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 (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 the family deductible to be met.	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?	$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-billing charges, preauthorization penalties, amounts in excess of the Maximum Allowable Amount, charges for bariatric procedures, 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. *Charges are held to a percentage of Medicare. (Reference Based Price).*	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	$35 copay/visit		Deductible does not apply. Subject to the Maximum Allowable Amount.
	Specialist visit	$35 copay/visit		Deductible does not apply. Subject to the Maximum Allowable Amount.
	Preventive care/screening/ immunization	No Charge **Routine services outside of the ACA and USPSTF recommended age range:** 30% coinsurance after deductible is met.		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 - 30% coinsurance, deductible does not apply; X-ray – 30% 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)	30% 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 1-877-646-1716.	Generic drugs	**Retail – 34 days** $15 copay /prescription **Retail-102 days or Mail Order** $30 copay /prescription	Not Covered (Walgreens and Costco are out-of-network)	Premier Tier: Select OTC and Generics = No Charge. Deductible does not apply.
	Preferred brand drugs	**Retail – 34 days** $55 copay/prescription **Retail-102 days or Mail Order** $110 copay /prescription	Not Covered (Walgreens and Costco are out-of-network)	You will pay the copay, PLUS the difference in cost between the generic and the brand name drug if generic is available. 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 Copay™ Program will be equal to the
	Non-preferred brand drugs	**Retail or Mail Order** 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
		Any Provider		
	Specialty drugs	$150 copay /prescription	Not Covered (Walgreens and Costco are out-of-network)	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. 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)	$300 copay/visit, then 30% coinsurance		Pre-authorization is required. No charge if services rendered at a **KPPFree** provider. Subject to the Maximum Allowable Amount.
	Physician/surgeon fees	30% coinsurance		No charge if services rendered at a **KPPFree** provider. Subject to the Maximum Allowable Amount.
If you need immediate medical attention	Emergency room care	$200 copay/visit, then 30% coinsurance		Copayment is waived if visit is due to an accident, life threatening condition or if admitted as an inpatient. Subject to the Maximum Allowable Amount.
	Emergency medical transportation	30% coinsurance		Subject to the Maximum Allowable Amount. Air Ambulance limited to 120% of the Medicare rate.

Common Medical Event	Services You May Need	What You Will Pay Any Provider	Limitations, Exceptions, & Other Important Information
	Urgent care	$35 copay/visit	Deductible does not apply. Subject to the Maximum Allowable Amount.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% 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	30% 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	$35 copay/visit	Deductible does not apply. Subject to the Maximum Allowable Amount. Some services may be subject to deductible and coinsurance.
	Inpatient services	30% coinsurance	Pre-authorization is required. Subject to the Maximum Allowable Amount.
If you are pregnant	Office visits	$35 copay/visit	Deductible does not apply. Subject to the Maximum Allowable Amount.
	Childbirth/delivery professional services	30% coinsurance	Subject to the Maximum Allowable Amount.
	Childbirth/delivery facility services	30% coinsurance	$300 surgical copayment may apply. Subject to the Maximum Allowable Amount.

Common Medical Event	Services You May Need	What You Will Pay Any Provider	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	30% coinsurance	
	Rehabilitation services	$35 copay/visit	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. Deductible does not apply. Subject to the Maximum Allowable Amount.
	Habilitation services	$35 copay/visit	
	Skilled nursing care	30% coinsurance	Pre-authorization is required. Limited to 30 days per Calendar Year. Subject to the Maximum Allowable Amount.
	Durable medical equipment	30% coinsurance	Limitations may apply. Subject to the Maximum Allowable Amount.
	Hospice services	30% 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.

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.

* 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 copay	**$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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$65
Coinsurance	$2,870
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,995**

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 copay	**$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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$790
Copayments	$1,530
Coinsurance	$40
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,380**

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

The plan's overall deductible	**$3,000**
Specialist copay	**$35**
Hospital (ER) copay	**$200**
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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,780
Copayments	$425
Coinsurance	$35
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,240**

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