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?	$7,350 for individuals / $14,700 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 **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/visit, (Deductible does not apply)	$35/visit, (Deductible does not apply)	Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Specialist visit	$35/visit, (Deductible does not apply)	$35/visit, (Deductible does not apply)	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)	Lab - 30% coinsurance (Deductible does not apply); X-ray – Deductible, then 30% coinsurance	Lab - 30% coinsurance (Deductible does not apply); X-ray – Deductible, then 30% coinsurance	No charge if services rendered at a **LabCard** laboratory. Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Imaging (CT/PET scans, MRIs)	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance	No charge if services rendered at a **KPPFree** or **One Call** provider. 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	$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 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)	
	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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300/visit, Deductible, then 30% coinsurance	$300/visit, Deductible, then 30% coinsurance	Pre-authorization is required. No charge if services rendered at a **KPPFree** provider. Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Physician/surgeon fees	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance	No charge if services rendered at a **KPPFree** provider. Out-of-Network 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	$200/visit, Deductible, then 30% coinsurance	Copayment is waived if admitted as an inpatient. Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Emergency medical transportation	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance	Air Ambulance limited to 120% of the Medicare rate.
	Urgent care	$35/visit (Deductible does not apply)	$35/visit (Deductible does not apply)	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)	$300/visit (if surgery), Deductible, then 30% coinsurance	$300/visit (if surgery), Deductible, then 30% coinsurance	Pre-authorization is required. No charge if services rendered at a **KPPFree** provider. Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Physician/surgeon fees	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance	No charge if services rendered at a **KPPFree** provider. Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)

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	$35/visit or Deductible, then 30% coinsurance	$35/visit or Deductible, then 30% coinsurance	Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Inpatient services	Deductible, then 30% coinsurance	Deductible, then 30% 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	$35/visit (Deductible does not apply)	$35/visit (Deductible does not apply)	Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Childbirth/delivery professional services	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance	Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Childbirth/delivery facility services	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance	$300 surgical copayment may apply. 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 30% coinsurance	Deductible, then 30% coinsurance	Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Rehabilitation services	$35/visit (Deductible does not apply)	$35/visit (Deductible does not apply)	No charge if services rendered at a **KPPFree** provider. 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)
	Habilitation services	$35/visit (Deductible does not apply)	$35/visit (Deductible does not apply)	
	Skilled nursing care	Deductible, then 30% coinsurance	Deductible, then 30% 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 30% coinsurance	Deductible, then 30% coinsurance	Limitations may apply. Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Hospice services	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance	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 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	

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
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Glasses
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Bariatric Services (limitations apply)
- Chiropractic care (limitations apply)
- Hearing Aids (limitations apply)
- Routine foot care (limitations apply)
- 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.

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

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 *[cost sharing]*	$35
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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$130
Coinsurance	$2,850
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$5,980**

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 *[cost sharing]*	$35
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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$1,530
Coinsurance	$0
What isn't covered	
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 *[cost sharing]*	$35
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	**$1,970**

In this example, Mia would pay:

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

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