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?	**KPP*Free*™ deductible:** $1,750/Individual ($3,500 embedded deductible). **All Other Providers:** $5,000/Individual; $10,000/Family	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. 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?	**$7,500/Individual; $15,000/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.** *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 Any Provider		Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance.		Subject to the Maximum Allowable Charge.
	Specialist visit	20% 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:** 20% 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, after deductible is met. **All Other Labs:** 20% coinsurance. Subject to the Maximum Allowable Charge. **X-ray:** 20% coinsurance. Subject to the Maximum Allowable Charge.		None.
	Imaging (CT/PET scans, MRIs)	**KPP*Free*™ Provider:** No charge, after deductible is met. **All Other Providers:** 20% coinsurance. Subject to the Maximum Allowable Charge.		Preauthorization is required if services are not rendered by a KPP*Free*™ provider.
If you need drugs to treat your illness or condition	Generic drugs	**Retail or Mail Order:** 10% coinsurance.	Not covered. (Walgreens is out-of-network).	Premier Tier: Select OTC and Generics = No charge after deductible.

*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 Any Provider		Limitations, Exceptions, & Other Important Information
More information about **prescription drug coverage** is available at www.liviniti.com or call (800) 710-9341.	Preferred brand drugs	**Retail (34 days):** 20% coinsurance.	Not covered. (Walgreens is out-of-network).	You will pay the deductible, 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.
		Retail (102 days) or Mail Order: 20% coinsurance.		
	Non-preferred brand drugs	**Retail or Mail Order:** 20% coinsurance.	Not covered. (Walgreens is out-of-network).	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. 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.
	Specialty drugs	20% coinsurance.	Not covered. (Walgreens is out-of-network).	Limited to a 34-day supply. Contact CRx Specialty at (877) 646-1716 or visit www.crxspecialty.com.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**KPP*Free*™ Provider:** No charge, after deductible is met.		Preauthorization is required if services are not rendered by a KPP*Free*™ provider.
		All Other Providers: $300 copay/visit, then 20% coinsurance. Subject to the Maximum Allowable 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 Any Provider	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees	**KPP*Free*™ Provider:** No charge, after deductible is met. **All Other Providers:** 20% coinsurance. Subject to the Maximum Allowable Charge.	None.
If you need immediate medical attention	Emergency room care	20% coinsurance.	Subject to the Maximum Allowable Charge.
	Emergency medical transportation	20% coinsurance.	Subject to the Maximum Allowable Charge. Air Ambulance limited to 120% of the Medicare rate.
	Urgent care	20% coinsurance.	Subject to the Maximum Allowable Charge.
If you have a hospital stay	Facility fee (e.g., hospital room)	**KPP*Free*™ Provider:** No charge, after deductible is met. **All Other Providers:** 20% coinsurance. Subject to the Maximum Allowable Charge.	Preauthorization is required if services are not rendered by a KPP*Free*™ provider.
	Physician/surgeon fees	**KPP*Free*™ Provider:** No charge, after deductible is met. **All Other Providers:** 20% coinsurance. Subject to the Maximum Allowable Charge.	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance.	Subject to the Maximum Allowable Charge.
	Inpatient services	20% coinsurance.	Preauthorization is required. Subject to the Maximum Allowable 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 Any Provider	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	20% coinsurance.	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Subject to the Maximum Allowable Charge. Dependent children are only covered as required by applicable law.
	Childbirth/delivery professional services	20% coinsurance.	Subject to the Maximum Allowable Charge.
	Childbirth/delivery facility services	20% coinsurance.	Preauthorization required if stay exceeds 48 hours after normal delivery or 96 hours after C-section for mother and/or newborn. Subject to the Maximum Allowable Charge.
If you need help recovering or have other special health needs	Home health care	20% coinsurance.	Limited to 30 days per calendar year. Subject to the Maximum Allowable Charge.
	Rehabilitation services Habilitation services	**KPP*Free*™ Provider:** No charge, after deductible is met. **All Other Providers:** 20% coinsurance. Subject to the Maximum Allowable Charge.	Physical therapy and chiropractic care visits are limited to the allowable of up to $120/visit. Each therapy is limited to 26 visits each per calendar year.
	Skilled nursing care	20% coinsurance, after deductible.	Preauthorization is required. Limited to 30 days per calendar year. Subject to the Maximum Allowable Charge.
	Durable medical equipment	20% coinsurance.	Limitations may apply. Subject to the Maximum Allowable Charge.
	Hospice services	20% 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.

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

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	• 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 plan 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 calendar year)	• 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. 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.

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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	**$5,000**
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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$1,520
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$6,520**

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 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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$85
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,105**

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

The plan's overall deductible	**$5,000**
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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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