**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 (949) 350-7325. 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 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. All services are covered before you meet a deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/. |
| **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: $6,700 person / $13,400 family<br>For non-participating providers: Unlimited per person & 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, the overall family out-of-pocket limit must be met. |
| **What is not included in the out-of-pocket limit?** | Premiums, penalty amounts, 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.simplepayhealth.com or call (800) 606-3564 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 (balance billing). 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?** | No. | You can see the specialist you choose without a referral. |

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 provider's office or clinic** | Primary care visit to treat an injury or illness | $60 - $115 copay/visit | $140 copay/visit | Includes telemedicine other than Teladoc. You pay a $0 copay if you receive consultation services through Teladoc. |
| | Specialist visit | $125 - $230 copay/visit | $275 copay/visit | |
| | Preventive care/screening/ immunization | No Charge | No Charge | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Basic labs: $45 - $105 copay/visit / Advanced labs: $125 copay/visit / X-rays & other diagnostic tests: $125 - $230 copay/ visit | Basic labs: $125 copay/ visit / Advanced labs, x-rays & other diagnostic tests: $275 copay/visit | ----------none---------- |
| | Imaging (CT/PET scans, MRIs) | $350 - $790 copay/scan | $950 copay/scan | Preauthorization recommended for PET scans and non-orthopedic CT/MRI's. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.optumrx.com | Generic drugs | $12 copay (retail)/ $30 copay (mail order) | Not Covered | Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription); 30-day supply (specialty drugs). The copay applies per prescription. There is no charge for preventive drugs. Mandatory generic provision applies. Step therapy provision applies. Specialty drugs must be obtained from the specialty pharmacy network. Fertility drugs limited to $10,000 per lifetime. |
| | Preferred brand drugs | $60 copay (retail)/ $150 copay (mail order) | Not Covered | |
| | Non-preferred brand drugs | $80 copay (retail)/ $200 copay (mail order) | Not Covered | |
| | Specialty drugs | $12 copay (generic)/ $60 copay (preferred)/ $80 copay (non-preferred) | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $1,200 - $2,570 copay/ occurrence | $3,085 copay/occurrence | Preauthorization recommended for certain surgeries. See your plan document for a detailed listing. |
| | Physician/surgeon fees | No Charge | No Charge | |

| 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 immediate medical attention** | Emergency room care | $860 copay/visit (emergency services)/ Not Covered (non-emergency services) | $860 copay/visit (emergency services)/ Not Covered (non-emergency services) | Non-participating providers paid at the participating provider level of benefits for emergency services. |
| | Emergency medical transportation | $860 copay/trip | $860 copay/trip | Non-participating providers paid at the participating provider level of benefits. |
| | Urgent care | $125 - $230 copay/visit | $275 copay/visit | ----------none---------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $3,500 - $6,000 copay/ admission | $7,800 copay/admission | Preauthorization 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 copay/visit / All other outpatient: $1,200 - $2,570 copay/visit (facility charges) / No Charge (professional fees) | Office visit: $140 copay/ visit / All other outpatient: $3,085 copay/ visit (facility charge) / No Charge (professional fees) | Includes telemedicine other than Teladoc. You pay a $0 copay if you receive consultation services through Teladoc. |
| | Inpatient services | $3,500 - $6,000 copay/ admission (facility charges) / No Charge (professional fees) | $7,800 copay/admission (facility charges) / No Charge (professional fees) | Preauthorization recommended. |
| **If you are pregnant** | Office visits | Office: $60 - $115 copay/ visit / Outpatient: $1,200 - $2,570 copay/visit / Diagnostic tests: $125 - $230 copay/visit | Office: $140 copay/visit / Outpatient: $3,085 copay/visit / Diagnostic tests: $275 copay/visit | Preauthorization recommended for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). Cost sharing does not apply to preventive services from a participating provider. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | No Charge | No Charge | |
| | Childbirth/delivery facility services | $3,500 - $6,000 copay/ admission | $7,800 copay/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** | Home health care | $125 - $230 copay/visit | $275 copay/visit | Limited to 120 visits per year. Preauthorization recommended. |
| | Rehabilitation services | $125 - $230 copay/visit | $275 copay/visit | Physical, speech/hearing & occupational therapy limited to a combined maximum of 60 visits per year. Includes telemedicine other than Teladoc. |
| | Habilitation services | $125 - $230 copay/visit | $275 copay/visit | Includes telemedicine other than Teladoc. |
| | Skilled nursing care | $3,200 - $6,000 copay/ admission | $7,800 copay/admission | Limited to 120 days per year. Preauthorization recommended. |
| | Durable medical equipment | $160 - $355 copay/item | $425 copay/item | Preauthorization recommended for electric/motorized scooters or wheelchairs and pneumatic compression devices. |
| | Hospice services | $385 - $855 copay/ services (hospice services) /$125 - $230 copay/visit (bereavement counseling) | $500 copay/services (hospice services)/ $275 copay/visit (bereavement counseling) | Bereavement counseling is covered. |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | Not Covered |
| | 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- **Cosmetic surgery**
- **Dental care (Adult & Child)**
- **Emergency room services for non-emergency services**
- **Glasses (Adult & Child)**
- **Long-term care**
- **Non-emergency care when traveling outside the U.S.**
- **Private-duty nursing (except for home health care & hospice)**
- **Routine eye care (Adult & Child)**
- **Routine foot care (except for metabolic or peripheral vascular disease or for diabetes)**
- **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 (for morbid obesity only)**
- **Chiropractic care (20 visits per year)**
- **Hearing aids (1 aid per hearing impaired ear every 24 month period)**
- **Infertility treatment ($25,000 per lifetime for ART & comprehensive services combined)**

**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 Omni Hotels Management Corporation at (949) 350-7325. 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 Omni Hotels Management Corporation at (949) 350-7325.

Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance Consumer Protection at (800) 252-3439.

**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, kwiijigo 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 plan's overall deductible** **$0**
- **Primary care physician copayment** **$60-$115**
- **Hospital (facility) copayment** **$3,500-$6,000**
- **Other copayment** **$3,200-$6,000**

**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** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $6,700 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | $6,760 |

### 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** **$125-$230**
- **Hospital (facility) copayment** **$1,200-$2,570**
- **Other copayment** **$3,200-$6,000**

**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** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $2,800 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | $2,820 |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$125-$230**
- **Hospital (facility) copayment** **$860**
- **Other copayment** **$3,200-$6,000**

**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 | $2,400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| 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.