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 documents at www.ManateeYourChoice.com. Note: the Uniform Glossary can be accessed at : www.dol.gov/ebsa/healthreform.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Each Calendar Year, In-network: $250; Out-of-network: $750. Out-of-network co-insurance and copayments don't count toward the deductible. Does not apply to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. The **deductible** starts over at the start of each new calendar year. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. Hospital Inpatient(Facility) : In-network: $250; Out-of-network: $750 per confinement. Behavioral Health & Substance Abuse: In-network : $0; Out-of-network: $200 for outpatient services. There are no other specific deductibles	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.
Is there an out-of-pocket limit on my expenses?	Yes. Medical: In-network $1,800 Out-of-network: $5,000. Hospital Inpatient(Facility) : In-network: $1,000; Out-of-network: $2,450	The **out-of-pocket limit** is the most you could pay annually for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Deductibles, Co-pays, Premiums, penalties for failure to obtain pre-authorization, balance-billed charges, services and health care this plan doesn't cover and services which have specific limits.	Even though you pay these expenses, they don't count toward the **out-of-pocket 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 network of providers?	Yes. For a list of **in-network providers**, see the "provider" tab at www.ManateeYourChoice.com or call 1-877-580-5019.	If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term **in-network**, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** 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 3. See your policy or plan document for additional information about **excluded services.**

- **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 in-network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	20% coinsurance	———— None ————
	Specialist visit	$25 copay per visit	20% coinsurance	———— None ————
	Other practitioner office visit	$25 copay per visit	20% coinsurance	This also includes Alternate Care Providers. Refer to plan document for separate tiered copays on Nutritional Therapy.
	Preventive care/ screening/ immunization	No charge	20% coinsurance	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	———— None ————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	Precertification required.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition- More information about prescription drug coverage is available by calling the plan's clinical pharmacist: 941-748-4501 ext.6406	Generic drugs	$5 for 1-30days $10 for 31-60days $15 for 61-90 days	$15 or 20% of drug cost, whichever is greater..	See the "Pharmacy Benefit" tab at www.manateeyourchoice.com for specifics on the formulary for this plan.
	Preferred brand drugs	$15 or 25% of drug cost, whichever is greater.	$20 or 30% of drug cost, whichever is greater.	
	Non-preferred brand drugs	$40 or 45% of drug cost, whichever is greater.	$50 or 55% of drug cost, whichever is greater.	
	Specialty drugs	25% coinsurance or $150 maximum or manufacturer's coupon.	25% coinsurance or $150 maximum or manufacturer's coupon.	Preauthorization required (must be obtained through Optum Specialty Pharmacy).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	———— None ————
	Physician/surgeon fee	20% coinsurance	20% coinsurance	———— None ————
If you need immediate medical attention	Emergency room services	$150 copay per visit	$150 copay per visit	Non emergency care is not covered.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Non emergency use is not covered.
	Urgent care	20% coinsurance	20% coinsurance	———— None ————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after $250 per confinement copay for inpatient	20% coinsurance after $750 per confinement copay for inpatient	———— None ————
	Physician/surgeon fee	20% coinsurance	20% coinsurance	———— None ————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs (MCG has opted out of the Mental Health Parity Act)	Behavioral Health - LAMP	Outpatient Counseling: No charge first 5 visits; $15 copay thereafter Psychiatric: 1st visit no copay; $15 copay thereafter	NA	Coverage limited to 42 visits per calendar year combined for Behavioral Health & Alcohol/Substance Abuse. Precertification required. 50% penalty for non- precertification.
	Behavioral Health - Other providers	Outpatient Counseling: No charge first 5 visits; $25 copay thereafter Psychiatric: $25 copay each visit	40% coinsurance	Coverage limited to 42 visits per calendar year combined for Behavioral Health & Alcohol/ Substance Abuse. Precertification required. 50% penalty for non- precertification.
	Behavioral Health & Substance Abuse - inpatient services	No charge	$300 per day copay for first 5 days & 40% coinsurance	Coverage limited to 30 days per calendar year combined for Behavioral Health & Alcohol/Substance Abuse. Precertification required. 50% penalty for non- precertification.
	Substance Abuse disorder - outpatient detox	20% coinsurance	$300 per day copay for first 5 days & 40% coinsurance	Coverage limited to 30 days per calendar year combined for Behavioral Health & Alcohol/Substance Abuse. Precertification required. 50% penalty for non- precertification.
	Substance Abuse disorder - intensive outpatient	20% coinsurance	$300 per day copay for first 5 days & 40% coinsurance	Coverage limited to 30 days per calendar year combined for Behavioral Health & Alcohol/Substance Abuse. Precertification required. 50% penalty for non- precertification.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	20% coinsurance	———— None ————
	Delivery (Facility)	20% coinsurance after $250 per confinement copay	20% coinsurance after $750 per confinement copay	———— None ————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Coverage limited to 120 visits per calendar year.
	Rehabilitation services	20% coinsurance	20% coinsurance	Coverage is limited to 20 separate visits for Speech, Physical and Occupational Therapy. Note: The 20 visits per calendar year include the max 5 visits per calendar year allowed at an outpatient hospital/facility. Refer to plan document for coverage limitation on other Alternate Care Benefits. No out-of-network benefits for Nutritional Therapy and Acupuncture.
	Habilitation services - Autism	$25 copay initial evaluation; $10 copay thereafter	20% coinsurance	Covers child to age 18 for treatment of Autism, subject to a $36,000 calendar year maximum & lifetime maximum of $200,000. Includes Applied Behavioral Analysis.
	Skilled Nursing Facility	No charge first 10 days; 20% coinsurance thereafter. Hospital Inpatient per confinement copay and coinsurance applies.	$200 copay per day first 20 days; 20% coinsurance thereafter. Hospital Inpatient per confinement copay and coinsurance applies.	Coverage limited to 60 days per calendar year.
	Durable medical equipment	20% coinsurance	20% coinsurance	Precertification required if over $1500.
	Hospice service	Inpatient: No charge; Outpatient: No charge	Inpatient: 20% coinsurance; Outpatient: No charge	
If your child needs dental or eye care	Eye exam	20% coinsurance	20% coinsurance	Same for Adults. Additional coverage for 1 routine exam for diagnosis of diabetes.
	Glasses	Not covered	Not covered	Same for Adults. Refer to plan document for coverage for glasses following cataract surgery
	Dental check-up(preventative)	None	Expenses over the Allowed Amount	Limited to 2 exams/calendar year. Refer to plan document for list of covered services.

