




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> ?	<b>\$5,000/Individual.</b> 2 covered persons must each meet the \$5,000 <a href="#">deductible</a> for the family <a href="#">deductible</a> to be met.	Generally, you must pay all of the costs from <a href="#">providers</a> 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, <a href="#">preventive services</a> , <a href="#">urgent care</a> , services rendered through <b>KPPFree™</b> , <b>QuestSelect</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> ?	<b>\$8,150/Individual; \$16,300/Family</b>	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, charges for bariatric procedures 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 <a href="#">Network providers</a> .	You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network 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</a> office or clinic	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="#">Copay</a> applies to encounter only.
	<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="#">Copay</a> applies to encounter only.
	<a href="#">Preventive care/screening/immunization</a>	No charge, <a href="#">deductible</a> waived.	No charge, <a href="#">deductible</a> waived.	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.
	<b>Routine services outside of the ACA and USPSTF recommended age range:</b> 30% <a href="#">coinsurance</a> .	<b>Routine services outside of the ACA and USPSTF recommended age range:</b> 30% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Amount.		
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Lab - 30% <a href="#">coinsurance</a> , <a href="#">deductible</a> waived.	Lab - 30% <a href="#">coinsurance</a> , <a href="#">deductible</a> waived. Subject to the Maximum Allowable Amount.	No charge if services rendered at a <b>QuestSelect</b> or select direct contract lab <a href="#">providers</a> .
		X-ray – 30% <a href="#">coinsurance</a> .	X-ray – 30% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Amount.	
	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	Generic drugs	<b>Retail - 34 days</b> \$15 <a href="#">copay</a> /prescription.	Not covered, ( <u>Walgreens and Costco are out-of-network</u> ).	Premier Tier - Select OTC and Generics = No Charge.
		<b>Retail-102 days/Mail Order</b> \$30 <a href="#">copay</a> /prescription.		

\*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)	
<p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.liviniti.com">www.liviniti.com</a> or call 1-800-710-9341.</p>	Preferred brand drugs	<p><b>Retail - 34 days</b> \$55 <a href="#">copay</a>/prescription.</p> <p><b>Retail-102 days/Mail Order</b> \$110 <a href="#">copay</a>/prescription.</p>	<p>Not covered, <u>(Walgreens and Costco are out-of-network).</u></p>	<p>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. List of Therapeutic Alternatives available at <a href="http://www.advantagehealthplans.com">www.advantagehealthplans.com</a>.</p> <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 copay 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>
	Non-preferred brand drugs	<p><b>Retail or Mail Order</b> 50% drug cost.</p>	<p>Not covered, <u>(Walgreens and Costco are out-of-network).</u></p>	<p>Limited to a 34-day supply. Contact CRx Specialty at (877) 646-1716 or visit <a href="http://www.crxspecialty.com">www.crxspecialty.com</a>.</p>
	<a href="#">Specialty drugs</a>	<p>\$150 <a href="#">copay</a>/prescription.</p>	<p>Not covered, <u>(Walgreens and Costco are out-of-network).</u></p>	<p>Limited to a 34-day supply. Contact CRx Specialty at (877) 646-1716 or visit <a href="http://www.crxspecialty.com">www.crxspecialty.com</a>.</p>
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	<p>\$300 <a href="#">copay</a>/visit, then 30% <a href="#">coinsurance</a>.</p>	<p>\$300 <a href="#">copay</a>/visit, then 30% <a href="#">coinsurance</a>. Subject to the Maximum Allowable Amount.</p>	<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	<p>30% <a href="#">coinsurance</a>.</p>	<p>30% <a href="#">coinsurance</a>. Subject to the Maximum Allowable Amount.</p>	<p>No charge if services rendered at a <b>KPPFree™</b> <a href="#">provider</a>.</p>
<p><b>If you need immediate medical attention</b></p>	<a href="#">Emergency room care</a>	<p>\$200 <a href="#">copay</a>/visit, then 30% <a href="#">coinsurance</a>.</p>		<p><a href="#">Copayment</a> is waived if visit is due to an accident, life threatening condition or if admitted as an inpatient.</p>

\*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="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a> .		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.
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	<b>Office Visit:</b> \$35 <a href="#">copay</a> /visit, <a href="#">deductible</a> waived.	<b>Office Visit:</b> \$35 <a href="#">copay</a> /visit, <a href="#">deductible</a> waived. Subject to the Maximum Allowable Amount.	None.
		<b>All Other Services:</b> 30% <a href="#">coinsurance</a> .	<b>All Other Services:</b> 30% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Amount.	
	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> for the initial visit only.	\$35 <a href="#">copay</a> for the initial visit only. Subject to the Maximum Allowable Amount.	<a href="#">Deductible</a> does not apply. Depending on the type of services, cost sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Dependent children are only covered as required by applicable law.
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a> .	30% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Amount.	None.
	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.

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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 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.	None.
	<a href="#">Rehabilitation services</a>	<b>Manipulative Therapy/PT:</b> \$35 <a href="#">copay</a> /visit, <a href="#">deductible</a> waived.	<b>Manipulative Therapy/PT:</b> \$35 <a href="#">copay</a> /visit, <a href="#">deductible</a> waived. Subject to the Maximum Allowable Amount.	No charge if services rendered at a <b>KPPFree™</b> <a href="#">provider</a> .
		<b>Speech Therapy/OT:</b> 30% <a href="#">coinsurance</a> .	<b>Speech Therapy/OT:</b> 30% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Amount.	
	<a href="#">Habilitation services</a>	<b>Manipulative Therapy/PT:</b> \$35 <a href="#">copay</a> /visit, <a href="#">deductible</a> waived.	<b>Manipulative Therapy/PT:</b> \$35 <a href="#">copay</a> /visit, <a href="#">deductible</a> waived. Subject to the Maximum Allowable Amount.	Physical Therapy/Manipulative Therapy limited to allowable of up to \$95/visit and 26 visits combined per Calendar Year.
		<b>Speech Therapy/OT:</b> 30% <a href="#">coinsurance</a> .	<b>Speech Therapy/OT:</b> 30% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Amount.	
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a> .	30% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Amount.	Limited to 30 days per Calendar Year. Pre-authorization is required.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a> .	30% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Amount.	Limitations may apply.
<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a> .	30% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Amount.	None.	
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	Certain limited benefits may be available under <a href="#">preventive services</a> .
	Children's glasses	Not covered.	Not covered.	Certain limited benefits may be available under <a href="#">preventive services</a> .

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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)	
	Children's dental check-up	Not covered.	Not covered.	Certain limited benefits may be available under <a href="#">preventive services</a> .

### 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> .)			
• Acupuncture	• Long-term care	• Private duty nursing	
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	• Routine eye care (adult)	
• Dental care (adult)		• Weight loss programs	
• Infertility treatment			

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)			
• Bariatric surgery (limited to 1 surgery per lifetime)	• Hearing Aids (limitations apply)	• Temporomandibular Joint Syndrome (limitations apply)	
• Chiropractic care (limited to 26 visits per year combined with PT)	• Routine foot care (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](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 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.

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*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](http://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](#) \$5,000
- [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>	\$5,000
<a href="#">Copayments</a>	\$45
<a href="#">Coinsurance</a>	\$2,270
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$7,315</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$5,000
- [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>	\$1,530
<a href="#">Coinsurance</a>	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,380</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$5,000
- [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>	\$1,780
<a href="#">Copayments</a>	\$425
<a href="#">Coinsurance</a>	\$35
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,240</b>

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