**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?** | $2,500/Individual; $5,000/Family ($3,000 embedded deductible).<br>**KPP Deductible:** $1,500/Individual ($3,000 embedded 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 Maximum Allowable Amount for out-of-network, charges for bariatric procedures, 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. | 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. **Out-of-Network charges are held to a percentage of Medicare (Maximum Allowable Amount).** |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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 | 20% coinsurance | 20% coinsurance. Subject to the Maximum Allowable Amount. | |
| | Specialist visit | 20% coinsurance | 20% coinsurance. Subject to the Maximum Allowable Amount. | |
| | Preventive care/screening/ immunization | No Charge<br>**Routine services outside of the ACA and USPSTF recommended age range:** 20% coinsurance. | No Charge<br>**Routine services outside of the ACA and USPSTF recommended age range:** 20% coinsurance. Subject to the Maximum Allowable Amount. | 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) | 20% coinsurance | 20% coinsurance. Subject to the Maximum Allowable Amount. | No charge after deductible if services rendered at a **LabCard** or select direct contract lab providers. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 20% coinsurance. Subject to the Maximum Allowable Amount. | No charge after deductible if services rendered at a **KPPFree** provider. |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.crxspecialty.com or call 1-877-646-1716. | Generic drugs | 10% coinsurance | Not Covered (Walgreens and Costco are out-of-network) | Premier Tier: Select OTC and Generics = No charge after deductible. |
| | Preferred brand drugs | 20% coinsurance | Not Covered (Walgreens and Costco are 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 | 50% drug cost | Not Covered (Walgreens and Costco are out-of-network) | |

| 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 | Generic – 10% coinsurance<br><br>Name Brand – 20% coinsurance | Not Covered (Walgreens and Costco are out-of-network) | List of Therapeutic Alternatives available at www.advantagehealthplans.com.<br><br>If you are eligible to receive a subsidy through a manufacturer copay program your copayment under the Variable 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.<br><br>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. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 20% coinsurance. Subject to the Maximum Allowable Amount. | Pre-authorization is required.<br><br>No charge after deductible if services rendered at a **KPPFree** provider. |
| | Physician/surgeon fees | 20% coinsurance | 20% coinsurance. Subject to the Maximum Allowable Amount. | No charge after deductible if services rendered at a **KPPFree** provider. |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | 20% coinsurance. Subject to the Maximum Allowable Amount. | |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance. Subject to the Maximum Allowable Amount. | Air Ambulance limited to 120% of the Medicare rate. |
| | Urgent care | 20% coinsurance | 20% coinsurance. Subject to the Maximum Allowable Amount. | |

| 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) | 20% coinsurance | 20% coinsurance. Subject to the Maximum Allowable Amount. | Pre-authorization is required.<br><br>No charge after deductible if services rendered at a **KPPFree** provider. |
| | Physician/surgeon fees | 20% coinsurance | 20% coinsurance. Subject to the Maximum Allowable Amount. | No charge after deductible if services rendered at a **KPPFree** provider. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance | 20% coinsurance. Subject to the Maximum Allowable Amount. | |
| | Inpatient services | 20% coinsurance | 20% coinsurance. Subject to the Maximum Allowable Amount. | Pre-authorization is required. |
| **If you are pregnant** | Office visits | 20% coinsurance | 20% coinsurance. Subject to the Maximum Allowable Amount. | |
| | Childbirth/delivery professional services | 20% coinsurance | 20% coinsurance. Subject to the Maximum Allowable Amount. | |
| | Childbirth/delivery facility services | 20% coinsurance | 20% coinsurance. Subject to the Maximum Allowable Amount. | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 20% coinsurance. Subject to the Maximum Allowable Amount. | |
| | Rehabilitation services | 20% coinsurance | 20% coinsurance. Subject to the Maximum Allowable Amount. | No charge after deductible if services rendered at a **KPPFree** provider.<br><br>Physical Therapy/Manipulative Therapy limited to allowable of up to $95/visit and 26 visits per Calendar Year. |
| | Habilitation services | 20% coinsurance | 20% coinsurance. Subject to the Maximum Allowable Amount. | |

| 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) | |
| | Skilled nursing care | 20% coinsurance | 20% coinsurance. Subject to the Maximum Allowable Amount. | Limited to 30 days per Calendar Year.<br><br>Pre-authorization is required. |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance. Subject to the Maximum Allowable Amount. | Limitations may apply. |
| | Hospice services | 20% coinsurance | 20% coinsurance. Subject to the Maximum Allowable Amount. | |
| **If your child needs dental or eye care** | 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 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.

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

**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.*

## 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 copayment** | **$0** |
| **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 | $2,500 |
| Copayments | $0 |
| Coinsurance | $2,020 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,580** |

### 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 copayment** | **$0** |
| **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 | $2,500 |
| Copayments | $0 |
| Coinsurance | $550 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$3,070** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$2,500** |
| **Specialist copayment** | **$0** |
| **Hospital (facility) coinsurance** | **20%** |
| **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 | $2,500 |
| Copayments | $0 |
| Coinsurance | $60 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,560** |

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