



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, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network (INN): Individual (IND) \$250/ Family (FAM) \$500. Out-of-Network (OON): IND \$750/ FAM \$1,500. OON co-insurance and copayments don't count toward the deductible (DED). Does not apply to preventive care.	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. In-network office visits, prescription drugs & preventive care are covered before you meet your deductible.	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?	Yes.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. Medical: INN: IND \$3,600/ FAM \$7,200. OON: IND \$10,000/ FAM \$20,000.	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, penalties for failure to obtain preauthorization, balance-billed charges, services which have specific limits, services & 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. For a list of in-network providers, see the "provider" tab at www.ManateeYourChoice.com or call 1-877-580-5019.	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.
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
		In-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	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	20% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	20% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	20% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Precertification may be required.
If you need drugs to treat your illness or condition <u>Prescription drug coverage is administered by Optum RX</u> More information about <u>prescription</u>	Generic drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$10 for 1-30 days, \$20 for 31-60 days, \$30 for 61-90 days	Not covered	See the "Pharmacy Benefit" tab at www.manateeyourchoice.com for specifics on the <u>formulary</u> for this <u>plan</u> . More information about <u>prescription drug coverage</u> is available by calling the <u>plan's</u> Pharmacy Technician: 941-748-4501 ext. 6418.
	Preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$15 or 25% up to \$100 maximum (30 days) whichever is greater	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<u>drug coverage</u> is available at www.optumrx.com	Non-preferred brand drugs	<u>Copay/prescription, deductible doesn't apply</u> : \$40 or 45% up to \$100 maximum (30 days) whichever is greater	Not covered	
	<u>Specialty drugs</u>	25% <u>coinsurance, deductible doesn't apply</u> with \$150 maximum or manufacturer's coupon.	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> after \$200 <u>copay/visit</u>	20% <u>coinsurance</u> after \$200 <u>copay/visit</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> after \$250 <u>copay/stay</u>	20% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	BH- LAMP OP Counseling: No charge first 5 visits; \$15 <u>copay</u> thereafter Psychiatric: 1st visit no <u>copay</u> ; \$30 <u>copay</u> thereafter BH - Other <u>providers</u> OP Counseling: No charge first 5 visits; \$30 <u>copay</u> thereafter Psychiatric: \$30 <u>copay</u> each visit	20% <u>coinsurance</u>	None
	Inpatient services	BH & SA - INP services No charge SA disorder - OP detox 20% <u>coinsurance</u> SA disorder - intensive OP 20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you are pregnant	Office visits	No charge	20% <u>coinsurance</u>	Cost sharing does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u> after \$250 <u>copay</u> /stay	20% <u>coinsurance</u>	
	Home health care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	120 visits/calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Coverage is combined to 90 separate visits for Speech, Physical and Occupational Therapy. Note: The 90 visits per calendar year include the max 5 visits per calendar year allowed at an outpatient hospital/facility. Refer to <u>plan</u> document for coverage limitation on other Alternate Care Benefits. No out-of-network benefits for Nutritional Therapy and Acupuncture.
	<u>Habilitation services</u>	20% <u>coinsurance</u> ; Autism: \$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply initial evaluation; \$10 <u>copay</u> thereafter	20% <u>coinsurance</u>	Covers for treatment of Autism. Includes Applied Behavioral Analysis. no age/frequency limits. Autism PT/OT/ST Habilitative/ Rehabilitative PT/OT/ST: no age/ frequency limits.
	<u>Skilled nursing care</u>	No charge first 10 days; 20% <u>coinsurance</u> thereafter.	\$200 <u>copay</u> per day (first 20 days) then 20% <u>coinsurance</u> thereafter.	60 days/calendar year. Hospital Inpatient per confinement <u>deductible</u> and <u>coinsurance</u> applies.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Hospice services</u>	No charge	20% <u>coinsurance</u>	None
If your child needs dental or eye care	Children's eye exam	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Same for Adults. Additional coverage for 1 routine exam for diagnosis of diabetes.
	Children's glasses	Not covered	Not covered	Same for Adults. Refer to <u>plan</u> document for coverage for glasses following cataract surgery.
	Children's dental check-up	None	Expenses over the Allowed Amount	Limited to 2 exams/calendar year. Refer to <u>plan</u> document for list of covered 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.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care - unless needed due to severe systemic disease.
- Weight loss programs - unless pre-approved by Medical Management.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture - 20 visits/calendar year for disease, injury & chronic pain in-network only.
- Bariatric surgery
- Chiropractic care - 20 visits/calendar year.
- Hearing aids - \$5,000 maximum/7 years.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Routine eye care (Adult) - Covers 1 routine exam for diagnosis of diabetes in addition to annual routine exam.

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:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-370-4526. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

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 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.

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

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 \$250
- Specialist copayment \$30
- 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:	
<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$300
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,670

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

- The plan's overall deductible \$250
- Specialist copayment \$30
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

- Primary care provider office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Diabetic supplies (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$100
<u>Copayments</u>	\$900
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,020

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

- The plan's overall deductible \$250
- Specialist copayment \$30
- 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:	
<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$300
<u>Copayments</u>	\$70
<u>Coinsurance</u>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$770

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

[Assistive Technology](#)

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

[Smartphone or Tablet](#)

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

TTY: 711

- English - **To access language services at no cost to you, call 1-800-370-4526.**
- Amharic - የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-370-4526 ይደውሉ።.
- Arabic - للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-800-370-4526.
- Armenian - Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-370-4526 հեռախոսահամարով:
- Carolinian (Kapasal Falawasch) - ngere aukke ghut allis reel kapasal Falawasch au fafaingi tilifon ye 1-800-370-4526.
- Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-800-370-4526.
- Chinese Traditional - 如欲使用免費語言服務，請致電 1-800-370-4526.
- Cushitic-Oromo - Tajaajiloota afaanii garuu bilisaa ati argaachuuf, bilibili 1-800-370-4526.
- French - Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526.
- French Creole (Haitian)- Pou jwenn sèvis lang gratis, rele 1-800-370-4526.
- German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-370-4526 an.
- Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-800-370-4526.
- Gujarati - તમારેકોઇ જાતના બર્થવિના ભાષાની સે વિના ઓની પછોર માટે, કોલ કરો 1-800-370-4526.
- Hindi - आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-800-370-4526 पर कॉल करें।.
- Hmong - Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-800-370-4526.
- Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-370-4526.
- Japanese - 言語サービスを無料でご利用いただくには、1-800-370-4526 までお電話ください。
- Karen - လာတၢ်ကမၤန့ၢ်ကိၣ်အတၢ်မၤစၢအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-800-370-4526 တက့ၢ်.
- Korean - 무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오.
- Laotian - ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-800-370-4526.
- Mon-Khmer, Cambodian - ដើម្បីទទួលបានសេវាកម្មភាសាដោយឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ។

