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 1-844-335-0166 or visit www.aptahealth.com/stein. 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 1-844-335-0166 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Cash Pay: $0 person / $0 family. All Other: $6,250 person / $12,500 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. In-network preventive care is 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?	Cash Pay: $0 person / $0 family. All Other: $7,150 person / $14,300 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?	Does not apply. Call Apta Concierge at 1-844-335-0166 to find a Cash Pay provider or for questions regarding providers.	This plan does not use a provider network.
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)	All Other Providers (You will pay the most)	
If you visit a health care provider's office or clinic or use Virtual Primary Care	Virtual Direct Primary Care Visit visits to treat an injury or illness	$0 copay	Not Covered	Contact Revive Health at 1-888-220-6650 or www.revive.health to receive services at no cost.
	Primary care visit to treat an injury or illness	Not Available	$40 copay.	Deductible does not apply.
	Specialist visit	$0 copay	20% coinsurance	Credit Card Eligible when coordinated through the Cash Pay program. Deductible applies.
	Preventive care/ screening/ immunization	Not Available	No Charge.	Deductible does not apply. 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 for.
If you have a test	Diagnostic test (x-ray, blood work)	$0 copay	20% coinsurance .	Services provided in an Outpatient Hospital setting would not be Cash Pay eligible. Deductible applies unless coordinated through the Cash Pay program. Preauthorization is required for PET Scans, MRI's and MRA's. Failure to obtain preauthorization will result in a $500 penalty.
	Imaging (CT/PET scans, MRIs)	$0 copay	20% 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)	All Other Providers (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.magellanrx.com	Generic drugs	$0 through Virtual Primary Care	$20 copay (30 day retail) $60 copay (90 day retail) $40 copay (90 day mail order)	Generic medications are available at no cost through Virtual Primary Care. Contact Revive Health at 1-888-220-6650 or www.revive.health to receive services at no cost. Copay applies per prescription. Covers up to a 90-day supply (retail prescription); 31-90 day supply (mail order prescription). No charge for ACA mandated preventive 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. Specialty drugs are limited to a 30-day supply (retail and mail-order). Specialty drugs must be obtained directly from the specialty pharmacy program after one fill at a retail pharmacy.
	Preferred brand drugs	Not Available	$50 copay (30 day retail) $150 copay (90 day retail) $100 copay (90 day mail order)	
	Non-preferred brand drugs	Not Available	$70 copay (30 day retail) $210 copay (90 day retail) $140 copay (90 day mail order)	
	Specialty drugs	Not Available	$70 copay (30 day retail)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0 copay	20% 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	20% coinsurance	
If you need immediate medical attention	Emergency room care	Not Available	$250 copay Waived if admitted.	----------None----------
	Emergency medical transportation	Not Available	20% coinsurance	Deductible applies.
	Urgent care	$0 copay	20% coinsurance	Credit Card eligible when coordinated through the Cash Pay Program. Urgent Care is available at no cost through Virtual Primary Care. Contact Revive Health at 1-888-220-6650 or www.revive.health to receive services at no cost. 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)	All Other Providers (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$0 copay	20% 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	20% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Outpatient Services	$0 copay	$40 copay	Credit Card eligible when coordinated through the Cash Pay Program. Mental Health Visits are available at no cost through Virtual Primary Care. Contact Revive Health at 1-888-220-6650 or www.revive.health to receive services at no cost.
	Inpatient services	$0 copay	20% 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 copay.	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	20% coinsurance	
	Childbirth/delivery facility services	$0 copay	20% 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)	All Other Providers (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$0 copay	20% 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	20% coinsurance	Deductible applies unless coordinated through the Cash Pay program. 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	$0 copay	20% coinsurance	Deductible applies unless coordinated through the Cash Pay program. Limited to 30 visits per plan year Preauthorization required. Failure to obtain preauthorization will result in a $500 penalty.
	Durable medical equipment	Not available	20% 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	$0 copay	20% coinsurance .	Deductible applies unless coordinated through the Cash Pay program. Bereavement counseling is covered if received within 6 months of death. Preauthorization is required. Failure to obtain preauthorization will result in a $500 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Cash Pay Provider (You will pay the least)	All Other Providers (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Available	No Charge	Charges 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.)

- Bariatric Surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Adult & Child)
- Habilitation services
- 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
- Acupuncture
- Hearing aids
- Infertility treatment

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
Arkansas Insurance Department, Consumer Services Division at (800) 852-5494.
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 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, kwiijigo holne' 866-326-7485.

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

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** **$6,250**
- **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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles*	$6,250
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,210**

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

- **The plan's overall deductible** **$6,250**
- **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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$900
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,220**

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

- **The plan's overall deductible** **$6,250**
- **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**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$200
Copayments	$250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$450**

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