Apex – Premier

Coverage Period: 01/01/2019 – 12/31/2019

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual or Family | **Plan Type:** MEC

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, go to www.regionalcare.com. 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 1-866-826-5317 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**No Deductible**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**
Are there services covered before you meet your deductible?	No.	
Are there other deductibles for specific services?	No	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for your health care expenses
What is the out-of-pocket limit for this plan?	There is no out-of-pocket limit for the plan	
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, Prior Authorization Penalties, and health care this plan does not 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, when utilizing a network provider, a discount is applied.	There are no benefits for out-of-network services
Do you need a referral to see a specialist?	No	Has to be an in-network specialist for the service to be covered by the plan

For more information about limitations and exceptions, see the plan or policy document at www.regionalcare.com. If you aren't clear about any of the bolded terms used in this form, see the glossary. You can view the glossary at **www.dol.gov/ebsa/healthreform** or call 800.795.7772 to request a copy.

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	$20 Copay/visit	Not Covered	Max 3 visits per plan year
	Specialist visit	$50 Copay/visit	Not Covered	Max 3 visits per plan year
	Preventive care/screening/ immunization	No Charge, 100% covered	Not Covered	
If you have a test	Diagnostic test (x-ray, blood work)	$50 copay/service	Not Covered	Max 5 services per plan year
	Imaging (CT/PET scans, MRIs)	$200 Copay	Not Covered	Max 1 MRI or CT Scan per plan year. Contrast and 3D Imaging MRI are excluded
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.welldynerx.com	Tier 1: Low Cost Generics	$1 Copay/per script	Not Covered	
	Tier 2: Generics	10% Coinsurance	Not Covered	
	Tier 3: Preferred brand	20% Coinsurance	Not Covered	
	Tier 4: Non-Preferred Brand	40% Coinsurance	Not Covered	
	Tier 5: Generic and Preferred Specialty Drugs	10% Coinsurance	Not Covered	Plan pays 90% up to a maximum of $150 per Rx
	Tier 6: Non-Preferred Specialty Drugs	20% Coinsurance	Not Covered	Plan pays 80% up to a maximum of $250 per Rx
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% Coinsurance up to $5,000, maximum payable benefit $2,500. If service rendered in	Not Covered	Maximum Benefit for all Inpatient/Outpatient, ER, hospital related services, 50% coinsurance to $5,000. Max total benefit, $2,500
	Physician/surgeon fees		Not Covered	

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If you need immediate medical attention	Emergency room care	ambulatory surgery center it must be	Not Covered	Maximum Benefit for all Inpatient/Outpatient, ER, hospital related services, 50% coinsurance to $5,000.
	Emergency medical transportation	affiliated with a network hospital	Not Covered	Max total benefit, $2,500
	Urgent care	$50 Copay/visit	Not Covered	Max 3 visits per plan year
If you have a hospital stay	Facility fee (e.g., hospital room)	50% Coinsurance up to $5,000, maximum payable benefit $2,500	Not Covered	
	Physician/surgeon fees		Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Not Covered	
	Inpatient services	Not Covered	Not Covered	
If you are pregnant	Office visits	Not Covered	Not Covered	
	Childbirth/delivery professional services	50% Coinsurance up to $5,000, maximum payable benefit $2,500	Not Covered	Maximum Benefit for all Inpatient/Outpatient, ER, hospital related services, 50% coinsurance to $5,000. Max total benefit, $2,500
	Childbirth/delivery facility services		Not Covered	
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	
	Rehabilitation services	Not Covered	Not Covered	
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	Not Covered	Not Covered	
	Durable medical equipment	Not Covered	Not Covered	
	Hospice services	Not Covered	Not Covered	
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	No Charge	No Charge	

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.)		
• Contrast or 3-D MRIs	• PET Scans	• Radiation Oncology
• Chemotherapy	• Therapy Services	• Chiropractic Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Hospital	• Emergency Room	• Specialty Drugs

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 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: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? No
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.

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 in-network pre-natal care and a hospital delivery)

The plan's overall deductible	N/A
Specialist *[$50 Copayments]*	$150
Hospital (facility) *Not Covered*	N/A
Other *[Lab Services, Copayment]*	$50
Other *[Preferred Brand Drugs, 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	**$10, 200**

In this example, Peg would pay:

Cost Sharing	
Deductibles	N/A
Copayments	$250
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$5,200
The Total Peg would pay is	**$6,950**

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

The plan's overall deductible	N/A
Specialist *[copayments]*	$50
Hospital *[Not Covered]*	N/A
Other *[Lab Services, Copayment]*	$50
Prescription Drugs, [Non-Preferred *Brand Drugs,* Coinsurance*]*	40%

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	**$2,800**

In this example, Joe would pay:

Cost Sharing	
Deductibles	N/A
Copayments	$300
Coinsurance	$560
What isn't covered	
Limits or exclusions	$65
The total Joe would pay is	**$925**

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

The plan's overall deductible	N/A
Specialist *[copayments]*	$50
Emergency Room *[Not Covered]*	N/A
Other *[X-ray Services, Copayment]*	$50
Prescription Drugs, [Generic, Coinsurance*]*	10%

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	**$2,950**

In this example, Mia would pay:

Cost Sharing	
Deductibles	N/A
Copayments (3)	$150
Coinsurance 10%	$500
What isn't covered	
Limits or exclusions	$825
The total Mia would pay is	**$1,475**

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