



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.Benebay.com or by calling 1-833-BENEBAW.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$3,000/Individual or \$6,000/Family	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. Preventive Care and primary care services are covered before you meet your deductible .	This plan covers some items and services even if you haven't 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
What is the out-of-pocket limit for this plan?	For network providers \$6550 individual / \$13,100 family; for out-of-network providers \$13,100 individual / \$26,200 family	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?	Copayments for certain services, premiums , balance-billing charges , and 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. Visit www.carevalet.com or call 1-833-BENEBAW for a list of network providers .	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.	This plan does not require you to seek a referral from your primary care physician prior to seeing a specialist .

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
		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	Office Visit 30% coinsurance after deductible	Office Visit 40% coinsurance after deductible	None
	Specialist visit	Office Visit 30% coinsurance after deductible	Office Visit 40% coinsurance after deductible	Preauthorization required
	Preventive Care/Screening Immunization	\$0 (No Charge)	Office Visit 40% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance after deductible	40% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs, Ultrasound)	30% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required
If you need drugs to treat your illness or condition	Generic drugs	Exclusive / Non-Exclusive Network \$0 / \$10 after deductible	40% coinsurance after deductible	Covers up to a 30 day supply (retail subscription); 31-90 day supply (mail order prescription).
	Brand drugs	Exclusive / Non-Exclusive Network \$30 / \$60 after deductible	40% coinsurance after deductible	
	Specialty Non-Preferred drugs	Exclusive / Non-Exclusive Network \$60 / \$100 after deductible	40% coinsurance after deductible	
If you have outpatient surgery	Facility fee (e.g., ambulatory Surgery center)	30% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required
	Physician/surgeon fees	30% coinsurance after deductible	40% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider Provider (You will pay the least) most)	Out-of-Network (You will pay the most)	
If you need immediate medical attention	Emergency room care	30% coinsurance after deductible	40% coinsurance after deductible	None
	Emergency medical transportation (Ambulance / Air Transportation)	30% coinsurance after deductible	40% coinsurance after deductible	3 visits per calendar year
	Urgent care	30% coinsurance after deductible	40% coinsurance after deductible	
If you have a hospital stay	Facility Fee (e.g., hospital room)	30% coinsurance after deductible	40% coinsurance after deductible	None
	Physician/surgeon fees	30% coinsurance after deductible	40% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required
	Inpatient services	30% coinsurance after deductible	40% coinsurance after deductible	
If you are pregnant	Office visits	30% coinsurance after deductible	40% coinsurance after deductible	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the Summary (i.e. ultrasound)
	Childbirth/delivery professional services	30% coinsurance after deductible	40% coinsurance after deductible	
	Childbirth/delivery facility services	30% coinsurance after deductible	40% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	30% coinsurance after deductible	40% coinsurance after deductible	60 day maximum per Calendar Year (includes outpatient private duty nursing when approved as Medically Necessary) 16-hour maximum per day Preauthorization required

Continued: If you need help recovering or have other special health needs	Rehabilitation services	30% coinsurance after deductible	40% coinsurance after deductible	60 visits per Calendar year combined for Pulmonary Rehabilitation, Cognitive, Physical, Speech, and Occupational Therapy. Cardiac Rehabilitation: Preauthorization required
	Skilled nursing care	30% coinsurance after deductible	40% coinsurance after deductible	
	Durable medical equipment Orthopedic Brace & Appliances	30% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required Preauthorization required on DME and prosthetics
	Hospice services	30% coinsurance after deductible	40% coinsurance after deductible	

Excluded Services & Other Covered Services (This isn't a complete list) Please see your plan document for a more comprehensive list of excluded services.

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information)		
Bariatric Surgery	Infertility Treatment	Routine eye care (Adult)
Cosmetic Surgery	Long Term Care	Routine Foot Care
Dental Care	Non-emergency care when traveling outside the U.S	Weight Loss Programs
Hearing Aids	.	
Other Covered Services (Limitations may apply to these services. Please see your plan document.)		
Acupuncture (if prescribed for rehabilitation purposes) (20 visits per Calendar Year) Subject to coinsurance and deductible		
Chiropractic Care (20 visits per Calendar Year) Subject to coinsurance and deductible		

Carrier Plan Name	Benebay BRONZE
Deductible <i>Individual</i> <i>Family</i>	\$3,000 \$3,000 / \$6,000
Coinsurance (Amount Member pays)	30%
Out of Pocket Maximum includes: Individual Family (Individual / Family Aggregate)	<i>Includes Deductible, Coinsurance & Rx</i> \$6,550 \$6,550 / \$13,100
Facility Services	
In-Patient Hospital Outpatient Surgery Emergency Room Urgent Care	30% after Deductible 30% after Deductible 30% after Deductible 30% after Deductible
Physician Services	
Preventive Primary Care Physician Specialist Primary Care Physician Selection Required?	\$0 30% after Deductible 30% after Deductible No
Independent Lab and Diagnostic Testing Services	
Lab X-Ray Advanced Imaging (MRI, PET, CT, etc)	30% after Deductible 30% after Deductible 30% after Deductible
Prescriptions	Generic: \$0 / Exclusive Network \$10 after deductible / Non- Exclusive.
	Brand: \$30 / Exclusive Network \$60 after deductible / Non- Exclusive.
	Specialty: \$60 / Exclusive Network \$100 after deductible / Non- Exclusive.
	Mail Order RX (90 day supply) 2.5 x Tier Copay
Policy Lifetime Maximum	Unlimited
Out of Network Benefits	Out of Network
Deductible (<i>Individual / Family</i>)	\$5,000 / \$10,000
Coinsurance (<i>Amount Member Pays</i>)	40%
Out of Pocket (<i>Individual / Family</i>)	\$13,100 / \$26,200

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. See your HR/Benefit coordinator for COBRA information or visit Florida State, HHS, DOL and/or other applicable agency contact information. 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 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 1-833-BENEBAY.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

- For more information about limitations and exceptions, see the plan or policy document.