



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](http://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:
<b>What is the overall deductible?</b>	\$0. Out-of-network (OON): Individual \$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.
<b>Are there services covered before you meet your deductible?</b>	Yes. Emergency care is 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other deductibles for specific services?</b>	Yes. \$200 for OON Outpatient Mental Disorder & Chemical Dependency. There are no other specific DED.	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.
<b>What is the out-of-pocket limit for this plan?</b>	Medical: Individual \$1,400. OON: Individual \$2,800. Hospital INP(Facility): INN: \$0; OON: \$2,550.	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.
<b>What is not included in the out-of-pocket limit?</b>	DED, Copays, Premiums, penalties for failure to obtain pre-authorization, 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.
<b>Will you pay less if you use a network provider?</b>	Yes. For a list of in-network providers, see the "provider" tab at <a href="http://www.ManateeYourChoice.com">www.ManateeYourChoice.com</a> 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.
<b>Do you need a referral to see a specialist?</b>	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 <b>provider's</b> 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)	No charge	20% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	No charge	20% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition  <b>Prescription drug coverage is administered by Optum RX</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>	Generic drugs	\$10 for 1-30days \$20 for 31-60days \$30 for 61-90 days	Not covered	See the "Pharmacy Benefit" tab at <a href="http://www.manateeyourchoice.com">www.manateeyourchoice.com</a> 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	\$15 or 25% of drug cost, whichever is greater.	Not covered	
	Non-preferred brand drugs	\$40 or 45% of drug cost, whichever is greater.	Not covered	
	<u>Specialty drugs</u>	25% <u>coinsurance</u> or \$150 maximum or manufacturer's coupon	Not covered	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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% <u>coinsurance</u>	None
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$150 <u>copay</u> /visit, <u>deductible</u> doesn't apply	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>	No charge	20% <u>coinsurance</u>	Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% <u>coinsurance</u> after \$250 <u>copay</u> /stay	Max: \$2,800 per occurrence out-of-network.
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	None
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> ; \$15 <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	NA-40% <u>coinsurance</u>	Coverage limited to 42 visits per calendar year combined for Behavioral Health & Alcohol/Substance Abuse. Precertification required. 50% penalty for non-precertification.

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)	
	Inpatient services	BH & SA - INP services No charge  SA disorder - OP detox 20% <u>coinsurance</u> , <u>deductible</u> doesn't apply  SA disorder - intensive OP 20% <u>coinsurance</u> , <u>deductible</u> doesn't apply	\$300 <u>copay</u> /day first 5 days; 40% <u>coinsurance</u> up to \$3,600 per occurrence	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	Office visits	No charge	20% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Max <u>copay</u> /calendar year: \$2,800 out-of-network.
	Childbirth/delivery professional services	\$100 <u>copay</u> /pregnancy, <u>deductible</u> doesn't apply	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	No charge	20% <u>coinsurance</u> after \$250 <u>copay</u> /stay	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	20% <u>coinsurance</u>	120 visits/calendar year.
	<u>Rehabilitation services</u>	<u>Deductible</u> doesn't apply: Occupational & Speech Therapy \$30 <u>copay</u> / visit; Physical Therapy No charge first 5 visits \$30 <u>copay</u> thereafter	20% <u>coinsurance</u>	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 <u>plan</u> document for coverage limitation on other Alternate Care Benefits. No out-of-network benefits for nutritional Therapy and Acupuncture.

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>Habilitation services</u>	Deductible doesn't apply: Occupational & Speech Therapy \$30 <u>copay</u> /visit; Physical Therapy No charge first 5 visits \$30 <u>copay</u> thereafter; Autism \$30 <u>copay</u> initial evaluation, \$10 <u>copay</u> thereafter	Not covered	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.
	<u>Skilled nursing care</u>	No charge first 10 days; 10% <u>coinsurance</u> , <u>deductible</u> doesn't apply thereafter	\$200 <u>copay</u> /day first 20 days; 20% <u>coinsurance</u> thereafter.	60 days/calendar year. Hospital Inpatient per confinement <u>copay</u> and <u>coinsurance</u> applies.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u> , <u>deductible</u> doesn't apply	20% <u>coinsurance</u>	Precertification required if over \$1,500.
	<u>Hospice services</u>	No charge	20% <u>coinsurance</u> for inpatient; except no charge for outpatient	Precertification required if over \$1,500.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	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	Not covered	Not covered	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
- Weight loss programs

### 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, including artificial insemination.
- 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](http://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](http://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](http://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 \$0
- Specialist copayment \$30
- Hospital (facility) copayment \$0
- Other copayment \$0

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$0
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$160</b>

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

- The plan's overall deductible \$0
- Specialist copayment \$30
- Hospital (facility) copayment \$0
- Other copayment \$0

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$0
<u>Copayments</u>	\$900
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$920</b>

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

- The plan's overall deductible \$0
- Specialist copayment \$30
- Hospital (facility) copayment \$0
- Other copayment \$0

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$0
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$300</b>

\*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.

### Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), [CRCoordinator@aetna.com](mailto:CRCoordinator@aetna.com).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

**Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).**

TTY: 711

**Language Assistance:**

To access language services at no cost to you, call 1-800-370-4526.

- Albanian - Për shërbime përkthimi falas për ju, telefononi 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 լեզվակախ ծառայություններից օգտվելու համար զանգահարեք 1-800-370-4526 հեռախոսահամարով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
- Bantu-Kirundi - Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-800-370-4526.
- Bengali-Bangala - আপনাকে বিনামূল্যে ভাষা পবিকষিা পপকে হকয এই নম্বকি পেবযক ান েরন: 1-800-370-4526 ।
- Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-800-370-4526.
- Burmese - သငှ်အေချဖှ်အေဗှကးေငြ်မေးရဲပဲ ဘာသာစကးးဝနဲေဆာငှးမ်း ရရှိို့ို့ငှ် 1-800-370-4526 သို့ှ ဖှ်းေခငှ်ိုပါ။
- Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-800-370-4526.
- Chamorro - Para un hago' i setbision lengguâhi ni dibâtde para hâgu, âgang 1-800-370-4526.
- Cherokee - Ⴀႃ႗ႃ Ⴀႃ႗ႃ Ⴀႃ႗ႃ Ⴀႃ႗ႃ Ⴀႃ႗ႃ Ⴀႃ႗ႃ Ⴀႃ႗ႃ Ⴀႃ႗ႃ 1-800-370-4526.
- Chinese - 如欲使用免費語言服務，請致電 1-800-370-4526.
- Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-800-370-4526.
- Cushite - Tajaajiiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-800-370-4526.
- Dutch - Voor gratis toegang tot taaldiensten, bell 1-800-370-4526.
- French - Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526.
- French Creole - 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 ખર્ચવિના ભાષાની સેિાઓની પહોોર માટે, કોલ કરો1-800-370-4526.



