




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> ?	<p><b>KPPFree™ Deductible:</b>                      \$1,700/Individual                      (\$3,400 embedded <a href="#">deductible</a>).</p> <p><b>\$2,500/Individual; \$5,000/Family</b>                      (\$3,400 embedded <a href="#">deductible</a>).</p>	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, <a href="#">preventive services</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. 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>\$5,000/Individual; \$10,000/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, amounts in excess of the Maximum Allowable Charge, 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 1-800-324-9396 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</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 Charge).</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	20% <a href="#">coinsurance</a> .	20% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Charge.	None.	
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a> .	20% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Charge.	None.	
	<a href="#">Preventive care/screening/</a> immunization	No charge, <a href="#">deductible</a> waived.	No charge, <a href="#">deductible</a> waived. Subject to the Maximum Allowable Charge.	<b>Routine services outside of the ACA and USPSTF recommended age range:</b> 20% <a href="#">coinsurance</a> . <b>Routine services outside of the ACA and USPSTF recommended age range:</b> 20% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Charge.	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> 20% <a href="#">coinsurance</a> .			
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	<b>QuestSelect or Direct Contracted Lab:</b> No charge, after <a href="#">deductible</a> .	20% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Charge.	None.	
		<b>All Other Labs &amp; X-ray:</b> 20% <a href="#">coinsurance</a> .			
	Imaging (CT/PET scans, MRIs)	<b>KPPFree™ Provider:</b> No charge, after <a href="#">deductible</a> .	20% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Amount.	<a href="#">Preauthorization</a> is required if services are not rendered by a KPPFree™ provider.	
		<b>All Other Providers:</b> 20% <a href="#">coinsurance</a> .			

\*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><b>If you need drugs to treat your illness or condition</b></p> <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 (800) 710-9341.</p>	Generic drugs	10% <a href="#">coinsurance</a> .	Not covered. <u>(Walgreens is out-of-network)</u> .	<p>Premier Tier: Select OTC and Generics = No charge after <a href="#">deductible</a>.</p> <p>You will pay the <a href="#">deductible</a> and <a href="#">coinsurance</a>, PLUS the difference in cost between the generic and the brand name drug if generic is available.</p> <p>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>
	Preferred brand drugs	20% <a href="#">coinsurance</a> .	Not covered. <u>(Walgreens is out-of-network)</u> .	
	Non-preferred brand drugs	50% of drug cost.	Not covered. <u>(Walgreens is out-of-network)</u> .	
	<a href="#">Specialty drugs</a>	<b>Generic:</b> 10% <a href="#">coinsurance</a> .	Not covered. <u>(Walgreens is out-of-network)</u> .	
<b>Name Brand:</b> 20% <a href="#">coinsurance</a> .				
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	<p><b>KPPFree™ Provider:</b> No charge, after <a href="#">deductible</a>.</p> <p><b>All Other Providers:</b> 20% <a href="#">coinsurance</a>.</p>	20% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Charge.	<a href="#">Preauthorization</a> is required if services are not rendered by a KPPFree™ provider.

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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)	
	Physician/surgeon fees	<b>KPPFree™ Provider:</b> No charge, after <a href="#">deductible</a> . <b>All Other Providers:</b> 20% <a href="#">coinsurance</a> .	20% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Charge.	None.
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a> .		None.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> .		Air Ambulance limited to 120% of the Medicare rate.
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a> .	20% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Charge.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	<b>KPPFree™ Provider:</b> No charge, after <a href="#">deductible</a> . <b>All Other Providers:</b> 20% <a href="#">coinsurance</a> .	20% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Charge.	<a href="#">Preauthorization</a> is required if services are not rendered by a KPPFree™ provider.
	Physician/surgeon fees	<b>KPPFree™ Provider:</b> No charge, after <a href="#">deductible</a> . <b>All Other Providers:</b> 20% <a href="#">coinsurance</a> .	20% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Charge.	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a> .	20% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Charge.	None.
	Inpatient services	20% <a href="#">coinsurance</a> .	20% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Amount.	<a href="#">Preauthorization</a> is required.
If you are pregnant	Office visits	20% <a href="#">coinsurance</a> .	20% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Charge.	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	20% <a href="#">coinsurance</a> .	20% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Charge.	None.

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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)	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> .	20% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Charge.	<a href="#">Preauthorization</a> required if stay exceeds 48 hours after normal delivery or 96 hours after C-section for mother and/or newborn.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a> .	20% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Charge.	Limited to 30 days per calendar year.
	<a href="#">Rehabilitation services</a>	<b>KPPFree™ Provider:</b> No charge, after <a href="#">deductible</a> .	20% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Charge.	Physical therapy and chiropractic care is limited to allowable of up to \$120/visit.  Each therapy is limited to 26 visits per calendar year.
		<b>All Other Providers:</b> 20% <a href="#">coinsurance</a> .		
	<a href="#">Habilitation services</a>	<b>KPPFree™ Provider:</b> No charge, after <a href="#">deductible</a> .  <b>All Other Providers:</b> 20% <a href="#">coinsurance</a> .	20% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Charge.	None.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a> .	20% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Charge.	Limited to 30 days per calendar year. <a href="#">Preauthorization</a> is required.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> .	20% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Charge.	Limitations may apply.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a> .	20% <a href="#">coinsurance</a> . Subject to the Maximum Allowable Charge.	None.
<b>If your child needs dental or eye care</b>	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> .
	Children's dental check-up	Not covered.	Not covered.	Certain limited benefits may be available under <a href="#">preventive services</a> .

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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)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Bariatric Surgery (limited to 1 surgery per lifetime)
- Chiropractic care (limited to 26 visits per calendar year)
- Hearing aids (limitations apply)
- Routine foot care (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](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.

*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](#) \$2,500
- [Specialist coinsurance](#) 20%
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,020
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$4,520</b>

### 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 coinsurance](#) 20%
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$560
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,080</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist coinsurance](#) 20%
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$60
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,560</b>

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