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 1-866-269-0047 or visit www.detegohealth.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 www.healthcare.gov/sbc-glossary or call 1-866-269-0047 to request a copy.

Important Questions	Apta Guardian	First Health Network	Out of Network	Why This Matters:
What is the overall deductible?	$0.00	$5,000/$10,000	$5,000 / $10,000	Generally, you must pay all 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. **See grid below**			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 your deductible for certain services.
What is the out-of-pocket limit for this plan?	$0.00	$7,000 / $14,000	$7,000 / $14,000	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, balanced-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 – Call 1-866-269-0047	First Health – Call 800-226-5116		You will pay the least by utilizing the Apta and Bowtie Medical Guardians to coordinate your care, you can reach them at 866-269-0047. If you choose not to use the Guardians, you can access a listing of First Health Network providers at http://firsthealth.com.
Do you need a referral to see a specialist?	Yes	No	No	Contact your Apta and Bowtie Medical Guardians at 866-269-0047 to reduce your out of pocket expenses to $0.

Important Questions	Apta Guardian	First Health Network	Out of Network	Why This Matters:
Coinsurance	100%/0%	70%/30%	50% / 50%	Plan covers 70% in network & 50% out of network. Member responsibility is 30% in network & 50% out of network.

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
		Apta Guardian	First Health Network	Out of Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	100% Covered	Deductible & then 30% Coinsurance	Deductible & 50% Coinsurance	
	Specialist visit	100% Covered	Deductible & then 30% Coinsurance	Deductible & 50% Coinsurance	
	Preventive care/screening/ immunization	100% Covered	Plan pays 100% of Plan Allowable	Deductible & 50% Coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	100% Covered	Deductible & then 30% Coinsurance	Deductible & 50% Coinsurance	
	Imaging (CT/PET scans, MRIs)	100% Covered	Deductible & then 30% Coinsurance	Deductible & 50% Coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kpp--rx.com	Tier 1	$10 Copay – Kroger Participating Pharmacy	$10 Copay – Kroger Participating Pharmacy	Non-Covered	Elite Impact Formulary. The Plan's Prescription Drug benefit may include other programs to maximize benefits under the Plan. Programs may require you to follow certain guidelines for medications to be covered under the Plan. Maximum benefit payable per month/per RX is $700.00 for retail & mail order and $1,500.00 for Specialty medication.
	Tier 2	$45 Copay – Kroger Participating Pharmacy	$45 Copay – Kroger Participating Pharmacy	Non-Covered	
	Tier 3	$85 Copay – Kroger Participating Pharmacy	$85 Copay – Kroger Participating Pharmacy	Non-Covered	
	Specialty drugs	$250 Copay – 30-day supply – must be obtained through designated pharmacy			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	100% Covered	Deductible & then 30% Coinsurance	Deductible & 50% Coinsurance	
	Physician/surgeon fees	100% Covered	Deductible & then 30%	Deductible & 50%	

[* For more information about limitations and exceptions, see the plan or policy document.]

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Apta Guardian	First Health Network	Out of Network	
			Coinsurance	Coinsurance	
If you need immediate medical attention	Emergency room care	100% Covered	Deductible & then 30% Coinsurance	Deductible & then 30% Coinsurance	
	Emergency medical transportation	Ground – 100%, Air – Non-Covered	Deductible & then 30% Coinsurance	Deductible & then 30% Coinsurance	
	Urgent care	100% Covered	Deductible & then 30% Coinsurance	Deductible & 50% Coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	100% Covered	Deductible & then 30% Coinsurance	Deductible & 50% Coinsurance	
	Physician/surgeon fees	100% Covered	Deductible & then 30% Coinsurance	Deductible & 50% Coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	100% Covered	Deductible & then 30% Coinsurance	Deductible & 50% Coinsurance	
	Inpatient services	100% Covered	Deductible & then 30% Coinsurance	Deductible & 50% Coinsurance	
If you are pregnant	Office visits	100% Covered	$0 Copay	Deductible & 50% Coinsurance	Service frequency based on ACA guidelines.
	Childbirth/delivery professional services	100% Covered	Deductible & then 30% Coinsurance	Deductible & 50% Coinsurance	
	Childbirth/delivery facility services	100% Covered	Deductible & then 30% Coinsurance	Deductible & 50% Coinsurance	
If you need help recovering or have other special health needs	Home health care	100% Covered	Deductible & then 30% Coinsurance	Deductible & 50% Coinsurance	
	Rehabilitation services	100% Covered	Deductible & then 30% Coinsurance	Deductible & 50% Coinsurance	Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Rehab (Max 20 visits each) Spinal Manipulation (Max 20 Visits)

[* For more information about limitations and exceptions, see the plan or policy document.]

