



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, call 1-720-704-3300 or visit www.aptahealth.com/rameyautogroup. 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 www.healthcare.gov/sbc-glossary or call 1-720-704-3300 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Cash Pay: \$0 person / \$0 family. For network providers \$4,500 person / \$9,000 family; for out-of-network providers \$4,500 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 is covered before you meet your deductible . Apta Cash Pay services do not apply to the 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.	No other deductible applies.
What is the out-of-pocket limit for this plan ?	Cash Pay: \$0 person / \$0 family. For network providers \$7,000 person / \$14,000 family; for out-of-network providers \$7,000 person / \$14,000 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 , balance billing charges, sanctions, reductions 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 ?	Call Apta Health Concierge at 1-720-704-3300 to find a Cash Pay provider. Or visit https://providersearch.multiplan.com/ (PHCS / logo on front of card) for a list of network providers	This plan uses a cash pay plan and a provider network . You will have no charge if you use Apta Cash Pay. 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.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



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
		Cash Pay Provider (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Virtual Primary Care Visit visits to treat an injury or illness	\$0 copay	Not Available	Not Available	Contact BowTie Medical at 1-720-704-3300 to receive services at no cost.
If you visit a health care provider's office or clinic or use Virtual or Direct Primary Care	Primary care visit to treat an injury or illness	\$0 copay	30% coinsurance	50% coinsurance	Deductible applies.
	Specialist visit	\$0 copay	30% coinsurance	50% coinsurance	Cash Pay Card Eligible when coordinated through the Cash Pay program. Deductible applies.
	Preventive care/screening /immunization	No Charge.	No Charge.	50% coinsurance	Deductible applies for Out-of-Network providers. Benefits include but are not limited to those recommended by the USPSTF (United States Preventive Services Taskforce) (A & B only), CDC (Center for Disease Control) Advisory Committee on Immunization Practices, and the HRSA (Health Resources and Services Administration) for women's and children's preventive care . 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.
If you have a test	Diagnostic test (x-ray, blood work)	\$0 copay	30% coinsurance	50% coinsurance	Deductible applies unless coordinated through the Cash Pay program.
	Imaging (CT/PET scans, MRIs)	\$0 copay	30% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Cash Pay Provider (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.primetherapeutics.com	Generic drugs	Not Available	\$4 copay (30-day supply) / \$8 copay (90-day supply)	Not Covered	Copay applies per prescription. Covers up to a 90-day supply (retail prescription); 1-90 day supply (mail order prescription). No charge for ACA mandated preventive drugs and smoking deterrents. Dispense as Written (DAW) applies. Specialty drugs – Failure to obtain preauthorization and enroll in the Select Drugs and Products SM Program for a prescription drug or product listed on the Specialty drugs and Products List will result in a cost containment penalty equal to 100% reduction in benefits payable. All Specialty drugs are subject to preauthorization and step-therapy that may require specific drug distribution channels be used. Specialty drugs must be obtained directly from the specialty pharmacy program.
	Preferred brand drugs	Not Available	\$35 copay (30-day supply) / \$70 copay (90-day supply)	Not Covered	
	Non-preferred brand drugs	Not Available	\$50 copay (30-day supply) / \$100 copay (90-day supply)	Not Covered	
	Specialty drugs	Not Available	\$500 copay (30-day supply)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$0 copay	30% coinsurance	50% coinsurance	Deductible applies unless coordinated through the Cash Pay program. Preauthorization required unless performed in an office setting. Failure to obtain preauthorization will result in a \$500 penalty.
	Physician/surgeon fees	\$0 copay	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	\$0 copay	30% coinsurance	30% coinsurance	Deductible applies unless coordinated through the Cash Pay program.
	Emergency medical transportation	Not Available	\$250 copay (ground) / \$500 copay (air)	\$250 copay (ground) / \$500 copay (air)	Copay applies. Not available on Cash Pay.
	Urgent care	\$0 copay	30% coinsurance	50% coinsurance	Deductible applies unless coordinated through the Cash Pay program. Urgent Care is available at no cost through Virtual Primary Care. Contact BowTie Medical at 1-720-704-3300 to receive services at no cost.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Cash Pay Provider (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0 copay	30% coinsurance	50% coinsurance	Deductible applies unless coordinated through the Cash Pay program. Preauthorization required. Failure to obtain preauthorization will result in a \$500 penalty.
	Physician/surgeon fees	\$0 copay	30% coinsurance	50% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	\$0 copay	30% coinsurance	50% coinsurance	Deductible applies unless coordinated through the Cash Pay program. Mental Health Consults are available at no cost through Virtual Primary Care. Contact BowTie Medical at 1-720-704-3300 to receive services at no cost.
	Inpatient services	\$0 copay	30% coinsurance	50% coinsurance	Deductible applies unless coordinated through the Cash Pay program. Preauthorization required. Failure to obtain preauthorization will result in a \$500 penalty.
If you are pregnant	Office visits	\$0 copay	No Charge (deductible waived) for preventive services . Other services 30% coinsurance	No Charge (deductible waived) for preventive services . Other services 50% coinsurance	Deductible applies unless coordinated through the Cash Pay program. 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. Depending on the type of services, a coinsurance and/or deductible applies unless coordinated through the Cash Pay program. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	\$0 copay	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	\$0 copay	30% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Cash Pay Provider (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	\$0 copay	30% coinsurance	50% coinsurance	Deductible applies unless coordinated through the Cash Pay program. Preauthorization required. Failure to obtain preauthorization will result in a \$500 penalty.
	Rehabilitation services	\$0 copay	30% coinsurance	50% coinsurance	Deductible applies unless coordinated through the Cash Pay program. Includes physical, speech & occupational therapy.
	Habilitation services	\$0 copay	30% coinsurance	50% coinsurance	Includes expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD and to expenses covered as a preventive service .
	Skilled nursing care	\$0 copay	30% coinsurance	50% coinsurance	Deductible applies unless coordinated through the Cash Pay program. Preauthorization required. Failure to obtain preauthorization will result in a \$500 penalty.
	Durable medical equipment	\$0 copay	30% coinsurance	50% coinsurance	Deductible applies unless coordinated through the Cash Pay program. Preauthorization required for any item in excess of \$1,500. Failure to obtain preauthorization will result in a \$500 penalty.
	Hospice services	\$0 copay	30% coinsurance	50% coinsurance	Deductible applies unless coordinated through the Cash Pay program. Failure to obtain preauthorization will result in a \$500 penalty. Bereavement counseling is covered if received within 6 months of death.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Cash Pay Provider (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	No Charge	No Charge	Charges limited to one exam/year.
	Children's glasses	Not covered	Not covered	Not covered	-----None-----
	Children's dental check-up	Not covered	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)	- Infertility treatment - Long-term care - 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	Hearing aids	Massage Therapy

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>. Additionally, a consumer assistance program can help you file your appeal. Contact the Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance at (877) 310-6560.U.S.

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 866-326-7485.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-326-7485.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 866-326-7485.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 866-326-7485.

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 pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$4,500
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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:

Cost Sharing	
Deductibles*	\$4,500
Copayments	\$0
Coinsurance	\$2,442
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$7,002

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$4,500
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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:

Cost Sharing	
Deductibles*	\$4,500
Copayments	\$0
Coinsurance	\$324
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$4,844

Mia's Simple Fracture

(emergency room visit and follow up care)

■ The plan's overall deductible	\$4,500
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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:

Cost Sharing	
Deductibles*	\$2,800
Copayments	\$0
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. These Examples show utilization with the [network provider](#) benefits.