> and testing.
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.simnsa.com">www.simnsa.com</a>	Generic drugs	\$10 <a href="#">copay</a> /prescription	Not covered	Drugs, supplies, and supplements are covered when prescribed by a Participating Provider and in accordance with <a href="#">plan</a> 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 <a href="#">preauthorization</a> . Failure to obtain <a href="#">preauthorization</a> may result in non-payment of benefits.
	Preferred brand drugs	\$10 <a href="#">copay</a> /prescription	Not covered	
	Non-preferred brand drugs	\$10 <a href="#">copay</a> /prescription	Not covered	
	<a href="#">Specialty drugs</a>	\$10 <a href="#">copay</a> /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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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	<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
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	\$7 <u>copay</u> /visit	Not covered	*See Summary of Benefits and Schedule of Copayments.
	Inpatient services	No charge	Not covered	None
If you are pregnant	Office visits	\$7 <u>copay</u> /visit	Not covered	None

[\* 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
		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
<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	Must be in accordance with <u>durable medical equipment formulary</u> guidelines. Certain equipment requires <u>preauthorization</u> . Since the <u>plan</u> service area is in Mexico, <u>Hospice Services</u> 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> .
	<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	\$7 copay/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).

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

## 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](http://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](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: Department of Managed Health Care at 1-888-466-2219 or [www.dmhc.com](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist [copayment]</a>	\$0
■ Hospital (facility) <a href="#">[copayment]</a>	\$0
■ Other <a href="#">[copayment]</a>	\$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*)

<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>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$0</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 [copayment]</a>	\$7
■ Hospital (facility) <a href="#">[copayment]</a>	\$0
■ Other <a href="#">[copayment]</a>	\$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*)

<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>	\$0
<a href="#">Copayments</a>	\$127
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$127</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 [copayment]</a>	\$7
■ Hospital (facility) <a href="#">[copayment]</a>	\$250
■ Other <a href="#">[copayment]</a>	\$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>	\$0
<a href="#">Copayments</a>	\$267
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$267</b>

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