




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://myaptahealth.com> or call the Apta Care Coordinators at 1-866-274-9478. 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 1-866-274-9478 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	For <a href="#">network providers</a> \$500 person / \$1,000 family; for <a href="#">out-of-network providers</a> \$3,000 person / \$6,000 family.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> , <a href="#">prescription drugs</a> , <a href="#">urgent care</a> and <a href="#">primary care provider</a> and <a href="#">specialist</a> services, telemedicine, and adult and children's eye exams are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">network providers</a> \$1,500 person / \$3,000 family; for <a href="#">out-of-network providers</a> \$6,000 person / \$12,000 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">Preauthorization</a> penalty amounts, <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.aetna.com/docfind/custom/mymeritain/">www.aetna.com/docfind/custom/mymeritain/</a> or call 1-800-343-3140 for a list of <a href="#">network providers</a> in the Aetna Open Choice PPO	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> , however, you will receive a higher benefit if a <a href="#">referral</a> is obtained.

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$15 <a href="#">copay</a> / office visit	40% <a href="#">coinsurance</a>	<a href="#">Copay</a> applies per visit regardless of what services are rendered. <a href="#">Deductible</a> does not apply for participating <a href="#">network providers</a> . You will pay a \$15 <a href="#">copay</a> if you receive video telemedicine services from Doctor on Demand. See <a href="#">plan</a> for further details.
	<a href="#">Specialist</a> visit	\$30 <a href="#">copay</a> / visit (with <a href="#">referral</a> ) \$60 <a href="#">copay</a> / visit (without <a href="#">referral</a> )	40% <a href="#">coinsurance</a>	You will receive a higher benefit if a referral is obtained for a <a href="#">specialist</a> visit.
	<a href="#">Preventive care/screening/immunization</a>	No charge	40% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. <a href="#">Deductible</a> applies.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies.
	Imaging (CT/PET scans, MRIs)	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies. <a href="#">Preauthorization</a> is required for PET Scans, MRI's, MRA's. Failure to obtain <a href="#">preauthorization</a> will result in a \$500 penalty.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.magellanrx.com">www.magellanrx.com</a>	Generic drugs (Tier 1)	\$20 <a href="#">copay</a> (retail) / \$40 <a href="#">copay</a> (mail order)	Not Covered	<a href="#">Copay</a> applies per prescription. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). No charge for ACA mandated <a href="#">preventive</a> drugs and smoking deterrents. No charge for OTC acid reflux medication or for allergies (with an Rx) from a retail pharmacy. Dispense as Written (DAW) applies.
	Preferred brand drugs (Tier 2)	\$40 <a href="#">copay</a> (retail) / \$80 <a href="#">copay</a> (mail order)	Not Covered	
	Non-preferred brand drugs (Tier 3)	\$60 <a href="#">copay</a> (retail) / \$120 <a href="#">copay</a> (mail order)	Not Covered	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://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 href="#">Specialty drugs</a> (Tier 4)	30% <a href="#">coinsurance</a>	Not Covered	<a href="#">Specialty drugs</a> – Failure to obtain <a href="#">preauthorization</a> and enroll in the Select Drugs and Products <sup>SM</sup> Program for a prescription drug or product listed on the <a href="#">Specialty drugs</a> and Products List will result in a cost containment penalty equal to 100% reduction in benefits payable. All <a href="#">Specialty drugs</a> are subject to <a href="#">preauthorization</a> and step-therapy that may require specific drug distribution channels be used.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	The <a href="#">deductible</a> applies. <a href="#">Preauthorization</a> required unless performed in an office setting. Failure to obtain <a href="#">preauthorization</a> will result in a \$500 penalty.
	Physician/surgeon fees	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$150 <a href="#">copay</a> , then 15% <a href="#">coinsurance</a>	\$150 <a href="#">copay</a> , then 15% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies. Non-participating <a href="#">providers</a> paid at the participating <a href="#">network provider</a> level.
	<a href="#">Emergency medical transportation</a>	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies. Non-participating <a href="#">providers</a> paid at the participating <a href="#">network provider</a> level.
	<a href="#">Urgent care</a>	\$75 <a href="#">copay</a> per visit	40% <a href="#">coinsurance</a>	<a href="#">Copay</a> applies per visit regardless of what services are rendered.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies. <a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> will result in a \$500 penalty.
	Physician/surgeon fees	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$15 <a href="#">copay</a> / visit	\$15 <a href="#">copay</a> / visit	<a href="#">Copay</a> applies per visit regardless of what services are rendered and the <a href="#">deductible</a> does not apply. You will pay a \$15 <a href="#">copay</a> and the <a href="#">deductible</a> does not apply if you receive video telemedicine services from Doctor On Demand.

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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)	
	Inpatient services	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> will result in a \$500 penalty.
If you are pregnant	Office visits	No Charge ( <a href="#">deductible</a> waived) for <a href="#">preventive services</a> . Other services 15% <a href="#">coinsurance</a> .	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required for inpatient hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. (C-section). Failure to obtain <a href="#">preauthorization</a> will result in a \$500 penalty. Baby does not count toward the mother's expense; therefore the family <a href="#">deductible</a> amount may apply. <a href="#">Cost-sharing</a> does not apply to <a href="#">preventive services</a> from a participating provider. Depending on the type of services, a <a href="#">coinsurance</a> and/or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies. Limited to 120 visits per <a href="#">plan</a> year. <a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> will result in a \$500 penalty.
	<a href="#">Rehabilitation services</a>	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies. Includes physical, speech & occupational therapy. No limit.
	<a href="#">Habilitation services</a>	Not Covered	Not Covered	<a href="#">Deductible</a> applies.
	<a href="#">Skilled nursing care</a>	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies. Limited to 60 days per <a href="#">plan</a> year. <a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> will result in a \$500 penalty.
	<a href="#">Durable medical equipment</a>	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies. <a href="#">Preauthorization</a> required for any item in excess of \$1,500. Failure to obtain <a href="#">preauthorization</a> will result in a \$500 penalty.
	<a href="#">Hospice services</a>	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies. Bereavement counseling is covered if received within 6 months of death. <a href="#">Preauthorization</a> is required. Failure to obtain <a href="#">preauthorization</a> will result in a \$500 penalty.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://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)	
If your child needs dental or eye care	Children's eye exam	No Charge	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric Surgery</li> <li>Cosmetic Surgery</li> <li>Dental Care (adult &amp; child)</li> <li>Glasses (adult &amp; child)</li> <li>Habilitation Services</li> <li>Infertility Treatment</li> </ul>	<ul style="list-style-type: none"> <li>Long Term Care</li> <li>Massage Therapy</li> <li>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.)</li> </ul>	<ul style="list-style-type: none"> <li>Private Duty Nursing (except for home health care &amp; hospice)</li> <li>Routine Foot Care</li> <li>Weight Loss Programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Chiropractic Care</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult &amp; Child)</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>

**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](http://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](http://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:**

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://myaptahealth.com>

Spanish (Español): Para obtener asistencia en Español, llame al 800-378-1179.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-378-1179.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码800-378-1179.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 800-378-1179.

*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](#) \$500
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 15%
- Other [coinsurance](#) 15%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a> *	\$500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,560</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 15%
- Other [coinsurance](#) 15%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a> *	\$500
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,380</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 15%
- Other [coinsurance](#) 15%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a> *	\$500
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,000</b>

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