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Apta Guardian	First Health Network	Out of Network	
	Habilitation services	100% Covered	Deductible & then 30% Coinsurance	Deductible & 50% Coinsurance	
	Skilled nursing care	100% Covered	Deductible & then 30% Coinsurance	Deductible & 50% Coinsurance	Paid at semiprivate room rate - Maximum of 60 days
	Durable medical equipment	100% Covered	Deductible & then 30% Coinsurance	Deductible & 50% Coinsurance	Limited to 12-month rental or purchase price, whichever is less. Over $500 Requires Precertification.
	Hospice services	100% Covered	Deductible & then 30% Coinsurance	Deductible & 50% Coinsurance	
If your child needs dental or eye care	Children's eye exam	Not Covered			
	Children's glasses	Not Covered			
	Children's dental check-up	Not Covered			

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.)

- Cosmetic Surgery
- Dental Care (Adult)
- Long Term Care
- Non-Emergency 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.)

- Durable Medical Equipment
- Chiropractic Care
-

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: [For ERISA plans: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa.] [For Non ERISA plans: the Department of Health and Humans Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x 61565 or www.cciio.cms.gov.] 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: [insert applicable contact information from instructions].

The U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa

[* For more information about limitations and exceptions, see the plan or policy document.]

Additionally, a consumer assistance program can help you file your appeal. Contact the
Arkansas Insurance Department, Consumer Services Division at (800) 852-5494.
California Consumer Assistance Program, operated by the California Department of Managed Health Care at (888) 466-2219.
Connecticut Office of the Healthcare Advocate at (866) 466-4446. Delaware Department of Insurance at (800) 282-8611.
Delaware Department of Insurance at (800) 282-8611.
DC Office of the Health Care Ombudsman and Bill of Rights at (877) 685-6391.
Georgia Office of Insurance and Safety Fire Commissioner at (800) 656-2298.
Guam Department of Revenue and Taxation at (671) 635-1846.
Illinois Department of Insurance at (877) 527-9431.
Kansas Insurance Department, Consumer Assistance Division at (800) 432-2484 (in state)/ (785) 296.
Kentucky Department of Insurance, Consumer Protection Division at (800) 595-6053.
Maine Consumers for Affordable Health Care at (800) 965-7476.
Maryland Office of the Attorney General, Health Education and Advocacy Unit at (877) 261-8807.
Massachusetts Health Care For All at (800) 272-4232.
Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Department of Insurance and Financial Services (DIFS) at (877) 999-6442.
(Mississippi) Health Help Mississippi at (877) 314-3843.
Missouri Department of Insurance at (800) 726-7390.
Office of the Montana State Auditor, Commissioner of Securities & Insurance at (800) 332-6148.
Nevada Office of Consumer Health Assistance, Governor's Consumer Health Advocate at (888) 333-1597.
New Hampshire Department of Insurance at (800) 852-3416.
New Jersey Department of Banking and Insurance at (800) 446-7467 or (609) 292-7272.
New Mexico Public Regulation Commission, Consumer Relations Division at (855) 857-0972 or (888) 427-5772.
Community Service Society of New York, Community Health Advocates at (888) 614-5400.
North Carolina Department of Insurance, Health Insurance Smart NC at (855) 408-1212.
Oklahoma Insurance Department at (800) 522-0071.
Oregon Health Connect at (866) 698-6155.
Pennsylvania Insurance Department at (877) 881-6388.
Puerto Rico Oficina de la Procuradora del Paciente at (787) 979-0909.
Rhode Island Consumer Assistance Program, Rhode Island Parent Information Network, Inc. at (855) 747-3224.
South Carolina Department of Insurance, Consumer and Individual Licensing Services at (800) 768-3467.
Tennessee Department of Commerce & Insurance at (615) 741-2241.
Texas Consumer Health Assistance Program, Texas Department of Insurance at (855) 839-2427 (855-TEX-CHAP).
Vermont Legal Aid at (800) 889-2047.
Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance at (877) 310-6560.U.S.
U.S. Virgin Islands Division of Banking and Insurance at (340) 773-6459.
Washington Consumer Assistance Program at (800) 562-6900.
West Virginia Offices of the Insurance Commissioner, Consumer Service Division at (888) 879-9842.

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.

[* For more information about limitations and exceptions, see the plan or policy document.]

Language Access Services: [Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码[insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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

[* For more information about limitations and exceptions, see the plan or policy document.]

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	**$5,000**
Specialist *[cost sharing]*	**$0**
Hospital (facility) *[cost sharing]*	**30%**
Other *[cost sharing]*	**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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$3,810
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$8,810**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	**$5,000**
Specialist *[cost sharing]*	**$0**
Hospital (facility) *[cost sharing]*	**30%**
Other *[cost sharing]*	**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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$5,600**

Mia's Simple Fracture

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

The plan's overall deductible	**$5,000**
Specialist *[cost sharing]*	**$0**
Hospital (facility) *[cost sharing]*	**30%**
Other *[cost sharing]*	**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**
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.