




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, go to www.simplepayhealth.com or call (480) 969-3800. 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 www.healthcare.gov/sbc-glossary or call SimplePay Health at (800) 606-3564 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. All services are covered before you meet a <u>deductible</u> .	This <u>plan</u> 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 <u>plan</u> 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 www.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 <u>providers</u> : \$6,000 person / \$12,000 family For non-participating <u>providers</u> : Unlimited per person & 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> ?	<u>Premiums</u> , <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.simplepayhealth.com or call (800) 606-3564 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 (<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 <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$60 - \$115 <u>copay</u> /visit	\$140 <u>copay</u> /visit	Includes telemedicine other than Teladoc. You pay a \$0 <u>copay</u> if you receive consultation services through Teladoc. You pay a \$0 <u>copay</u> for services received at a MinuteClinic.
	<u>Specialist</u> visit	\$125 - \$230 <u>copay</u> /visit	\$275 <u>copay</u> /visit	
	<u>Preventive care</u> / <u>screening</u> /immunization	No Charge	No Charge	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Basic labs: \$45 - \$105 <u>copay</u> /visit / Advanced labs, x-rays & other <u>diagnostic tests</u> : \$125 - \$230 <u>copay</u> /visit	Basic labs: \$125 <u>copay</u> /visit / Advanced labs, x-rays & other <u>diagnostic tests</u> : \$275 <u>copay</u> /visit	-----none-----
	Imaging (CT/PET scans, MRIs)	\$350 - \$790 <u>copay</u> /scan	\$950 <u>copay</u> /scan	<u>Preauthorization</u> recommended for PET scans and non-orthopedic CT/MRI's.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.medone-rx.com	Generic drugs	\$35 - \$70 <u>copay</u> (30-day retail)/ \$70 - \$140 <u>copay</u> (90-day retail) / \$70 <u>copay</u> (mail order)	Not Covered	Covers up to a 90-day supply (retail prescription); 90-day supply (mail order prescription). The <u>copay</u> applies per prescription. There is no charge for preventive drugs. Dispense as Written (DAW) provision applies. Step therapy provision applies. <u>Specialty drugs</u> must be obtained from the specialty pharmacy <u>network</u> . *Refer to RxAlly at (877) 794-2218 for assistance in obtaining <u>specialty drugs</u> .
	Preferred brand drugs	\$65 - \$120 <u>copay</u> (30-day retail)/ \$130 - \$240 <u>copay</u> (90-day retail) / \$120 <u>copay</u> (mail order)	Not Covered	
	Non-preferred brand drugs	\$95 - \$185 <u>copay</u> (30-day retail)/ \$190 - \$370 <u>copay</u> (90-day retail) / \$185 <u>copay</u> (mail order)	Not Covered	
	<u>Specialty drugs</u>	Not Covered*	Not Covered	

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$1,200 - \$2,570 <u>copay</u> / occurrence	\$3,085 <u>copay</u> / occurrence	<u>Preauthorization</u> recommended for certain surgeries. See your <u>plan</u> document for a detailed listing.
	Physician/surgeon fees	No Charge	No Charge	
If you need immediate medical attention	<u>Emergency room care</u>	\$860 <u>copay</u> / visit	\$860 <u>copay</u> / visit	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits.
	<u>Emergency medical transportation</u>	\$860 <u>copay</u> / trip	\$860 <u>copay</u> / trip	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits.
	<u>Urgent care</u>	\$125 - \$230 <u>copay</u> / visit	\$275 <u>copay</u> / visit	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$3,500 - \$6,000 <u>copay</u> / admission	\$7,800 <u>copay</u> / admission	<u>Preauthorization</u> recommended.
	Physician/surgeon fees	No Charge	No Charge	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: \$60 - \$115 <u>copay</u> / visit / All other outpatient: \$1,200 - \$2,570 <u>copay</u> / visit (facility charges) / No Charge (professional fees)	Office visit: \$140 <u>copay</u> / visit / All other outpatient: \$3,085 <u>copay</u> / visit (facility charge) / No Charge (professional fees)	Includes telemedicine other than Teladoc.
	Inpatient services	\$3,500 - \$6,000 <u>copay</u> / admission (facility charges) / No Charge (professional fees)	\$7,800 <u>copay</u> / admission (facility charges) / No Charge (professional fees)	<u>Preauthorization</u> recommended.
If you are pregnant	Office visits	Initial visit: \$60 - \$115 <u>copay</u> / All other prenatal and postnatal care: Office: \$60 - \$115 <u>copay</u> / visit / Outpatient: \$1,200 - \$2,570 <u>copay</u> / visit / <u>Diagnostic tests</u> : \$125 - \$230 <u>copay</u> / visit	Initial visit: \$140 <u>copay</u> / All other prenatal and postnatal care: Office: \$140 <u>copay</u> / visit / Outpatient: \$3,085 <u>copay</u> / visit / <u>Diagnostic tests</u> : \$275 <u>copay</u> / visit	<u>Preauthorization</u> recommended for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). <u>Cost sharing</u> does not apply to <u>preventive services</u> from a participating <u>provider</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby does not count toward the mother's expense; therefore the family <u>deductible</u> amount may apply.
	Childbirth/delivery professional services	No Charge	No Charge	
	Childbirth/delivery facility services	\$3,500 - \$6,000 <u>copay</u> / admission	\$7,800 <u>copay</u> / admission	

