




Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
SimplePay Health Employee Benefit Plan

Coverage Period: 01/01/2021 to 12/31/2021
Coverage for: Employee, Family | Plan Type: EPO

⚠ 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, www.simplepayhealth.com. 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 1-800-606-3564 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Network : No Deductible	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes, Preventive Care is covered before you meet your 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 https://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 ?	Network : \$5,000 Employee, \$10,000 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, penalties, amounts over Usual and Customary fees and excluded charges.	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. Call 1-800-606-3564 or visit www.simplepayhealth.com 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 don't need a referral to see a specialist .	You can see the specialist you choose without a referral .

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 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	\$20 - \$80 copay	Not Covered	Teladoc (Telehealth) - No Charge for a Network Provider.
	Specialist visit	\$30 - \$100 copay	Not Covered	If you receive services in addition to office visit, an additional copay , deductible , or coinsurance may apply (e.g. surgery).
	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)	\$50 - \$200 copay	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$200 - \$800 copay	Not Covered	None

* For more information about limitations and exceptions, see the plan or policy document at www.simplepayhealth.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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.simplepayhealth.com	<u>Tier 1</u> Your Lowest Cost Option	Retail: \$5- \$10 copay Mail: \$10 copay	Not Covered	<p>Provider means pharmacy for purposes of this section.</p> <p>Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply.</p>
	<u>Tier 2</u> Your Mid-Range Cost Option	Retail: \$50 - \$75 copay Mail: \$100 copay	Not Covered	<p>You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us.</p> <p>Certain drugs may have a precertification requirement or may result in a higher cost. If you use a non-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount.</p>
	<u>Tier 3</u> Your Mid-Range Cost Option	Retail: \$75 - \$125 copay Mail: \$150 copay	Not Covered	<p>Certain preventive medications (including certain contraceptives) are covered at No Charge.</p>
	<u>Tier 4</u> Your Highest Cost Option	Mail Order Only: \$150 copay	Not Covered	<p>See the website listed for information on drugs covered by your plan. Not all drugs are covered.</p> <p>You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.</p>
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$500 to \$2,000 copay	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you need immediate medical	Emergency room care	\$350 copay	\$350 copay	None
	Emergency medical transportation	\$350 copay	\$350 copay	None

* For more information about limitations and exceptions, see the plan or policy document at www.simplepayhealth.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)	
attention	Urgent care	\$30 - \$100 copay	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,000 - \$4,000 copay	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$500 - \$2,000 copay	Not Covered	See your policy or plan document for additional information about EAP benefits.
	Inpatient services	\$1,000 - \$4,000 copay	Not Covered	
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of service, a copay , coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	\$30 - \$100 copay	Not Covered	
	Childbirth/delivery facility services	\$1,000 - \$4,000 copay	Not Covered	
If you need help recovering or have other special health needs	Home health care	\$30 - \$100 copay	Not Covered	Limited to 60 visits per calendar year.
	Rehabilitation services	\$30 - \$100 copay	Not Covered	Occupational, Physical, and Speech therapy are each limited to 20 visits per calendar year. Cardiac is limited to 20 visits per calendar year.
	Habilitation services	\$30 - \$100 copay	Not Covered	
	Skilled nursing care	\$1,000 - \$4,000 copay	Not Covered	Limited to 60 days per calendar year (combined with inpatient rehabilitation).
	Durable medical equipment	\$100 - \$400 copay	Not Covered	Covers 1 per type of DME (including repair/replacement) every 3 years.
	Hospice services	\$300 - \$1,000 copay	Not Covered	None
If your child needs dental or eye care	Children's eye exam	\$0 copay	Not Covered	
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses. See Vision benefits.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up. See Dental benefits.

* For more information about limitations and exceptions, see the plan or policy document at www.simplepayhealth.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](#).)

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Foot Care
- Weight Loss Programs

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

- Chiropractic Care (Manipulative Care – Limited to 20 visits per calendar year)
- Hearing Aids
- Routine Eye Exam

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. 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: The Department of Labor at 1-866-487-2365 or SimplePay Health at 1-800-606-3564

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 1-800-606-3564.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-606-3564.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-606-3564.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-606-3564.

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](#) \$30-\$100
- Inpatient Hospital [copayment](#) \$1,000 - \$4,000
- Other [coinsurance](#) 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	\$2,540
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$2,540
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$2,540

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](#) \$30-\$100
- Inpatient Hospital [copayment](#) \$1,000 - \$4,000
- Other [coinsurance](#) 0%

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	\$1,500
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,500

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$30-\$100
- Emergency Room [copayment](#) \$350
- Other [coinsurance](#) 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	\$710
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$710
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$710

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: rmurry@essilorusa.com

Mail: Civil Rights Coordinator. 13555 North Stemmons Frwy, Dallas, TX 75234

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어 (**Korean**) 를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서 (Summary of Benefits and Coverage, SBC) 에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزايا والتغطية (Summary of Benefits and Coverage, SBC) هذا.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項： **日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。
本「保障および給付の概要」 (Summary of Benefits and Coverage, SBC) に記載されているフリーダイヤルにてお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage, SBC) تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawm Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (**Khmer**) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាប់រង (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yániiti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shq'odí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'e'ásti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'í bik'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).