This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the plan document by contacting the Benefits Department at Diamond Resorts International at benefitsdept@diamondresorts.com or by calling 1-702-684-8008.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**In-Network:** Individual: **$250** Family: **$500** Does not apply to copayments, preventive care, office visits	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your plan document/SPD to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	**In-Network:** Individual: **$5,000** Family: **$10,000**	The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Copayments, penalties for failing to follow precertification, amounts in excess of UCR, expenses not covered by the plan	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.cigna.com for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.

Important Questions	Answers	Why this Matters:
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed below (see Excluded Services & Other Covered Services). See your plan document/SPD for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**.
- Under this plan you must use participating **providers.**.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment/visit	Not Covered	--------none--------
	Specialist visit	$40 copayment/visit	Not Covered	--------none--------
	Other practitioner office visit	$20 copayment/visit	Not Covered	--------none--------
	Preventive care/screening/immunization	$0 copayment/visit	Not Covered	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not Covered	--------none--------
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not Covered	Precertification required; covered benefits will be reduced by 50% for the non compliance of pre-certification
If you need drugs to treat your illness or condition	ACA Approved Preventive drugs ACA Approved Birth Control OTC – Over the Counter Ulcer & Allergy Meds	Covered 100% - $0 copay / prescription (retail)	Not Covered	--------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
More information about **prescription drug coverage** is available at www.partnersrx.com	Generic drugs	$10 co-payment / prescription (retail)	Not Covered	--------none--------
	Preferred brand drugs	$30 copayment / prescription (retail)	Not Covered	--------none--------
	Non-preferred brand drugs	$40 co-payment / prescription (retail)	Not Covered	--------none--------
	Specialty drugs	10% up to $150	Not Covered	Specialty drugs may require precertification. Specialty drugs may be subject to dispensing limits.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not Covered	Precertification required; covered benefits will be reduced by 50% for the non compliance of pre-certification
	Physician/surgeon fees	10% coinsurance	Not Covered	Outpatient surgery done in office in-network $50 copay. Precertification required; covered benefits will be reduced by 50% for the non compliance of pre-certification.
If you need immediate medical attention	Emergency room services	10% coinsurance	Not Covered	--------none--------
	Emergency medical transportation	Ground: 10% coinsurance Air: 20% coinsurance	Ground: 10% coinsurance Air: 20% coinsurance	--------none--------
	Urgent care	$20 copayment/visit	Not Covered	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not Covered	Precertification required; covered benefits will be reduced by 50% for the non compliance of pre-certification

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Physician/surgeon fee	10% coinsurance	Not Covered	Precertification required; covered benefits will be reduced by 50% for the non compliance of pre-certification
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copayment/visit	Not Covered	--------none--------
	Mental/Behavioral health inpatient services	10% coinsurance	Not Covered	Precertification required; covered benefits will be reduced by 50% for the non compliance of pre-certification
	Substance use disorder outpatient services	$20 copayment/visit	Not Covered	--------none--------
	Substance use disorder inpatient services	10% coinsurance	Not Covered	Precertification required; covered benefits will be reduced by 50% for the non compliance of pre-certification
If you are pregnant	Prenatal and postnatal care	10% coinsurance	Not Covered	--------none--------
	Delivery and all inpatient services	10% coinsurance	Not Covered	Precertification required for extended stay.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not Covered	Limited to 100 visits per year. Limited to $40 maximum per visit allowed amount. Precertification required; covered benefits will be reduced by 50% for the non compliance of pre-certification
	Rehabilitation services	10% coinsurance	Not Covered	Therapies included: occupational, physical, speech. Limited to 60 visits per calendar year combined with Chiropractic visits.
	Habilitation services	Not Covered	Not Covered	Not Covered

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Skilled nursing care	10% coinsurance	Not Covered	Limited to 100 days per year. Precertification required; covered benefits will be reduced by 50% for the non compliance of pre-certification
	Durable medical equipment	10% coinsurance	Not Covered	--------none--------
	Hospice service	10% coinsurance	Not Covered	Includes Intermittent Home Care Services; 24-Hour Home Care and Inpatient Care. Precertification required; covered benefits will be reduced by 50% for the non compliance of pre-certification
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Vision Benefits are through EyeMed Visioncare – www.eyemedvisioncare.com – 1-866-723-0513
	Glasses	Not Covered	Not Covered	Vision Benefits are through EyeMed Visioncare – www.eyemedvisioncare.com – 1-866-723-0513
	Dental check-up	Not Covered	Not Covered	Dental Benefits are through Delta Dental – www.deltadentalins.com – 1-800-521-2651

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic Surgery
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Most Coverage Provided Outside the U.S.
- Non-Emergency Care while Traveling outside the U.S.
- Private Duty Nursing
- Routine Foot Care
- Obesity for the purpose of weight loss
- Weight Loss Programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Allergy Testing & Treatment
- Chiropractic Care
- Diabetes related Services & Supplies
- Family Planning
- Morbid Obesity

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-755-6973. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: BRMS, 80 Iron Point Circle, Suite 200, Folsom, CA 95630 or www.dol.gov/ebsa/healthreform or Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-444-3272.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-444-3272.

Chinese (中文): 如果需要中文的帮助，**请拨**打**这**个号**码** 1-866-444-3272.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-444-3272.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,365
- **Patient pays** $1,175

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$250
Copays	$30
Coinsurance	$705
Limits or exclusions	$190
Total	**$1,175**

These amounts assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not notified the plan, your costs may be higher. For more information, contact 1-866-755-6973 or visit us at www.brmsclaims.com.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,225
- **Patient pays** $1,175

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$250
Copays	$590
Coinsurance	$115
Limits or exclusions	$220
Total	**$1,175**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact 1-866-755-6973 or visit us at www.brmsclaims.com.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles, copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.