

 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, visit <https://butler.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 : \$1,650 person / \$3,300 family; for out-of-network providers \$3,300 person or \$6,600 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 services 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 \$4,950 person / \$8,460 family. There is no maximum for out-of-network providers .	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 www.umar.com or call 1-877-610-8817 for a list of network providers with 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.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral , however, you will pay a lower copay if a referral is obtained.

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

 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	\$30 copay / office visit	50% coinsurance	Copay applies per visit regardless of what services are rendered. Deductible does not apply for participating network providers . You will pay a \$10 copay if you receive video telemedicine services from OC24. See plan for further details.
	Specialist visit	\$50 copay / visit (with referral) \$90 copay /visit (without referral)	50% coinsurance	You will pay a lower copay if a referral is obtained for a specialist visit. Deductible does not apply for participating network providers.
	Preventive care/screening/immunization	No charge Deductible Waived	50% coinsurance	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	50% coinsurance	*No Charge for preventive, deductible waived in office setting. The deductible applies in outpatient setting.
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	The 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.magellanrx.com	Generic drugs (Tier 1)	\$10 copay (retail) / \$20 copay (mail order)	No Coverage	The deductible does not apply. Copay applies per prescription. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription through MagellanRx Mail Order pharmacy only). 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.
	Preferred brand drugs (Tier 2)	\$35 copay (retail) / \$70 copay (mail order)	No Coverage	
	Non-preferred brand drugs (Tier 3)	\$75 copay (retail) / \$150 copay (mail order)	No Coverage	

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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)	
	Specialty drugs (Tier 4)	25% coinsurance up to a maximum of \$150	Not Covered	Specialty drugs – Failure to get 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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% 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	50% coinsurance	
If you need immediate medical attention	Emergency room care	\$200 copay per visit; Deductible Waived	\$200 copay per visit; Deductible Waived	Non-participating providers paid at the participating network provider level.
	Emergency medical transportation	No charge	No charge	Non-participating providers paid at the participating network provider level.
	Urgent care	\$75 copay per visit Deductible Waived	50% coinsurance	Copay applies per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	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	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copay / visit	50% coinsurance	Copay applies per visit regardless of what services are rendered and the deductible does not apply.
	Inpatient services	25% coinsurance	50% coinsurance	Deductible applies. Preauthorization required unless performed in an office setting. Failure to obtain preauthorization will result in a \$500 penalty.
If you are pregnant	Office visits	No Charge (deductible waived) for preventive	50% coinsurance	Preauthorization required for inpatient hospital stays in excess of 48 hrs. (vaginal delivery) or

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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)	
	Childbirth/delivery professional services	services . Other services 25% coinsurance .	50% coinsurance	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 facility services	25% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	Deductible applies. Limited to 120 visits per plan year. Preauthorization required. Failure to obtain preauthorization will result in a \$500 penalty.
	Rehabilitation services	25% coinsurance	50% coinsurance	Deductible applies. Includes physical, speech & occupational therapy. Limits apply.
	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	50% 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	50% 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	50% coinsurance	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;	No Charge	Coverage limited to one exam per calendar year.
	Children's glasses	Not Covered	Not covered	None

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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)	
	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 .)		
<ul style="list-style-type: none"> Acupuncture Cosmetic Surgery Dental Care (adult & child) Glasses (adult & child) Habilitation Services Hearing Aids 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"> Bariatric Surgery 	<ul style="list-style-type: none"> Chiropractic Care 	<ul style="list-style-type: none"> 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, kwijigo holne' 800-826-9781.

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	\$1,650
■ Specialist copayment	\$50
■ 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,650
Copayments	\$300
Coinsurance	\$2,787.50
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,797.50

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1,650
■ Specialist copayment	\$50
■ 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles *	\$1,650
Copayments	\$1,200
Coinsurance	\$1,437.50
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$4,347.50

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,650
■ Specialist copayment	\$50
■ 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles *	\$1,650
Copayments	\$50
Coinsurance	\$62.50
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,762.50

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