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 deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. There is no deductible.	See the Common Medical Events chart below for your costs for services this plan covers.
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?	**For participating providers $6,350 individual / $12,700 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?	Premiums, balance-billing charges and health care this plan doesn't 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. See www.simnsa.com or call 1-800-424-4652 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most 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 (a balance bill). 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?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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)	
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.

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)	
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 drugs require preauthorization. Failure to obtain preauthorization may result in non-payment of benefits.
	Preferred brand drugs	$5 copay/prescription	Not covered	
	Non-preferred brand drugs	$5 copay/prescription	Not covered	
	Specialty drugs	$5 copay/prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Preauthorization is required for certain services. Failure to obtain preauthorization for non-emergency procedures may result in non-payment of benefits.
	Physician/surgeon fees	No charge	Not covered	Preauthorization is required for certain services. Failure to obtain preauthorization for non-emergency procedures may result in non-payment of benefits.
If you need immediate medical attention	Emergency room care	$250 copay/visit	$250 copay/visit	Copay is waived if you are admitted to the hospital.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$25 copay/visit	$50 copay/visit outside Mexico; $25 copay/visit in Mexico	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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	Preauthorization is required for certain services. Failure to obtain preauthorization for non-emergency procedures may result in non-payment of benefits.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$5 copay/visit	Not covered	See Summary of Benefits and Schedule of Copayments.
	Inpatient services	No charge	Not covered	None
If you are pregnant	Office visits	$5 copay/visit	Not covered	Cost sharing does not apply to certain preventative services. Depending on the type of services, copay 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
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Since the plan service area is in Mexico, Home Health, Rehabilitation, Habilitation, and Skilled Nursing services are only available in limited situations and preauthorization is required. Please consult your plan document (available at www.simnsa.com). Skilled Nursing Facilities are not available in the plan service area.
	Rehabilitation services	$10 copay/visit	Not covered	
	Habilitation services	$10 copay/visit	Not covered	
	Skilled nursing care	No charge	Not covered	
	Durable medical equipment	No charge	Not covered	Must be in accordance with durable medical equipment formulary guidelines. Certain equipment requires preauthorization.
	Hospice services	No charge	Not covered	Since the plan service area is in Mexico, Hospice Services are only available in limited situations. Please consult your plan document (available at www.simnsa.com).

[* 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)	
If your child needs dental or eye care	Children's eye exam	$5 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 plan at 619-407-4082 (U.S.) or 683-29-02 (Mexico).

Excluded Services & Other Covered Services:

- Chiropractic Care
- Cosmetic Surgery
- Dental Care
- 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 Programs

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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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.

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

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

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**

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**

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**

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.