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, https://TAC.myaptahealth.com or call the Apta Care Coordinators at 1-877-610-8817. 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.healthcare.gov/sbc-glossary/ or call the Apta Care Coordinators at 1-877-610-8817 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $1,000 person / $3,000 family; for out-of-network providers $3,000 person / $9,000 family.	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 services are 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?	Yes. $50 person / $100 family for prescription drug coverage. There are no other specific deductibles.	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.
What is the out-of-pocket limit for this plan?	For network providers $4,500 person / $10,000 family; for out-of-network providers $50,000 person / Unlimited family. Prescription drug coverage out-of-pocket limit of $2,000 person / $4,000 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, Preauthorization 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 https://www.umr.com/oss/cms/umr/choice_plus_excl.html or call 1-	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

Important Questions	Answers	Why This Matters:
	800-826-9781 for a list of network providers in the Choice Plus Network.	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, but referrals are encouraged.

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	$25 copay / office visit	40% coinsurance	Copay applies per visit regardless of what services are rendered. Deductible does not apply for participating network providers.
	Specialist visit	$40 copay / visit (with or without referral)	40% coinsurance	Referrals are encouraged for a specialist visit.
	Preventive care/screening/ immunization	No charge	40% coinsurance	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)	20% coinsurance	40% coinsurance	Deductible applies.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required for PET Scans, MRI's and MRA's. Failure to obtain preauthorization will result in a $500 penalty.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	Retail: 20% ($10 min copay) Mail Order: 20% ($25 min copay)	Not Covered	Copay applies per prescription. Covers up to a 90-day supply (retail and mail order prescriptions). No charge for ACA mandated preventive drugs and smoking deterrents. Specialty drugs are limited to a 30-day supply (retail and mail-order). Specialty drugs must be obtained directly from the specialty
	Preferred brand drugs	Retail: 20% ($55 min copay) Mail Order: 20% ($137.50 min copay)	Not Covered	

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)	
	Non-preferred brand drugs	Retail: 20% ($80 min copay) Mail Order: 20% ($200 min copay)	Not Covered	pharmacy program.
	Specialty drugs (Tier 4)	20% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	The deductible applies. Preauthorization required unless performed in an office setting. Failure to obtain preauthorization will result in a $500 penalty.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Deductible applies. Non-participating providers paid at the participating network provider level.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Deductible applies. Non-participating providers paid at the participating network provider level.
	Urgent care	20% coinsurance	40% coinsurance	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization required. Failure to obtain preauthorization will result in a $500 penalty.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay / office visit	40% coinsurance	Copay applies per visit regardless of what services are rendered and the deductible does not apply.
	Inpatient services	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization required. Failure to obtain preauthorization will result in a $500 penalty.
If you are pregnant	Office visits	No Charge (deductible waived) for preventive services. Other services $25 copay / visit	40% coinsurance	Preauthorization required for inpatient hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. (C-section). Failure to obtain preauthorization will result in a $500 penalty. Baby does not count toward the mother's expense; therefore the family deductible amount may apply. Cost-sharing does not apply to preventive services from a
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility	20% coinsurance	40% coinsurance	

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)	
	services			participating provider. Depending on the type of services, a coinsurance and/or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Deductible applies. Limited to 120 visits per plan year. Preauthorization required. Failure to obtain preauthorization will result in a $500 penalty.
	Rehabilitation services	$25 copay / visit	40% coinsurance	Includes physical, speech & occupational therapy. Includes Chiropractor visits limited to 35 visits per year.
	Habilitation services	$25 copay / visit	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Deductible applies. Limited to 60 days per plan year. Preauthorization required. Failure to obtain preauthorization will result in a $500 penalty.
	Durable medical equipment	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization required for any item in excess of $1,500. Failure to obtain preauthorization will result in a $500 penalty.
	Hospice services	20% coinsurance	40% coinsurance	Deductible applies. Bereavement counseling is covered if received within 6 months of death. Preauthorization is required. Failure to obtain preauthorization will result in a $500 penalty.
If your child needs dental or eye care	Children's eye exam	No Charge	Not covered	Coverage limited to one exam/year.
	Children's glasses	Not Covered	Not covered	None
	Children's dental check-up	No Charge	Not covered	Coverage limited to one exam/year.

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 (adult & child)
- Glasses (adult & child)
- Infertility Treatment
- Long Term Care
- Massage Therapy
- Non-emergency care when traveling outside the U.S. (If you become sick or injured while traveling, the plan may cover expenses incurred up to 120 consecutive days. This 120-day time limit does not apply if you are traveling for business or are a student.)
- Private Duty Nursing (except for home health care & hospice)
- 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
- Bariatric Surgery
- Hearing Aids
- Routine eye care (Adult & Child)

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 Department of Health and Humans Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x 61565 or www.cciio.cms.gov. 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 https://www.dol.gov/agencies/ebsa
Additionally, a consumer assistance program can help you file your appeal. Contact the
Texas Consumer Health Assistance Program, Texas Department of Insurance at (855) 839-2427 (855-TEX-CHAP).

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 800-826-9781.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-826-9781.

* For more information about limitations and exceptions, see the plan or policy document at https://TAC.myaptahealth.com

Chinese (中文): 如果需要中文的帮助，请拨打这个号码800-826-9781.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-826-9781.

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

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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	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,000
Copayments	$320
Coinsurance	$2,264
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,644**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,000
Copayments	$200
Coinsurance	$876
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,096**

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

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,000
Copayments	$160
Coinsurance	$328
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,488**

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