
 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 1-800-324-9396 or visit our website www.advantagehealthplans.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.advantagehealthplans.com or call 1-800-324-9396 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$3,000 for individual / 2 covered persons must each meet the \$3,000 deductible for 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, physician office services, preventive services, services rendered through KPPFree , One Call , and LabCard providers.	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 ?	\$7,900 for individuals / \$15,800 for 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-billed charges, penalties for failure to obtain preauthorization, amounts in excess of the Reference Based Price for out-of-network, 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 ?	Not Applicable.	This plan does not use a provider network . You can receive covered services from any provider .
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
		No Network Provider, Subject to Reference Based Price		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35/visit, (Deductible does not apply)		Charges are held to a percentage of Medicare. (Reference Based Price)
	Specialist visit	\$35/visit, (Deductible does not apply)		Charges are held to a percentage of Medicare. (Reference Based Price)
	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. Charges are held to a percentage of Medicare. (Reference Based Price)
If you have a test	Diagnostic test (x-ray, blood work)	Lab - 30% coinsurance (Deductible does not apply); X-ray – Deductible , then 30% coinsurance		No charge if services rendered at a LabCard laboratory. Charges are held to a percentage of Medicare. (Reference Based Price)
	Imaging (CT/PET scans, MRIs)	Deductible , then 30% coinsurance		No charge if services rendered at a KPPFree or One Call provider . Charges are held to a percentage of Medicare. (Reference Based Price)
Common Medical Event	Services You Man Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network	Non-Network	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.scriptcare.com or calling 1-800-880-9988	Generic drugs	\$15/prescription (34 days) \$30/prescription (102 days retail or mail order) (Deductible does not apply);	Not Covered (Walgreens is out-of-network)	Select OTC = No Charge
	Preferred brand drugs	\$55/prescription (34 days) \$110/prescription (102 days retail or mail order) (Deductible does not apply);	Not Covered (Walgreens is out-of-network)	You will pay the copayment , PLUS the difference in cost between the generic and the brand name drug if generic is available.
	Non-preferred brand drugs	50% drug cost (retail or mail order) (Deductible does not apply);	Not Covered (Walgreens is out-of-network)	List of Therapeutic Alternatives available at www.advantagehealthplans.com

* For more information about limitations and exceptions, see the plan or policy document at www.advantagehealthplans.com.

Common Medical Event	Services You Man Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network	Non-Network	
	Specialty drugs	\$150/prescription (approved specialty vendor only) (Deductible does not apply);	Not Covered (Walgreens is out-of-network)	Script Care Specialty Pharmacy 1-866-443-1991.
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		No Network Provider, Subject to Reference Based Price		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$300/visit, Deductible , then 30% coinsurance		Pre-authorization is required. No charge if services rendered at a KPPFree provider . Charges are held to a percentage of Medicare. (Reference Based Price)
	Physician/surgeon fees	Deductible , then 30% coinsurance		No charge if services rendered at a KPPFree provider . Charges are held to a percentage of Medicare. (Reference Based Price)
If you need immediate medical attention	Emergency room care	\$200/visit, Deductible , then 30% coinsurance		Copayment is waived if admitted as an inpatient. Charges are held to a percentage of Medicare. (Reference Based Price)
	Emergency medical transportation	Deductible , then 30% coinsurance		Air Ambulance limited to 120% of the Medicare rate.
	Urgent care	\$35/visit (Deductible does not apply)		Charges are held to a percentage of Medicare. (Reference Based Price)
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300/visit (if surgery), Deductible , then 30% coinsurance		Pre-authorization is required. No charge if services rendered at a KPPFree provider . Charges are held to a percentage of Medicare. (Reference Based Price)
	Physician/surgeon fees	Deductible , then 30% coinsurance		No charge if services rendered at a KPPFree provider . Charges are held to a percentage of Medicare. (Reference Based Price)

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		No Network Provider, Subject to Reference Based Price		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35/visit or Deductible , then 30% coinsurance		Charges are held to a percentage of Medicare. (Reference Based Price) Pre-authorization is required.
	Inpatient services	Deductible , then 30% coinsurance		Charges are held to a percentage of Medicare. (Reference Based Price)
If you are pregnant	Office visits	\$35/visit (Deductible does not apply)		Charges are held to a percentage of Medicare. (Reference Based Price)
	Childbirth/delivery professional services	Deductible , then 30% coinsurance		Charges are held to a percentage of Medicare. (Reference Based Price)
	Childbirth/delivery facility services	Deductible , then 30% coinsurance		\$300 surgical copayment may apply. Charges are held to a percentage of Medicare. (Reference Based Price)
If you need help recovering or have other special health needs	Home health care	Deductible , then 30% coinsurance		Charges are held to a percentage of Medicare. (Reference Based Price)
	Rehabilitation services	\$35/visit (Deductible does not apply)		No charge if services rendered at a KPPFree provider .
	Habilitation services	\$35/visit (Deductible does not apply)		Physical Therapy/Manipulative Therapy limited to allowable of up to \$95/visit and 26 visits per Calendar Year. Charges are held to a percentage of Medicare. (Reference Based Price)
	Skilled nursing care	Deductible , then 30% coinsurance		Limited to 365 days per lifetime. Charges are held to a percentage of Medicare. (Reference Based Price)
	Durable medical equipment	Deductible , then 30% coinsurance		Limitations may apply. Charges are held to a percentage of Medicare. (Reference Based Price)
	Hospice services	Deductible , then 30% coinsurance		Charges are held to a percentage of Medicare. (Reference Based Price)

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Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
		No Network Provider, Subject to Reference Based Price	
If your child needs dental or eye care	Children's eye exam	No Coverage	
	Children's glasses	No Coverage	
	Children's dental check-up	No Coverage	

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) Dental care (Child) 	<ul style="list-style-type: none"> Glasses Infertility treatment Long-term care Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Routine eye care (Adult) Routine eye care (Child) TMJ 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 Services (limitations apply) Chiropractic care (limitations apply) 	<ul style="list-style-type: none"> Hearing Aids (limitations apply) Routine foot care (limitations apply) 	<ul style="list-style-type: none"> Private-duty nursing (limitations apply)

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: call 1-800-324-9396 or visit our website www.advantagehealthplans.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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-324-9396.

————— *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	\$3,000
■ Specialist [<i>cost sharing</i>]	\$35
■ Hospital (facility) [<i>cost sharing</i>]	30%
■ Other [<i>cost sharing</i>]	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	\$12,840
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$130
Coinsurance	\$2,840
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$5,970

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$3,000
■ Specialist [<i>cost sharing</i>]	\$35
■ Hospital (facility) [<i>cost sharing</i>]	30%
■ Other [<i>cost sharing</i>]	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	\$7,460
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,800
Copayments	\$1,530
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$3,330

Mia's Simple Fracture

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

■ The plan's overall deductible	\$3,000
■ Specialist [<i>cost sharing</i>]	\$35
■ Hospital (facility) [<i>cost sharing</i>]	30%
■ Other [<i>cost sharing</i>]	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	\$1,970
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,470
Copayments	\$250
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,720