Summary of Benefits and Coverage: What this Plan covers and what it costs

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**)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)- other than Preventative.
- Glasses
- Hearing aids
- 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 preapproved by Medical Management.

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.)

- Acupuncture - Covers 20 visits per calendar year.
- Bariatric surgery.
- Chiropractic care - Coverage limited to 20 visits per calendar year.
- Infertility treatment - Covers diagnosis and treatment of underlying cause only.
- Routine eye care (Adult) - Covers 1 routine exam for diagnosis of diabetes in addition to annual routine exam

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 1-941-748-4501.

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: Aetna at 1-888-982-3862.

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.

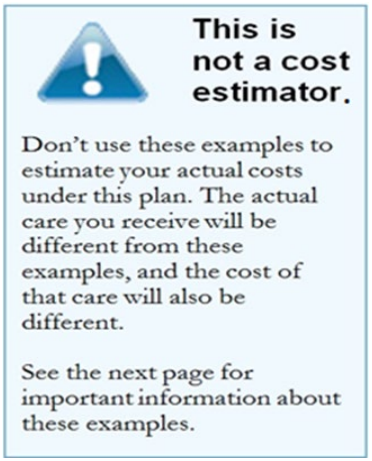
Does this Coverage Meet the Minimum Value Standard?

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.

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

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.



Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,852
- **Patient pays:** $1,688

Sample care costs:

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

Patient pays:

Deductibles	$500
Copays	$0
Coinsurance	$1,188
Limits or exclusions	$0
Total	**$1,688**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,200
- **Patient pays:** $1,200

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
Total	**$5,400**

Patient pays:

Deductibles	$250
Copays	$700
Coinsurance	$250
Limits or exclusions	$0
Total	**$1,200**

Note: Your plan may have both **copays** and **coinsurance** for covered services; if so, these examples use **copays** only. Your costs may be higher.

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-o expenses.