Enhance Therapies -Silver RBP Plan: American Plan Administrators **Coverage for:** Individual, Individual + Family| **Plan Type:** RBP

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, contact 1-718-625-6300. 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.cciio.cms.gov or call 1-718-625-6300 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,500 person / $5,000 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 and primary 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. 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, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	$6,000 person/ $12,000 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 (unless balance-billing is prohibited), 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?	No. See www.Multiplan.com/phcspracanc	Providers outside of the PHCS network will be processed in accordance with "Referenced Based Pricing (RBP) and reimbursed at the in-network benefit level.
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
		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	$35 copay/office visit deductible does not apply		----------None----------
	Specialist visit	$60 copay/office visit deductible does not apply		----------None----------
	Preventive care/screening/ immunization	No charge		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)	No charge/office based $150 copay/lab hospital $300 copay/x-ray hospital deductible does not apply		
	Imaging (CT/PET scans, MRIs)	$100 copay/office based $500 copay/hospital deductible does not apply		Preauthorization is required. If you don't get preauthorization, services will not be covered.*
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.proactrx.com	Generic drugs	$20 copay / Retail prescription $40 copay / Mail Order	Not Covered	Covers up to a 3 retail 30 days fill (retail subscription); 90 day supply (mail order prescription).
	Preferred brand drugs	$40 copay / Retail prescription $80 copay / Mail Order	Not Covered	
	Non-preferred brand drugs	$60 copay / Retail prescription $120 copay / Mail Order	Not Covered	
	Specialty drugs	Not Covered		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance		Preauthorization is required. If you don't get preauthorization, services will not be covered.*
	Physician/surgeon fees	25% coinsurance		
If you need immediate medical attention	Emergency room care	$450 copay deductible does not apply		Copay Waived if admitted Coverage is limited to Urgent Emergency Room visits only
	Emergency medical transportation	25% coinsurance		Coverage is limited to Emergency Ground Transportation only
	Urgent care	$75 copay deductible does not apply		----------None----------
If you have a hospital	Facility fee (e.g., hospital room)	25% coinsurance		Preauthorization is required. If you don't get

* For more information about limitations and exceptions, or to request the SPD contact us at 1-718-625-6300.

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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)	
stay	Physician/surgeon fees	25% coinsurance		preauthorization, services will not be covered.*
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$60 copay/ visit deductible does not apply		----------None----------
	Inpatient services	25% coinsurance		Preauthorization is required. If you don't get preauthorization, services will not be covered.*
If you are pregnant	Office visits	$35 copay/ visit deductible does not apply		----------None----------
	Childbirth/delivery professional services	25% coinsurance		----------None----------
	Childbirth/delivery facility services	25% coinsurance		Preauthorization is required. If you don't get preauthorization, services will not be covered.*
If you need help recovering or have other special health needs	Home health care	25% coinsurance		Coverage is limited to 40 days per year. Preauthorization is required. If you don't get preauthorization, services will not be covered.*
	Rehabilitation services	$60 copay/ visit deductible does not apply		Coverage is limited to 30 combined visits per year
	Habilitation services	Not Covered		----------None----------
	Skilled nursing care	25% coinsurance		Coverage is limited to 60 days per year. Preauthorization is required. If you don't get preauthorization, services will not be covered.*
	Durable medical equipment	25% coinsurance		Preauthorization is required when the amount is > $500
	Hospice services	25% coinsurance		Coverage is limited to 30 days per year Preauthorization is required. If you don't get preauthorization, services will not be covered.*
If your child needs dental or eye care	Children's eye exam	No Charge		Coverage is limited to 1 exam per 24 months
	Children's glasses	No Charge		Coverage is limited to $100 per 24 months
	Children's dental check-up	Not Covered		----------None----------

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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
- Habilitation Services
- Infertility treatment
- Long term care
- Medical Care when traveling outside the U.S.
- Private Duty Nursing
- 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
- Eye Exam

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA or visit www.dol.gov/ebsa/healthreform; Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or visit www.cciio.cms.gov; or please call APA at 1-718-625-6300 or visit www.apatpa.com 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: APA at 1-718-625-6300 or visit www.apatpa.com.

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? 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:
If you are in need of language assistance, please reference the multi-language taglines and nondiscrimination notification at the end of this document, or call us at 1-718-625-6300

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 $2,500
- Specialist copayment $60
- 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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$340
Coinsurance	$2,490
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$5,330

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

- The plan's overall deductible $2,500
- Specialist copayment 0$60
- 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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$720
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,720

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

- The plan's overall deductible $2,500
- Specialist copayment 0$60
- Hospital (facility) copayment/coinsurance $450
- Other copayment $150

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$650
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$850

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