
 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](http://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](http://www.advantagehealthplans.com) or call 1-800-324-9396 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$750 for individual / 2 covered persons must each meet the \$750 <a href="#">deductible</a> for family.	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, physician office services, preventive services, services rendered through <b>KPPFree</b> , <b>One Call</b> , and <b>LabCard</b> providers.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without cost-sharing and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$5,750 for individuals / \$11,500 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 <a href="#">plan</a> , 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 <a href="#">out-of-pocket limit</a> ?	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 <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.advantagehealthplans.com">www.advantagehealthplans.com</a> or call 1-800-324-9396 for a list of Network providers.	This <a href="#">plan</a> uses a <a href="#">provider</a> network. You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan</a> 's network. You will pay the most if you use an out-of-network <a href="#">provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider</a> 's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your network <a href="#">provider</a> might use an out-of-network <a href="#">provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$35/visit, ( <a href="#">Deductible</a> does not apply)	\$35/visit, ( <a href="#">Deductible</a> does not apply)	Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	<a href="#">Specialist</a> visit	\$35/visit, ( <a href="#">Deductible</a> does not apply)	\$35/visit, ( <a href="#">Deductible</a> does not apply)	Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	<a href="#">Preventive care/screening/immunization</a>	No Charge	No Charge	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.  Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Lab - 30% <a href="#">coinsurance</a> ( <a href="#">Deductible</a> does not apply);  X-ray – <a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	Lab - 30% <a href="#">coinsurance</a> ( <a href="#">Deductible</a> does not apply);  X-ray – <a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	No charge if services rendered at a <b>LabCard</b> laboratory.  Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Imaging (CT/PET scans, MRIs)	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	No charge if services rendered at a <b>KPPFree</b> or <b>One Call</b> <a href="#">provider</a> .  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 <a href="#">prescription drug coverage</a> is available at <a href="http://www.scriptcare.com">www.scriptcare.com</a> or calling 1-800-880-9988	Generic drugs	\$15/prescription (34 days) \$30/prescription (102 days retail or mail order) ( <a href="#">Deductible</a> does not apply);	Not Covered ( <a href="#">Walgreens is out-of-network</a> )	Select OTC = No Charge
	Preferred brand drugs	\$55/prescription (34 days) \$110/prescription (102 days retail or mail order) ( <a href="#">Deductible</a> does not apply);	Not Covered ( <a href="#">Walgreens is out-of-network</a> )	You will pay the <a href="#">copayment</a> , 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) ( <a href="#">Deductible</a> does not apply);	Not Covered ( <a href="#">Walgreens is out-of-network</a> )	List of Therapeutic Alternatives available at <a href="http://www.advantagehealthplans.com">www.advantagehealthplans.com</a>

\* For more information about limitations and exceptions, see the plan or policy document at [www.advantagehealthplans.com](http://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)	
	<a href="#">Specialty drugs</a>	\$150/prescription (approved specialty vendor only) ( <a href="#">Deductible</a> does not apply);	Not Covered ( <a href="#">Walgreens is out-of-network</a> )	Script Care Specialty Pharmacy 1-866-443-1991.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$300/visit, <a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	\$300/visit, <a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	Pre-authorization is required.  No charge if services rendered at a <b>KPPFree provider</b> .  Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Physician/surgeon fees	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	No charge if services rendered at a <b>KPPFree provider</b> .  Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$200/visit, <a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	\$200/visit, <a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	<a href="#">Copayment</a> is waived if admitted as an inpatient.  Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	<a href="#">Emergency medical transportation</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	Air Ambulance limited to 120% of the Medicare rate.
	<a href="#">Urgent care</a>	\$35/visit ( <a href="#">Deductible</a> does not apply)	\$35/visit ( <a href="#">Deductible</a> 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), <a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	\$300/visit (if surgery), <a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	Pre-authorization is required.  No charge if services rendered at a <b>KPPFree provider</b> .  Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Physician/surgeon fees	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	No charge if services rendered at a <b>KPPFree provider</b> .  Out-of-Network 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
		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 <a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	\$35/visit or <a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price) Pre-authorization is required.
	Inpatient services	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
If you are pregnant	Office visits	\$35/visit ( <a href="#">Deductible</a> does not apply)	\$35/visit ( <a href="#">Deductible</a> does not apply)	Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Childbirth/delivery professional services	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	Childbirth/delivery facility services	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	\$300 surgical <a href="#">copayment</a> 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	<a href="#">Home health care</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	<a href="#">Rehabilitation services</a>	\$35/visit ( <a href="#">Deductible</a> does not apply)	\$35/visit ( <a href="#">Deductible</a> does not apply)	No charge if services rendered at a <b>KPPFree provider</b> . Physical Therapy/Manipulative Therapy limited to allowable of up to \$95/visit and 26 visits per Calendar Year.
	<a href="#">Habilitation services</a>	\$35/visit ( <a href="#">Deductible</a> does not apply)	\$35/visit ( <a href="#">Deductible</a> does not apply)	Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	<a href="#">Skilled nursing care</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	Limited to 365 days per lifetime. Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	<a href="#">Durable medical equipment</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	Limitations may apply. Out-of-Network charges are held to a percentage of Medicare. (Reference Based Price)
	<a href="#">Hospice services</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	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](http://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](#).)**

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Dental care (Child)</li> </ul> | <ul style="list-style-type: none"> <li>• Glasses</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Routine eye care (Child)</li> <li>• TMJ</li> <li>• Weight loss programs</li> </ul> |
|---|--|---|

**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"> <li>• Bariatric Services (limitations apply)</li> <li>• Chiropractic care (limitations apply)</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing Aids (limitations apply)</li> <li>• Routine foot care (limitations apply)</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing (limitations apply)</li> </ul> |
|---|---|--|

**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](http://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](http://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](http://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](#) \$750
- [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*)

<b>Total Example Cost</b>	<b>\$12,840</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$130
Coinsurance	\$3,530
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$4,410</b>

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

- The [plan's](#) overall [deductible](#) \$750
- [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*)

<b>Total Example Cost</b>	<b>\$7,460</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$1,530
Coinsurance	\$320
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,600</b>

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

- The [plan's](#) overall [deductible](#) \$750
- [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*)

<b>Total Example Cost</b>	<b>\$1,970</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$250
Coinsurance	\$220
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,220</b>