

 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](#), [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 ?	\$2,500 for individual / \$5,000 for family (\$2,700 embedded individual deductible)	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 services	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.
What is the out-of-pocket limit for this plan ?	\$5,000 for individuals / \$10,000 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 ?	Yes. See www.advantagehealthplans.com or call 1-800-324-9396 for a list of Network providers.	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 [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	Deductible , then 20% coinsurance	Deductible , then 20% coinsurance	Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Specialist visit	Deductible , then 20% coinsurance	Deductible , then 20% coinsurance	Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Preventive care/screening/immunization	No Charge	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. Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
If you have a test	Diagnostic test (x-ray, blood work)	Deductible , then 20% coinsurance	Deductible , then 20% coinsurance	For services rendered at a LabCard laboratory no charge after deductible . Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Imaging (CT/PET scans, MRIs)	Deductible , then 20% coinsurance	Deductible , then 20% coinsurance	For services rendered at a KPPFree or One Call provider no charge after deductible . Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
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	Deductible , then 10% coinsurance (34 days retail or 102 retail or mail order)	Not Covered (Walgreens is out-of-network)	Select OTC = no charge after deductible
	Preferred brand drugs	Deductible , then 20% coinsurance (34 days retail or 102 days retail or mail order)	Not Covered (Walgreens is out-of-network)	You will pay the deductible and coinsurance , PLUS the difference in cost between the generic and the brand name drug if generic is available.
	Non-preferred brand drugs	Deductible , then 50% drug cost (retail or mail order)	Not Covered (Walgreens is out-of-network)	List of Therapeutic Alternatives available at www.advantagehealthplans.com
Common	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important

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

Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information
	Specialty drugs	Deductible , then 10% for Generic, or 20% for Name Brand (approved specialty vendor only)	Not Covered (Walgreens is out-of-network)	Script Care Specialty Pharmacy 1-866-443-1991.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible , then 20% coinsurance	Deductible , then 20% coinsurance	Pre-authorization is required. For services rendered at a KPPFree provider no charge after deductible . Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Physician/surgeon fees	Deductible , then 20% coinsurance	Deductible , then 20% coinsurance	For services rendered at a KPPFree provider no charge after deductible . Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
If you need immediate medical attention	Emergency room care	Deductible , then 20% coinsurance	Deductible , then 20% coinsurance	Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Emergency medical transportation	Deductible , then 20% coinsurance	Deductible , then 20% coinsurance	Air Ambulance limited to 120% of the Medicare rate.
	Urgent care	Deductible , then 20% coinsurance	Deductible , then 20% coinsurance	Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible , then 20% coinsurance	Deductible , then 20% coinsurance	Pre-authorization is required. For services rendered at a KPPFree provider no charge after deductible . Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Physician/surgeon fees	Deductible , then 20% coinsurance	Deductible , then 20% coinsurance	For services rendered at a KPPFree provider no charge after deductible . Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)

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

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	Deductible , then 20% coinsurance	Deductible , then 20% coinsurance	Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Inpatient services	Deductible , then 20% coinsurance	Deductible , then 20% coinsurance	Pre-authorization is required. Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
If you are pregnant	Office visits	Deductible , then 20% coinsurance	Deductible , then 20% coinsurance	Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Childbirth/delivery professional services	Deductible , then 20% coinsurance	Deductible , then 20% coinsurance	Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Childbirth/delivery facility services	Deductible , then 20% coinsurance	Deductible , then 20% coinsurance	Out-of-Network 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 20% coinsurance	Deductible , then 20% coinsurance	Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Rehabilitation services	Deductible , then 20% coinsurance	Deductible , then 20% coinsurance	For services rendered at a KPPFree provider no charge after deductible .
	Habilitation services	Deductible , then 20% coinsurance	Deductible , then 20% coinsurance	Physical Therapy/Manipulative Therapy limited to allowable of up to \$95/visit and 26 visits per Calendar Year. Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Skilled nursing care	Deductible , then 20% coinsurance	Deductible , then 20% coinsurance	Limited to 365 days per lifetime. Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Durable medical equipment	Deductible , then 20% coinsurance	Deductible , then 20% coinsurance	Limitations may apply. Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Hospice services	Deductible , then 20% coinsurance	Deductible , then 20% coinsurance	Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
If your child needs dental or eye care	Children's eye exam	No Coverage	No Coverage	
	Children's glasses	No Coverage	No Coverage	
	Children's dental check-up	No Coverage	No Coverage	

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

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](#).)

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|-----------------------|--|----------------------------|
| • Acupuncture | • Glasses | • Routine eye care (Adult) |
| • Cosmetic surgery | • Infertility treatment | • Routine eye care (Child) |
| • Dental care (Adult) | • Long-term care | • TMJ |
| • Dental care (Child) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|--|---|--|
| • Bariatric Services (limitations apply) | • Hearing Aids (limitations apply) | • Private-duty nursing (limitations apply) |
| • Chiropractic care (limitations apply) | • Routine foot care (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	\$2,500
■ Specialist [<i>cost sharing</i>]	\$0
■ Hospital (facility) [<i>cost sharing</i>]	20%
■ Other [<i>cost sharing</i>]	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	\$12,840
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$0
Coinsurance	\$2,170
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$4,670

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$2,500
■ Specialist [<i>cost sharing</i>]	\$0
■ Hospital (facility) [<i>cost sharing</i>]	20%
■ Other [<i>cost sharing</i>]	20%

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	\$2,500
Copayments	\$0
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$3,500

Mia's Simple Fracture

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

■ The plan's overall deductible	\$2,500
■ Specialist [<i>cost sharing</i>]	\$0
■ Hospital (facility) [<i>cost sharing</i>]	20%
■ Other [<i>cost sharing</i>]	20%

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	\$1,970
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,970