




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, go to [www.manateebenefits.com](http://www.manateebenefits.com) or call (855) 497-1307. 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.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call Care Coordinators at (855) 497-1307 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	For participating <u>providers</u> : \$2,500 person/\$5,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. For participating <u>providers</u> : <u>Preventive care</u> , <u>emergency room care</u> (facility fee & professional fees for mental health/substance use providers – all <u>providers</u> ), <u>urgent care</u> , <u>diagnostic test</u> (independent lab only), maternity care (initial visit only), hospital stay (facility fee), inpatient mental health and substance use, <u>rehabilitation services</u> and office visits are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	For participating <u>providers</u> : \$5,000 person/\$10,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.manateebenefits.com">www.manateebenefits.com</a> or call: (855) 497-1307 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		Participating Provider (You will pay the least)	Non-Participating 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 <b>copay</b> /visit	Not Covered	<p><b>Copay</b> applies per visit regardless of what services are rendered.</p> <p>Includes telemedicine other than Teladoc. See your <b>plan</b> document for any costs associated with the Teladoc programs.</p> <p>You may have to pay for services that aren't <b>preventive</b>. Ask your <b>provider</b> if the services you need are <b>preventive</b>. Then check what your <b>plan</b> will pay for.</p>
	<b>Specialist</b> visit	\$60 <b>copay</b> /visit	Not Covered	
	<b>Preventive care</b> / <b>screening</b> /immunization	No Charge	Not Covered	
If you have a test	<b>Diagnostic test</b> (x-ray, blood work)	No Charge (independent lab)/30% coinsurance (all other outpatient facilities)	Not Covered	-----none-----
	Imaging (CT/PET scans, MRIs)	30% <b>coinsurance</b>	Not Covered	<b>Preauthorization</b> recommended for MRI/MRA and PET scans.
If you need drugs to treat your illness or condition More information about <b>prescription drug coverage</b> is available at <a href="http://www.ventegra.com">www.ventegra.com</a>	Generic drugs	\$10 <b>copay</b> (30-day retail)/\$20 <b>copay</b> (60-day retail)/\$25 <b>copay</b> (90-day retail & mail order)	Not Covered	<p><b>Deductible</b> does not apply. Covers up to a 90-day supply (retail prescription); 90-day supply (mail order prescription); 30-day supply (<b>specialty drugs</b>). The <b>copay</b> applies per prescription. There is no charge for preventive drugs. Dispense as Written (DAW) provision applies. <b>Specialty drugs</b> must be obtained directly from the specialty pharmacy. Step therapy provision applies.</p>
	Preferred brand drugs	\$30 <b>copay</b> (30-day retail)/\$60 <b>copay</b> (60-day retail)/\$75 <b>copay</b> (90-day retail & mail order)	Not Covered	
	Non-preferred brand drugs	\$60 <b>copay</b> (30-day retail)/\$120 <b>copay</b> (60-day retail)/\$150 <b>copay</b> (90-day retail & mail order)	Not Covered	
	<b>Specialty drugs</b>	\$60 <b>copay</b> (30-day retail)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <b>coinsurance</b>	Not Covered	<b>Preauthorization</b> recommended.
	Physician/surgeon fees	30% <b>coinsurance</b>	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$1,200 <u>copay</u> /visit (facility fee)/\$60 <u>copay</u> /visit (professional fees – mental health & substance use <u>providers</u> )/30% <u>coinsurance</u> (professional fees- all other <u>providers</u> ) (emergency services)/\$1,200 <u>copay</u> /visit (facility fee)/30% <u>coinsurance</u> (professional fees) (non-emergency services)	\$1,200 <u>copay</u> /visit (facility fee)/\$60 <u>copay</u> /visit (professional fees – mental health & substance use <u>providers</u> )/30% <u>coinsurance</u> (professional fees- all other <u>providers</u> ) (emergency services)/Not Covered (non-emergency services)	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits for <u>emergency services</u> . <u>Copay</u> is waived if admitted to the hospital.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u> ( <u>emergency services</u> )/30% <u>coinsurance</u> (non-emergency services)	30% <u>coinsurance</u> ( <u>emergency services</u> )/Not Covered (non-emergency services)	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits for <u>emergency services</u> .
	<u>Urgent care</u>	\$60 <u>copay</u> /visit	Not Covered	<u>Copay</u> applies per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300 <u>copay</u> /admission	Not Covered	<u>Preauthorization</u> recommended.
	Physician/surgeon fees	30% <u>coinsurance</u>	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copay</u> /visit (office visit)/30% <u>coinsurance</u> (all other outpatient)	Not Covered	Includes telemedicine other than Teladoc. See your <u>plan</u> document for any costs associated with the Teladoc programs. <u>Preauthorization</u> recommended for partial hospitalization and intensive outpatient care.
	Inpatient services	\$300 <u>copay</u> /admission (facility fee)/\$60 <u>copay</u> /visit (physician fees)	Not Covered	
If you are pregnant	Office visits	30% <u>coinsurance</u> (\$30 <u>copay</u> on initial visit)	Not Covered	<u>Preauthorization</u> recommended for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). <u>Cost sharing</u> does not apply to <u>preventive services</u> from a participating <u>provider</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby does not count
	Childbirth/delivery professional services	30% <u>coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	\$300 <u>copay</u> /admission	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
				toward the mother's expense; therefore the family <u>deductible</u> amount may apply.
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	30% <u>coinsurance</u>	Not Covered	Limited to 20 visits per year. <u>Preauthorization</u> recommended.
	<u>Rehabilitation services</u>	\$60 <u>copay</u> /visit (outpatient rehab)/30% <u>coinsurance</u> (inpatient rehab)	Not Covered	Physical, speech, occupational therapy and chiropractic care limited to a combined maximum of 35 visits per year. Inpatient rehab is limited to 30 days per year. <u>Preauthorization</u> recommended for the inpatient rehab.
	<u>Habilitation services</u>	Not Covered	Not Covered	This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	Not Covered	Limited to 90 days per year. <u>Preauthorization</u> recommended.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> recommended for rentals or purchase over \$1,500.
	<u>Hospice services</u>	30% <u>coinsurance</u>	Not Covered	Bereavement counseling is covered if received within 6 months of death. <u>Preauthorization</u> recommended.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

