The Royal Care Low Plan: American Plan Administrators

Coverage for: Individual, Individual + Family| **Plan Type:** EPO

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?	participating providers $6,850 person / $13,700 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, 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?	For participating providers $6,850 person / $13,700 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?	Yes, see www.magnacare.com	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.

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	No Charge	Not Covered	----------None----------
	Specialist visit	No Charge	Not Covered	----------None----------
	Preventive care/screening/ immunization	No charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Preauthorization is required for CT/PET scans, MRIs.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.magellanrx.com	Generic drugs	$10 copay / Retail prescription $30 copay / Mail Order	Not Covered	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	Not Covered	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	
	Specialty drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Preauthorization is required. If you don't get preauthorization, services will not be covered.*
	Physician/surgeon fees	No charge	Not Covered	
If you need immediate medical attention	Emergency room care	No Charge	30% coinsurance	Copay Waived if admitted. Coverage is limited to Urgent Emergency Room visits only Refer to your Benefit Summary for a list of approved Network facilities
	Emergency medical transportation	Not Covered	Not Covered	Coverage is limited to Emergency Ground Transportation only
	Urgent care	No Charge	Not Covered	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Coverage is limited to 30 days per year, including inpatient mental health. Refer to your Benefit Summary for a list of approved Network facilities Preauthorization is required. If you don't get preauthorization, services will not be covered.*
	Physician/surgeon fees	No Charge	Not Covered	----------None----------

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

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 need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	Not Covered	----------None----------
	Inpatient services	No Charge	Not Covered	Coverage is limited to 30 days per year, including inpatient medical services. Refer to your Benefit Summary for a list of approved Network facilities Preauthorization is required. If you don't get preauthorization, services will not be covered.*
If you are pregnant	Office visits	No Charge	Not Covered	----------None----------
	Childbirth/delivery professional services	No charge	Not Covered	----------None----------
	Childbirth/delivery facility services	No Charge	Not Covered	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	No Charge	Not Covered	Coverage is limited to 40 visits per year. Preauthorization is required. If you don't get preauthorization, services will not be covered.*
	Rehabilitation services	No Charge	Not Covered	Benefits are covered only at a freestanding P/T Center. P/T preformed at Outpatient hospital is not covered.
	Habilitation services	Not Covered	Not Covered	----------None----------
	Skilled nursing care	No Charge	Not Covered	Coverage is limited to 10 visits per year Preauthorization is required. If you don't get preauthorization, services will not be covered.*
	Durable medical equipment	No Charge	Not Covered	Preauthorization is required when the amount is > $1,000
	Hospice services	No Charge Inpatient-Not Covered	Not Covered	Coverage is limited to 210 days per lifetime 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 deductible does not apply	Not Covered	Coverage is limited to 1 routine exam per 24 months
	Children's glasses	No charge deductible does not apply	Not Covered	Covers up to $100 per 24 months
	Children's dental check-up	No charge deductible does not apply	Not Covered	Coverage is limited to $250 per year

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

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
- Chiropractic Care
- Cosmetic Surgery
- 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.)

- Hearing Aids- covered once every 3 years
- Inpatient Rehab – Max of 30 days per year
- Podiatry – Max of 15 treatments per year

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.

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

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	$6,850
Specialist copayment	$0
Hospital (facility) copayment	$0
Other copayment	$0

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	$6,850
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$6,850

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

The plan's overall deductible	$6,850
Specialist copayment	$0
Hospital (facility) copayment	$0
Other copayment	$0

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	$6,850
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$6,850

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

The plan's overall deductible	$6,850
Specialist copayment	$0
Hospital (facility) copayment	$0
Other copayment	$0

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	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,900

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