




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, visit [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.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-800-324-9396 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$2,000 for individual / 2 covered persons must each meet the \$2,000 <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>LabCard</b> and select direct contract lab <a href="#">providers</a> .	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 plan 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> ?	\$7,000 for individuals / \$14,000 for family	The <a href="#">out-of-pocket limit</a> 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 <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> 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 Maximum Allowable Amount 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 <b>1-800-324-9396</b> for a list of Network providers.	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. <b>Out-of-Network charges are held to a percentage of Medicare (Maximum Allowable Amount).</b>
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 office or clinic</a>	Primary care visit to treat an injury or illness	\$35 <a href="#">copay</a> /visit	\$35 <a href="#">copay</a> /visit, subject to the Maximum Allowable Amount.	<a href="#">Deductible</a> does not apply.
	<a href="#">Specialist</a> visit	\$35 <a href="#">copay</a> /visit	\$35 <a href="#">copay</a> /visit, subject to the Maximum Allowable Amount.	<a href="#">Deductible</a> does not apply.
	<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.
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 – 30% <a href="#">coinsurance</a>	Lab - 30% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply; X-ray – 30% <a href="#">coinsurance</a> Subject to the Maximum Allowable Amount.	No charge if services rendered at a <b>LabCard</b> or select direct contract lab <a href="#">providers</a> . <a href="#">Deductible</a> does not apply.
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> , subject to the Maximum Allowable Amount.	No charge if services rendered at a <b>KPPFree</b> <a href="#">provider</a> .
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.crxspecialty.com">www.crxspecialty.com</a> or call 877-646-1716	Generic drugs	\$15 <a href="#">copay</a> /prescription (34 days) \$30 <a href="#">copay</a> /prescription (102 days retail or mail order)	Not Covered ( <a href="#">Walgreens and Costco are out-of-network</a> )	Premier Tier: Select OTC and Generics = No Charge.
	Preferred brand drugs	\$55 <a href="#">copay</a> /prescription (34 days) \$110 <a href="#">copay</a> /prescription (102 days retail or mail order)	Not Covered ( <a href="#">Walgreens and Costco are 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)	Not Covered ( <a href="#">Walgreens and Costco are 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 <a href="#">copay</a> /prescription	Not Covered ( <u>Walgreens and Costco are out-of-network</u> )	<p>If you are eligible to receive a subsidy through a manufacturer copay program your <a href="#">copayment</a> under the Variable Copay™ Program will be equal to the maximum subsidy available through that manufacturer <a href="#">copay</a> program. Any manufacturer copay subsidy obtained under the Variable Copay™ Program will not accumulate toward your <a href="#">deductible</a> or out-of-pocket costs.</p> <p>If you are receiving a <a href="#">prescription drug</a> through a manufacturer free drug program and you enroll in the Manufacturer Free Drug Initiative, that drug will not be covered under the Plan.</p>
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$300 <a href="#">copay</a> /visit, then 30% <a href="#">coinsurance</a>	\$300 <a href="#">copay</a> /visit, then 30% <a href="#">coinsurance</a> .  Subject to the Maximum Allowable Amount.	<p>Pre-authorization is required.</p> <p>No charge if services rendered at a <b>KPPFree</b> <a href="#">provider</a>.</p>
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> , subject to the Maximum Allowable Amount.	No charge if services rendered at a <b>KPPFree</b> <a href="#">provider</a> .
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$200 <a href="#">copay</a> /visit, then 30% <a href="#">coinsurance</a>	\$200 <a href="#">copay</a> /visit, then 30% <a href="#">coinsurance</a> .  Subject to the Maximum Allowable Amount.	<a href="#">Copayment</a> is waived if visit is due to an accident, life threatening condition or if admitted as an inpatient.
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> , subject to the Maximum Allowable Amount.	Air Ambulance limited to 120% of the Medicare rate.
	<a href="#">Urgent care</a>	\$35 <a href="#">copay</a> /visit	\$35 <a href="#">copay</a> /visit, subject to the Maximum Allowable Amount.	<a href="#">Deductible</a> does not apply.

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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 have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> , subject to the Maximum Allowable Amount.	Pre-authorization is required.  No charge if services rendered at a <b>KPPFree</b> <a href="#">provider</a> .  \$300 surgical <a href="#">copayment</a> may apply.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> , subject to the Maximum Allowable Amount.	No charge if services rendered at a <b>KPPFree</b> <a href="#">provider</a> .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <a href="#">copay</a> /visit	\$35 <a href="#">copay</a> /visit, subject to the Maximum Allowable Amount.	Some services will be subject to <a href="#">deductible</a> and <a href="#">coinsurance</a> .
	Inpatient services	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> , subject to the Maximum Allowable Amount.	Pre-authorization is required.
If you are pregnant	Office visits	\$35 <a href="#">copay</a> /visit	\$35 <a href="#">copay</a> /visit, subject to the Maximum Allowable Amount.	<a href="#">Deductible</a> does not apply.
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> , subject to the Maximum Allowable Amount.	
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> , subject to the Maximum Allowable Amount.	\$300 surgical <a href="#">copayment</a> may apply.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> , subject to the Maximum Allowable Amount.	<a href="#">Deductible</a> does not apply.
	<a href="#">Rehabilitation services</a>	\$35 <a href="#">copay</a> /visit	\$35 <a href="#">copay</a> /visit, subject to the Maximum Allowable Amount.	No charge if services rendered at a <b>KPPFree</b> <a href="#">provider</a> .  Physical Therapy/Manipulative Therapy limited to allowable of up to \$95/visit and 26 visits per Calendar Year.

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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)	
	<a href="#">Habilitation services</a>	\$35 <a href="#">copay</a> /visit	\$35 <a href="#">copay</a> /visit, subject to the Maximum Allowable Amount.	Limited to 30 days per Calendar Year.  Limitations may apply.
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> , subject to the Maximum Allowable Amount.	
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> , subject to the Maximum Allowable Amount.	
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> , subject to the Maximum Allowable Amount.	
<b>If your child needs dental or eye care</b>	Children's eye exam	No Coverage	No Coverage	Certain limited benefits may be available under Preventive Services as set forth in the ACA.
	Children's glasses	No Coverage	No Coverage	Certain limited benefits may be available under Preventive Services as set forth in the ACA.
	Children's dental check-up	No Coverage	No Coverage	Certain limited benefits may be available under Preventive Services as set forth in the ACA.

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<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>• Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> 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> <li>• Temporomandibular Joint Syndrome (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.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.advantagehealthplans.com](http://www.advantagehealthplans.com)

**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 on how 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**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**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.*

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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](#) \$2000
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 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>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$65
<a href="#">Coinsurance</a>	\$3,170
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$5,235</b>

**Managing Joe's Type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$2000
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 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>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$790
<a href="#">Copayments</a>	\$780
<a href="#">Coinsurance</a>	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,610</b>

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$2000
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 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>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,350
<a href="#">Copayments</a>	\$460
<a href="#">Coinsurance</a>	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,860</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.