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?	**$1,500/Individual.** 2 covered persons must each meet the $1,500 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 **KPP*Free*™, 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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$4,500/Individual; $10,500/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-billed charges, amounts in excess of the Maximum Allowable Charge, and health care 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?	**Yes.** See www.advantagehealthplans.com or call **1-800-324-9396** for a list of Network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. **Out-of-Network charges are held to a percentage of Medicare (Maximum Allowable Charge).**
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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit, deductible waived.	$25 copay/visit, deductible waived. Subject to the Maximum Allowable Charge.	Some services provided during the office visit may be subject to the deductible and coinsurance.
	Specialist visit	$25 copay/visit, deductible waived.	$25 copay/visit, deductible waived. Subject to the Maximum Allowable Charge.	Some services provided during the office visit may be subject to the deductible and coinsurance.
	Preventive care/screening/ immunization	No charge, deductible waived.	No charge, deductible waived. Subject to the Maximum Allowable Charge.	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.
		Routine services outside of the ACA and USPSTF recommended age range: 20% coinsurance.	**Routine services outside of the ACA and USPSTF recommended age range:** 20% coinsurance. Subject to the Maximum Allowable Charge.	
If you have a test	Diagnostic test (x-ray, blood work)	**QuestSelect or Direct Contracted Lab:** No charge, deductible waived.	**Lab:** 20% coinsurance, deductible waived. Subject to the Maximum Allowable Charge.	None.
		All Other Labs: 20% coinsurance, deductible waived.		
		X-ray: 20% coinsurance.	**X-ray:** 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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	**KPP*Free*™ Provider:** No charge, deductible waived. **All Other Providers:** 20% coinsurance.	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 More information about **prescription drug coverage** is available at www.liviniti.com or call (800) 710-9341.	Generic drugs	**Retail or Mail Order:** $10 copay/drug.	Not covered. (Walgreens is out-of-network).	Premier Tier: Select OTC and Generics = No Charge.
	Preferred brand drugs	**Retail (34 days):** $45 copay/drug. **Retail (102 days) or Mail Order:** $90 copay/drug.	Not covered. (Walgreens is out-of-network).	You will pay the copayment, 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 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.
	Non-preferred brand drugs	**Retail or Mail Order:** 50% of drug cost.	Not covered. (Walgreens is out-of-network).	
	Specialty drugs	$150 copay/drug.	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.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**KPP*Free*™ Provider:** No charge, deductible waived. **All Other Providers:** $300 copay/visit, then 20% coinsurance.	$300 copay/visit, then 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, deductible waived. **All Other Providers:** 20% coinsurance.	20% coinsurance. Subject to the Maximum Allowable Charge.	None.
If you need immediate medical attention	Emergency room care	$100 copay/visit, then 20% coinsurance.		Copayment is waived if Accident, Life Threatening, or Admitted
	Emergency medical transportation	20% coinsurance.		Air Ambulance limited to 120% of the Medicare rate.
	Urgent care	$25 copay/visit, deductible waived.	$25 copay/visit, deductible waived. Subject to the Maximum Allowable Charge.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	**KPP*Free*™ Provider:** No charge, deductible waived. **All Other Providers:** 20% coinsurance.	20% coinsurance. Subject to the Maximum Allowable Charge.	Preauthorization is required if services are not rendered by a KPP*Free*™ provider. $300 surgical copay may apply.
	Physician/surgeon fees	**KPP*Free*™ Provider:** No charge, deductible waived. **All Other Providers:** 20% coinsurance.	20% coinsurance. Subject to the Maximum Allowable Charge.	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Office Visits:** $25 copay/visit, deductible waived. **All Other Services:** 20% coinsurance.	**Office Visits:** $25 copay/visit, deductible waived. Subject to the Maximum Allowable Charge. **All Other Services:** 20% coinsurance. Subject to the Maximum Allowable Charge.	None.

*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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Inpatient services	20% coinsurance.	20% coinsurance. Subject to the Maximum Allowable Amount.	Preauthorization is required.
If you are pregnant	Office visits	$25 copay for the initial visit only, deductible waived.	$25 copay for the initial visit only, deductible waived. 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% coinsurance.	20% coinsurance. Subject to the Maximum Allowable Charge.	None.
	Childbirth/delivery facility services	20% coinsurance.	20% coinsurance. Subject to the Maximum Allowable Charge.	Preauthorization required if stay exceeds 48 hours after normal delivery or 96 hours after C-section for mother and/or newborn. $300 surgical copayment may apply.
If you need help recovering or have other special health needs	Home health care	20% coinsurance.	20% coinsurance. Subject to the Maximum Allowable Charge.	Limited to 30 days per calendar year.
	Rehabilitation services Habilitation services	**KPP*Free*™ Provider:** No charge, deductible waived. **Chiropractic Care & PT:** $25 copay/visit, deductible waived.	**Chiropractic Care & PT:** $25 copay/visit, deductible waived. 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.
		Speech Therapy & OT: 20% coinsurance.	**Speech Therapy & OT:** 20% coinsurance. Subject to the Maximum Allowable Charge.	
	Skilled nursing care	20% coinsurance.	20% coinsurance. Subject to the Maximum Allowable Charge.	Limited to 30 days per calendar year. Preauthorization is required.

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)	
	Durable medical equipment	20% coinsurance.	20% coinsurance. Subject to the Maximum Allowable Charge.	Limitations may apply.
	Hospice services	20% coinsurance.	20% coinsurance. Subject to the Maximum Allowable Charge.	None.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	Certain limited benefits may be available under preventive services.
	Children's glasses	Not covered.	Not covered.	Certain limited benefits may be available under preventive services.
	Children's dental check-up	Not covered.	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.)

- 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. 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.

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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	**$1,500**
Specialist copayment	**$25**
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	$1,500
Copayments	$35
Coinsurance	$2,220
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,755**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,500**
Specialist copayment	**$25**
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	$790
Copayments	$1,145
Coinsurance	$25
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,980**

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

The plan's overall deductible	**$1,500**
Specialist copayment	**$25**
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	$1,500
Copayments	$260
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,860**

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