




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 1,850 person / \$3,700 family; for out-of-network providers \$5,550 person / \$11,100 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 , the overall family deductible must be satisfied, whether paid by a single individual or all family members, before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care and children's eye exams 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?	No.	You don't have to meet deductibles for specific 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.	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.umar.com/oss/cms/umar/choice_plus_excl.html or call 1-800-826-9781 for a list of network providers in the Choice Plus network.	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.

Important Questions	Answers	Why This Matters:
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	20% coinsurance	40% coinsurance	Deductible applies. Includes Chiropractor visits limited to 35 visits per year.
	Specialist visit	20% coinsurance	40% coinsurance	Deductible applies. Referrals are encouraged for a specialist visit.
	Preventive care/screening/immunization	No charge	40% coinsurance	Deductible does not apply to participating providers. 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)	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 & Mail Order: 20% coinsurance	Not Covered	The deductible 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. Specialty drugs must be obtained directly from the specialty pharmacy program.
	Preferred brand drugs	Retail & Mail Order: 20% coinsurance	Not Covered	
	Non-preferred brand drugs	Retail & Mail Order: 20% coinsurance	Not Covered	
	Specialty drugs	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
	Physician/surgeon fees	20% coinsurance	40% coinsurance	

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://TAC.myaptahealth.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)	
				a \$500 penalty.
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	20% coinsurance	40% coinsurance	Deductible applies.
	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 for preventive services . Other services 20% coinsurance .	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 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).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
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	20% coinsurance	40% coinsurance	Deductible applies. Includes physical, speech

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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)	
	Habilitation services	20% coinsurance	40% coinsurance	& occupational therapy. Deductible applies.
	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 .)		
<ul style="list-style-type: none"> • Acupuncture • Cosmetic Surgery • Dental Care (adult & child) • Glasses (adult & child) • Infertility Treatment 	<ul style="list-style-type: none"> • 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.) 	<ul style="list-style-type: none"> • 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.)	
<ul style="list-style-type: none"> • Chiropractic Care • Bariatric Surgery 	<ul style="list-style-type: none"> • 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

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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.

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, kwijigo 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](#) \$1,850
- [Specialist copayment](#) 20%
- 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,850
Copayments	\$0
Coinsurance	\$2,158
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,068

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,850
- [Specialist copayment](#) 20%
- 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,850
Copayments	\$0
Coinsurance	\$750
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,600

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,850
- [Specialist copayment](#) 20%
- 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,850
Copayments	\$0
Coinsurance	\$190
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,040

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.