




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. 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 or call 1-800-324-9396 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$1,500 for individual / 2 covered persons must each meet the \$1,500 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, LabCard and select direct contract lab 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 deductible for specific services.
What is the out-of-pocket limit for this plan?	\$4,500 for individuals / \$10,500 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 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-billing charges, preauthorization penalties, amounts in excess of the Maximum Allowable Amount, and expenses for services 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. <i>Charges are held to a percentage of Medicare. (Reference Based Price).</i>	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
		Any Provider		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay /visit		Deductible does not apply. Subject to the Maximum Allowable Amount.
	Specialist visit	\$25 copay /visit		Deductible does not apply. Subject to the Maximum Allowable Amount.
	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.
If you have a test	Diagnostic test (x-ray, blood work)	Lab - 20% coinsurance , deductible does not apply; X-ray – 20% coinsurance		No charge if services rendered at a LabCard or select direct contract lab providers . Subject to the Maximum Allowable Amount.
	Imaging (CT/PET scans, MRIs)	20% coinsurance		No charge if services rendered at a KPPFree provider .
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.crxspecialty.com or call 877-646-1716	Generic drugs	\$10 copay /prescription(34 days) \$10 copay /prescription (102 days retail or mail order)	Not Covered (<u>Walgreens and Costco are out-of-network</u>)	Premier Tier: Select OTC and Generics = No Charge. Deductible does not apply.
	Preferred brand drugs	\$45 copay /prescription(34 days) \$90 copay /prescription (102 days retail or mail order)	Not Covered (<u>Walgreens and Costco are out-of-network</u>)	You will pay the copay , 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 (<u>Walgreens and Costco are out-of-network</u>)	List of Therapeutic Alternatives available at www.advantagehealthplans.com .
				If you are eligible to receive a subsidy through a manufacturer copay program your copayment under the Variable

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Any Provider		
	Specialty drugs	\$150 copay /prescription	Not Covered (<u>Walgreens and Costco are out-of-network</u>)	<p>Copay™ Program will be equal to the maximum subsidy available through that manufacturer copay program. Any manufacturer copay subsidy obtained under the Variable Copay™ Program will not accumulate toward your deductible or out-of-pocket costs.</p> <p>If you are receiving a prescription drug 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>
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$300 copay /visit, then 20% coinsurance		<p>Pre-authorization is required.</p> <p>No charge if services rendered at a KPPFree provider.</p> <p>Subject to the Maximum Allowable Amount.</p>
	Physician/surgeon fees	20% coinsurance		<p>No charge if services rendered at a KPPFree provider.</p> <p>Subject to the Maximum Allowable Amount.</p>
If you need immediate medical attention	Emergency room care	\$100 copay /visit, then 20% coinsurance		<p>Copayment is waived if visit is due to an accident, life threatening condition or if admitted as an inpatient.</p> <p>Subject to the Maximum Allowable Amount.</p>
	Emergency medical transportation	20% coinsurance		<p>Subject to the Maximum Allowable Amount.</p> <p>Air Ambulance limited to 120% of the Medicare rate.</p>

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Any Provider		
	Urgent care		\$25 copay /visit	Deductible does not apply. Subject to the Maximum Allowable Amount.
If you have a hospital stay	Facility fee (e.g., hospital room)		20% coinsurance	Pre-authorization is required. \$300 surgical copayment may apply. Subject to the Maximum Allowable Amount. No charge if services rendered at a KPPFree provider .
	Physician/surgeon fees		20% coinsurance	Subject to the Maximum Allowable Amount. No charge if services rendered at a KPPFree provider .
If you need mental health, behavioral health, or substance abuse services	Outpatient services		\$25 copay /visit	Subject to the Maximum Allowable Amount. Some services may be subject to deductible and coinsurance .
	Inpatient services		20% coinsurance	Pre-authorization is required. Subject to the Maximum Allowable Amount.
If you are pregnant	Office visits		\$25 copay /visit	Deductible does not apply. Subject to the Maximum Allowable Amount.
	Childbirth/delivery professional services		20% coinsurance	Subject to the Maximum Allowable Amount.
	Childbirth/delivery facility services		20% coinsurance	\$300 surgical copayment may apply. Subject to the Maximum Allowable Amount.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Any Provider		
If you need help recovering or have other special health needs	Home health care	20% coinsurance		No charge if services rendered at a KPPFree provider .
	Rehabilitation services	\$25 copay /visit		
	Habilitation services	\$25 copay /visit		Physical Therapy/Manipulative Therapy limited to allowable of up to \$95/visit and 26 visits per Calendar Year.
	Skilled nursing care	20% coinsurance		Deductible does not apply. Subject to the Maximum Allowable Amount.
	Durable medical equipment	20% coinsurance		Limited to 30 days per Calendar Year.
	Hospice services	20% coinsurance		Subject to the Maximum Allowable Amount.
If your child needs dental or eye care	Children's eye exam	No Coverage		Certain limited benefits may be available under Preventive Services as set forth in the ACA.
	Children's glasses	No Coverage		Certain limited benefits may be available under Preventive Services as set forth in the ACA.
	Children's dental check-up	No Coverage		Certain limited benefits may be available under Preventive Services as set forth in the ACA.

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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)
- 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)
- Temporomandibular Joint Syndrome (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 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.

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](#) \$1,500
- [Specialist copay](#) \$25
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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 \$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$45
Coinsurance	\$2,220
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$3,765

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copay](#) \$25
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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 \$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$790
Copayments	\$535
Coinsurance	\$25
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,350

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copay](#) \$25
- Hospital (facility) [copay](#) \$100
- Other [coinsurance](#) 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 \$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,350
Copayments	\$285
Coinsurance	\$50
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,685

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