



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 ?	\$750/Individual. 2 covered persons must each meet the \$750 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 , urgent care , services rendered through KPPFree™ , QuestSelect 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 ?	\$5,750/Individual; \$11,500/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, amounts in excess of the Maximum Allowable Charge, 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	\$35 copay /visit, deductible waived.		Some services provided during the office visit may be subject to the deductible and coinsurance . Subject to the Maximum Allowable Charge.
	Specialist visit	\$35 copay /visit, deductible waived.		Some services provided during the office visit may be subject to the deductible and coinsurance . Subject to the Maximum Allowable Charge.
	Preventive care/screening/immunization	No charge, deductible waived. Routine services outside of the ACA and USPSTF recommended age range: 30% coinsurance .		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)	QuestSelect or Direct Contracted Lab: No charge, deductible waived.		None.
		All Other Labs: 30% coinsurance , deductible waived. Subject to the Maximum Allowable Charge.		
		X-ray: 30% coinsurance . Subject to the Maximum Allowable Charge.		
	Imaging (CT/PET scans, MRIs)	KPPFree™ Provider: No charge, deductible waived.		Preauthorization is required if services are not rendered by a KPPFree™ provider .
All Other Providers: 30% coinsurance . Subject to the Maximum Allowable Charge.				
If you need drugs to treat your illness or condition	Generic drugs	Retail (34 days): \$15 copay /drug, deductible waived.	Not covered. (Walgreens is out-of-network).	Premier Tier: Select OTC and Generics = No Charge.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Any Provider		
<p>More information about prescription drug coverage is available at www.liviniti.com or call (800) 710-9341.</p>		<p>Retail (102 days) or Mail Order: \$30 copay/drug, deductible waived.</p>		
	Preferred brand drugs	<p>Retail (34 days): \$55 copay/drug, deductible waived.</p>	<p>Not covered. <u>(Walgreens is out-of-network).</u></p>	<p>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.</p> <p>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.</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>
		<p>Retail (102 days) or Mail Order: \$110 copay/drug, deductible waived.</p>		
	Non-preferred brand drugs	<p>Retail or Mail Order: 50% of drug cost.</p>	<p>Not covered. <u>(Walgreens is out-of-network).</u></p>	
Specialty drugs	<p>\$150 copay/drug, deductible waived.</p>	<p>Not covered. <u>(Walgreens is out-of-network).</u></p>	<p>Limited to a 34-day supply. Contact CRx Specialty at (877) 646-1716 or visit www.crxspecialty.com.</p>	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Any Provider		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	KPPFree™ Provider: No charge, deductible waived.		Preauthorization is required if services are not rendered by a KPPFree™ provider .
		All Other Providers: \$300 copay /visit, then 30% coinsurance . Subject to the Maximum Allowable Charge.		
	Physician/surgeon fees	KPPFree™ Provider: No charge, deductible waived.		None.
		All Other Providers: 30% coinsurance . Subject to the Maximum Allowable Charge.		
If you need immediate medical attention	Emergency room care	\$200 copay /visit, then 30% coinsurance .	Copayment is waived if admitted as an inpatient. Subject to the Maximum Allowable Charge.	
	Emergency medical transportation	30% coinsurance .	Subject to the Maximum Allowable Charge. Air Ambulance limited to 120% of the Medicare rate.	
	Urgent care	\$35 copay /visit, deductible waived.	Subject to the Maximum Allowable Charge.	
If you have a hospital stay	Facility fee (e.g., hospital room)	KPPFree™ Provider: No charge, deductible waived.		Preauthorization is required if services are not rendered by a KPPFree™ provider . \$300 surgical copayment may apply.
		All Other Providers: 30% coinsurance . Subject to the Maximum Allowable Charge.		
	Physician/surgeon fees	KPPFree™ Provider: No charge, deductible waived.		None.
		All Other Providers: 30% coinsurance . Subject to the Maximum Allowable Charge.		

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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 mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: \$35 copay /visit, deductible waived.	Subject to the Maximum Allowable Charge.
		All Other Services: 30% coinsurance .	
	Inpatient services	30% coinsurance .	Preauthorization is required. Subject to the Maximum Allowable Charge.
If you are pregnant	Office visits	\$35 copay for the initial visit only, deductible waived.	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% coinsurance .	Subject to the Maximum Allowable Charge.
	Childbirth/delivery facility services	30% coinsurance .	Preauthorization required if stay exceeds 48 hours after normal delivery or 96 hours after C-section for mother and/or newborn \$300 surgical copay may apply. Subject to the Maximum Allowable Charge.
If you need help recovering or have other special health needs	Home health care	30% coinsurance .	Limited to 30 days per calendar year. Subject to the Maximum Allowable Charge.
	Rehabilitation services	KPPFree™ Provider: No charge, deductible waived.	Physical therapy and chiropractic care is limited to allowable of up to \$120/visit.
		Chiropractic Care & PT: \$35 copay /visit, deductible waived. Subject to the Maximum Allowable Charge.	
	Habilitation services		Each therapy is limited to 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
		Any Provider	
		Speech Therapy & OT: 30% coinsurance . Subject to the Maximum Allowable Charge.	
	Skilled nursing care	30% coinsurance .	Limited to 30 days per calendar year. Preauthorization is required. Subject to the Maximum Allowable Charge.
	Durable medical equipment	30% coinsurance .	Limitations may apply. Subject to the Maximum Allowable Charge.
	Hospice services	30% coinsurance .	Subject to the Maximum Allowable Charge.
If your child needs dental or eye care	Children's eye exam	Not covered.	Certain limited benefits may be available under preventive services .
	Children's glasses	Not covered.	Certain limited benefits may be available under preventive services .
	Children's dental check-up	Not covered.	Certain limited benefits may be available under preventive services .

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 .)		
<ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care (adult) • Infertility treatment 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private duty nursing • Routine eye care (adult) • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Bariatric surgery (limited to 1 surgery per lifetime) • Chiropractic care (limited to 26 visits per calendar year) 	<ul style="list-style-type: none"> • Hearing Aids (limitations apply) • Routine foot care (limitations apply) 	<ul style="list-style-type: none"> • 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

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

[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](#) \$750
- [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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$750
Copayments	\$65
Coinsurance	\$3,550
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$4,365

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$750
- [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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$750
Copayments	\$1,530
Coinsurance	\$50
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,350

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$750
- [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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$750
Copayments	\$425
Coinsurance	\$340
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,515

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