Summary of Benefits and Coverage: What this Plan Covers & What it Costs
Benzer Pharmacy: Gold Plan

Coverage Period: Beginning on or after 03/01/2019
Coverage for: Individual / Family | Plan Type: PPO

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-BENEBAY.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,500/Individual or $4,500/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** $5,550 individual / $11,000 family; for **out-of-network providers** $11,000 individual / $22,000 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-BENEBAY 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 Network Provider (You will pay the least)	Out-of-Network (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 Copay/visit Deductible does not apply	Office Visit 50% coinsurance after deductible	None
	Specialist visit	$50 Copay/visit Deductible does not apply	Office Visit 50% coinsurance after deductible	Preauthorization required for procedures at a facility.
	Preventive Care/Screening Immunization	$0 (No Charge)	Office Visit 50% coinsurance deductible waived	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)	Routing PCP lab $0 co-pay / Independent diagnostic lab or testing center $50 co-pay	50% coinsurance after deductible	Preauthorization required
	Imaging (CT/PET scans, MRIs, Ultrasound	$250 Copay/visit	50% coinsurance after deductible	
If you need drugs to treat your illness or condition	Generic drugs	Exclusive / Non-Exclusive Network $0 / $10	50% 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 $0 / $10	50% coinsurance after deductible	
	Non-Preferred drugs	Exclusive / Non-Exclusive Network $0 / $10	50% coinsurance after deductible	
If you have outpatient surgery	Facility (Ambulatory Surgery Center) Hospital (Outpatient Hospital)	$200 Copay/visit 30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required
	Physician/surgeon fees	$50 co-pay	50% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	$250 Copay/visit	50% coinsurance after deductible	None
	Emergency medical transportation (Ambulance / Air Transportation)	30% coinsurance after deductible	50% coinsurance after deductible	3 visits per calendar year
	Urgent care	$60 Copay/visit	50% coinsurance after deductible	
If you have a hospital stay	Facility Fee (e.g., hospital room)	30% coinsurance after deductible	50% coinsurance after deductible	None
	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Inpatient/Outpatient Facility	30% coinsurance after deductible	50% coinsurance after deductible	60 days per Plan Year Preauthorization required
	Professional (Specialist) Visit	$50 Copay/Visit	50% coinsurance after deductible	35 days per Plan Year Preauthorization required
If you are pregnant	Office visits Pre and Post Natal Care	$25 Copay/visit Deductible does not apply	50% 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	$50 Copay/visit Deductible does not apply	50% coinsurance after deductible	
	Childbirth/delivery facility services	30% coinsurance after deductible	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	30% coinsurance after deductible	50% 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	$50 copay/visit, deductible does not apply. *(Not covered by office visit co-pay)*	50% coinsurance after deductible	35 visits per plan year combined for Pulmonary Rehabilitation, Cognitive, Physical, Speech, and Occupational Therapy. Cardiac Rehabilitation. Sleep Study (Sleep Apnea) Preauthorization required
	Skilled nursing care	30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required
	Durable medical equipment Orthopedic Brace & Appliances	30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required over 1K.
	Hospice services	30% coinsurance after deductible	50% coinsurance after deductible	None

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 GOLD
Deductible *Individual* *Family*	 $1,500 $1,500 / $4,500
Coinsurance (Amount Member pays)	30%
Out of Pocket Maximum includes:	*Includes Deductible, Coinsurance & Rx*
Individual Family (Individual / Family Aggregate)	$5,500 $5,500 / $11,000
Facility Services	
In-Patient Hospital Outpatient Surgery Emergency Room Urgent Care	30% after Deductible $200 $250 $60
Physician Services	
Preventive Primary Care Physician Specialist Primary Care Physician Selection Required?	$0 $25 $50 No
Independent Lab and Diagnostic Testing Services	
Lab X-Ray Advanced Imaging (MRI, PET, CT, etc)	$0 $50 $250
Prescriptions	**Generic:** $0 / Exclusive Network | $10 / Non- Exclusive
	Brand: $30 / Exclusive Network | $60 / Non- Exclusive
	Non-Preferred: $60 / Exclusive Network | $100 / 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 (*Individual / Family)* **Coinsurance** *(Amount Member Pays)* **Out of Pocket** *(Individual / Family)*	$4,500 / $13,500 50% $11,000 / $22,000

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 call1-800-318-2596.

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.