



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.kbasolution.com](http://www.kbasolution.com) or by calling 1-800-278-5488.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Network \$0; Non-network \$500 Doesn't apply to preventive care. <u>Co-payments</u> do not apply to the <u>deductible</u> .	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket</u> limit on my expenses?	Yes. Network providers \$1,850 person/\$12,700 family; Non-Network providers no maximum	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket</u> limit?	Premiums, balance-billed charges, penalties & health care this plan doesn't cover. All co-pays apply to the <u>out-of-pocket</u> limit.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of <u>providers</u> , see <a href="http://www.multiplan.com">www.multiplan.com</a> or call 888-342-7427.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a <u>specialist</u> .	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <u>excluded services</u> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		Network Provider	Non-Network Provider	
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	\$15 co-pay/visit	60% co-insurance	Co-pay applies to the office visit charge only.
	Minimum annual care requirements for 25 chronic diseases	No charge	60% co-insurance	Services are limited to those stated in the plan document.
	Specialist visit	\$25 co-pay/visit	60% co-insurance	Co-pay applies to the office visit charge only.
	Minimum annual care requirements for 25 chronic diseases	No charge	60% co-insurance	Services are limited to those stated in the plan document.
	Other practitioner office visit	No coverage for chiropractor or acupuncture	No coverage for chiropractor or acupuncture	-none-
	Preventive care/screening/immunization	No charge	60% co-insurance	Services are limited to those mandated by the Patient Protection Affordable Care Act.
If you have a test	Diagnostic test (x-ray, blood work)	\$50 co-pay/service	60% co-insurance	-none-
	Minimum annual care requirements for 25 chronic diseases	No charge	60% co-insurance	Services are limited to those stated in the plan document.
	Imaging (CT/PET scans, MRIs)	\$400 co-pay/image	60% co-insurance	-none-

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# American Staff Corp. MVP Health Plan: Key Benefit Administrators

Coverage Period: 12/01/2014 – 11/30/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual or Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		Network Provider	Non-Network Provider	
<b>If you need drugs to treat your illness or condition</b>  <b>More information about prescription drug coverage is available at <a href="http://www.caremark.com">www.caremark.com</a></b>	Generic drugs	\$15 co-pay retail & \$37.50 co-pay mail order	Not covered	Limit of 34 day supply retail & 90 day supply mail order.
	Preferred brand drugs	\$25 co-pay retail & \$62.50 co-pay mail order	Not covered	Limit of 34 day supply retail & 90 day supply mail order.
	Non-preferred brand drugs	\$75 co-pay retail & \$187.50 co-pay mail order	Not covered	Limit of 34 day supply retail & 90 day supply mail order.
	Specialty drugs	Not covered	Not covered	-none-
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	-none-
	Physician/surgeon fees	Not covered	Not covered	-none-
<b>If you need immediate medical attention</b>	Emergency room services	\$400 co-pay/visit	\$400 co-pay/visit	Co-pay applies to network out-of-pocket. Non-network subject to network out-of-pocket.
	Emergency medical transportation	Not covered	Not covered	-none-
	Urgent care	Primary care physician \$15 co-pay/visit; Specialist \$25 co-pay/visit	60% co-insurance	Co-pay applies to the office visit charge only.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not covered	Not covered	-none-
	Physician/surgeon fee	Primary care physician \$15 co-pay/visit; Specialist \$25 co-pay/visit	Not covered	Surgeon fees are not covered.
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	Not covered	Not covered	-none-
	Mental/Behavioral health inpatient services	Not covered	Not covered	-none-
	Substance use disorder outpatient services	Not covered	Not covered	-none-

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Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		Network Provider	Non-Network Provider	
	Substance use disorder inpatient services	Not covered	Not covered	-none-
If you are pregnant	Prenatal and postnatal care	0% co-insurance	60% co-insurance	No charge for routine prenatal.
	Delivery and all inpatient services	Not covered	Not covered	-none-
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	-none-
	Rehabilitation services	Not covered	Not covered	-none-
	Habilitation services	Not covered	Not covered	-none-
	Skilled nursing care	Not covered	Not covered	-none-
	Durable medical equipment	Not covered	Not covered	-none-
	Hospice service	Not covered	Not covered	-none-
If your child needs dental or eye care	Eye exam	Not covered	Not covered	-none-
	Glasses	Not covered	Not covered	-none-
	Dental check-up	Not covered	Not covered	-none-

**Excluded Services & Other Covered Services:**

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Weight loss programs (PPACA services only)

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## Your Rights to Continue Coverage:

If you lose coverage under the plan, then depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 800-278-5488. You may also contact your state insurance department, the US Department of Labor, Employee Benefits Security Administration at 866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or [www.ciio.dms.gov](http://www.ciio.dms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Key Benefit Administrators at 800-278-5488 or Employee Benefits Security Administration at 1-866-444-3272. [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides. This plan does not prevent an otherwise qualified individual from obtaining a premium tax credit through the Health Care Marketplace.

## Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 800-278-5488.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-278-5488.

CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 800-278-5488.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 800-278-5488.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$190
- Patient pays \$7,350

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$0
Copays	\$640
Coinsurance	\$0
Limits or exclusions	\$6,710
<b>Total</b>	<b>\$7,350</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,160
- Patient pays \$2,240

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$0
Copays	\$890
Coinsurance	\$0
Limits or exclusions	\$1,350
<b>Total</b>	<b>\$2,240</b>

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 800-352-5071.

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your

providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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