**Excluded Services & Other Covered Services:**

<b>Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)</b>		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult &amp; Child)</li> <li>• Glasses (Adult &amp; Child)</li> <li>• Habilitation services</li> <li>• Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment (except diagnosis or treatment of underlying medical condition)</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult &amp; Child)</li> <li>• Routine foot care (except for metabolic or peripheral vascular disease or for diabetes)</li> <li>• Weight loss programs</li> </ul>

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

- Acupuncture (26 visits per year)
- Bariatric surgery (for morbid obesity only – one surgery per lifetime)
- Chiropractic care (35 visits per year, combined with outpatient physical, speech & occupational therapy)

**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: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at (877) 267-2323 x 61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov), or Care Coordinators at (855) 497-1307. 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 (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 Care Coordinators at (855) 497-1307.

**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 1-800-378-1179.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-378-1179.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwüijigo holne' 1-800-378-1179.

*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 <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Primary care physician copayment</u>	\$30
■ Hospital (facility) <u>copayment</u>	\$300
■ Other <u>coinsurance</u>	30%

This EXAMPLE event includes services like:

Primary care physician 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:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$300
Coinsurance	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,760</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Specialist copayment</u>	\$60
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%

This EXAMPLE event includes services like:

Specialist office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

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

<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,820</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Specialist copayment</u>	\$60
■ Hospital (facility) <u>copayment</u>	\$1,200
■ Other <u>coinsurance</u>	30%

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:

<i>Cost Sharing</i>	
Deductibles	\$1,700
Copayments	\$800
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,500</b>