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 help recovering or have other special health needs	<u>Home health care</u>	\$125 - \$230 <u>copay</u> /visit	\$275 <u>copay</u> /visit	Limited to 120 visits per year. <u>Preauthorization</u> recommended.
	<u>Rehabilitation services</u>	\$125 - \$230 <u>copay</u> /visit	\$275 <u>copay</u> /visit	Physical, speech/hearing & occupational therapy limited to a combined maximum of 60 visits per year. Cardiac rehab limited to 36 visits per year; post-cochlear implant aural therapy limited to 30 visits per year; and respiratory/pulmonary therapy limited to 20 visits per year.
	<u>Habilitation services</u>	\$125 - \$230 <u>copay</u> /visit	\$275 <u>copay</u> /visit	-----none-----
	<u>Skilled nursing care</u>	\$3,200 - \$6,000 <u>copay</u> /admission	\$7,800 <u>copay</u> / admission	Limited to 120 days per year. <u>Preauthorization</u> recommended.
	<u>Durable medical equipment</u>	\$160 - \$355 <u>copay</u> /item	\$425 <u>copay</u> /item	<u>Preauthorization</u> recommended for electric/motorized scooters or wheelchairs and pneumatic compression devices.
	<u>Hospice services</u>	\$385 - \$855 <u>copay</u> /services	\$1,025 <u>copay</u> / services	Bereavement counseling is covered if received within 6 months of death.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	1 eye exam every 2 years.
	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> .)			
<ul style="list-style-type: none"> Acupuncture Bariatric surgery Cosmetic surgery Dental care (Adult & Child) Glasses (Adult & Child) 	<ul style="list-style-type: none"> Infertility treatment (except diagnosis and correction of underlying medical condition) Long-term care Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Private-duty nursing (except for home health care & hospice) Routine foot care (except for metabolic or peripheral vascular disease) 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.)			
<ul style="list-style-type: none"> Chiropractic care (20 visits per year) 	<ul style="list-style-type: none"> Hearing aids (1 hearing aid per hearing impaired ear per year) 	<ul style="list-style-type: none"> Routine eye care (Adult & Child – 1 eye exam every 2 years) 	

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or Copa Health, Inc. at (480) 969-3800. 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 the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or Copa Health, Inc. at (480) 969-3800.

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 1-800-378-1179.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-378-1179.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-378-1179.

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 <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Primary care physician coinsurance</u>	0%
■ Hospital (facility) <u>copayment</u>	\$5,000
■ Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

Primary care physician 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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$6,000
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$6,060

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$125-\$230
■ Hospital (facility) <u>copayment</u>	\$1,200-\$2,570
■ Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

Specialist 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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$3,700
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,720

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$125-\$230
■ Hospital (facility) <u>copayment</u>	\$860
■ Other <u>coinsurance</u>	0%

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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$2,400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,400

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