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://LVB.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 **1-833-740-3136** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers: $5,000 person / $10,000 family; for out-of-network providers $10,000 person / $20,000 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 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 $10,000 person / $20,000 family; for out-of-network providers $20,000 person / $40,000 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 1-800-826-9781 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.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.

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% coinsurance	45% coinsurance	Deductible applies. You will pay $45 per visit if you receive vide telemedicine services from OC24. See plan for further details.
	Specialist visit	25% coinsurance	45% coinsurance	Deductible applies.
	Preventive care/screening/ immunization	No charge	45% 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)	25% coinsurance	45% coinsurance	Deductible applies.
	Imaging (CT/PET scans, MRIs)	25% coinsurance	45% coinsurance	Deductible applies. Preauthorization required. 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.truescripts.com	Generic drugs	1-30 day supply: $10 co-pay after deductible met 31-90 day supply: $25 co-pay after deductible met Mail Order Not Covered	Not Covered	The deductible applies per prescription. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). No charge for ACA mandated preventive drugs and smoking deterrents. Dispense as Written (DAW) applies. Specialty drugs must be obtained directly from the specialty pharmacy program.
	Preferred brand drugs	1-30 day supply: $35 co-pay after deductible met 31-90 day supply: $87.50 co-pay after deductible met Mail Order Not Covered	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at https://LVB.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)	
	Non-preferred brand drugs	1-30 day supply: $60 co-pay after deductible met 31-90 day supply: $150 co-pay after deductible met Mail Order Not Covered	Not Covered	Rx Deductible & OOP is Rx/Medical Combined. Please see above.
	Specialty drugs	(Tier 1) $60 co-pay (Tier 2) 20% to $550 max (Tier 3) 20% to $2,000 max (Tier 4) 20% (Tier 5) 50% Mail Order Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	45% 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	25% coinsurance	45% coinsurance	
If you need immediate medical attention	Emergency room care	25% coinsurance	45% coinsurance	Deductible applies. Non-participating providers paid at the participating network provider level.
	Emergency medical transportation	25% coinsurance	45% coinsurance	Deductible applies. Non-participating providers paid at the participating network provider level.
	Urgent care	25% coinsurance	45% coinsurance	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	45% coinsurance	Deductible applies. Preauthorization required. Failure to obtain preauthorization will result in a $500 penalty.
	Physician/surgeon fees	25% coinsurance	45% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	45% coinsurance	Deductible applies. You will pay $45 per visit if you receive vide telemedicine services from OC24.
	Inpatient services	25% coinsurance	45% coinsurance	Deductible applies. Preauthorization required. Failure to obtain preauthorization will result in

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 are pregnant	Office visits	No Charge for preventive services. Other services 25% coinsurance.	45% coinsurance	Deductible applies. 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	25% coinsurance	45% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	45% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	45% coinsurance	Deductible applies. Limited to 60 visits per plan year. Preauthorization required. Failure to obtain preauthorization will result in a $500 penalty.
	Rehabilitation services	25% coinsurance	45% coinsurance	Deductible applies. Limited to 30 visits per plan year. Includes physical, speech & occupational therapy.
	Habilitation services	Not Covered	Not Covered	This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD and to expenses covered as a preventive service.
	Skilled nursing care	25% coinsurance	45% coinsurance	Limited to 60 days per plan year. Preauthorization required. Failure to obtain preauthorization will result in a $500 penalty.
	Durable medical equipment	25% coinsurance	45% 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	25% coinsurance	45% coinsurance	Deductible applies. Bereavement counseling

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)	
				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	Not Covered	Not covered	None

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
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (adult & child)
- Glasses (adult & child)
- Habilitation Services
- 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
- 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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa. 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

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, 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	**$5,000**
Specialist copayment	**25%**
Hospital (facility) coinsurance	**25%**
Other coinsurance	**25%**

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*	$5,000
Copayments	$10
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,970**

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

The plan's overall deductible	**$5,000**
Specialist copayment	**25%**
Hospital (facility) coinsurance	**25%**
Other coinsurance	**25%**

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*	$5,000
Copayments	$80
Coinsurance	$10
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,110**

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

The plan's overall deductible	**$5,000**
Specialist copayment	**25%**
Hospital (facility) coinsurance	**25%**
Other coinsurance	**25%**

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*	$2,800
Copayments	$
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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