



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.gulfcoastprovider.net](http://www.gulfcoastprovider.net) or call (877) 697-2299. 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 Meritain Health, Inc. at (800) 318-2023 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	For SMH/GCPN <u>providers</u> : \$500 person / \$1,000 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 SMH/GCPN <u>providers</u> : <u>Preventive care</u> , imaging, <u>diagnostic tests</u> , <u>emergency room care</u> , <u>emergency medical transportation</u> , <u>urgent care</u> , <u>home health care</u> , <u>hospice services</u> , outpatient mental health & substance abuse services, <u>rehabilitation services</u> , <u>habilitation 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 SMH/GCPN <u>providers</u> : \$6,000 person / \$12,000 family ( <u>deductible</u> , <u>coinsurance</u> & <u>copays</u> )	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>preauthorization</u> penalty amounts, <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.gulfcoastprovider.net/Members/FindProvider">www.gulfcoastprovider.net/Members/FindProvider</a> or call (877) 697-2299 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</u> charge 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
		SMH/GCPN Providers (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit /15% <u>coinsurance</u> (all other services)	Not Covered	<u>Copay</u> applies to the physician office visit only. Includes telemedicine. <u>Preauthorization</u> required for office procedures in excess of \$2,000. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.  You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit (office visit)/ 15% <u>coinsurance</u> (all other services)	Not Covered	
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No Charge	Not Covered	
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge (lab – SMH), \$35 <u>copay</u> /visit (lab - all other lab providers) No charge (x-ray - SMH), \$35 <u>copay</u> /visit (x-ray – all other x-ray providers) \$35 <u>copay</u> /visit (non-contrast CT scan of the heart with calcium scoring – SMH)/ Not Covered (non-contrast CT scan of the heart with calcium scoring – all other providers)	Not Covered	Preauthorization required for some services. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service. See your <u>plan</u> for requirements. CT scan of the heart with calcium scoring only covered at SMH.
	Imaging (CT/PET scans, MRIs)	\$100 <u>copay</u> /visit	Not Covered	
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.navitus.com">www.navitus.com</a>	Generic drugs	\$8 <u>copay</u> (smhRxExpress 30-day retail)/\$9 <u>copay</u> (30-day retail)/\$16 <u>copay</u> (smhRxExpress 90-day retail)/\$20 <u>copay</u> (90-day retail & mail order)	\$9 <u>copay</u> (30-day retail)/ Not Covered (all other drugs)	
	Preferred brand drugs	40% <u>copay</u> (30-day retail - \$25 minimum/ \$100 max per script)/(90-day retail & mail order - \$50 minimum/\$100 max per script)	40% <u>copay</u> (30-day retail - \$25 minimum/ \$100 max per script)/ Not Covered (all other drugs)	

 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
		SMH/GCPN Providers (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Non-preferred brand drugs	60% <u>copay</u> (30-day retail - \$35 minimum/ \$100 max per script)/(90-day retail & mail order - \$75 minimum/\$100 max per script)	60% <u>copay</u> (30-day retail - \$35 minimum/ \$100 max per script)/ Not Covered (all other drugs)	<p>\$7,000 max per year with an additional \$1,500 if RX case manager utilized. \$1,000 per person <u>deductible</u> after benefit maximums reached; 50% <u>coinsurance</u> then applies with no script max; 40% <u>coinsurance</u> applies if pharmacy case manager utilized; 20% <u>coinsurance</u> applies if both pharmacy &amp; chronic disease case manager utilized. Covers up to a 90-day supply (retail prescription); 90-day supply (mail order prescription); 30-day supply (<u>specialty drugs</u>). The <u>copay</u> applies per prescription. There is no charge or <u>deductible</u> for preventive drugs. Mandatory generic provision applies. <u>Specialty drugs</u> must be obtained from the specialty pharmacy <u>network</u>. Maximums and per person <u>deductible</u> does not apply to <u>specialty drugs</u>). Step therapy provision applies. Some <u>specialty drugs</u> may be eligible for copay assistance through the Copay Max Plus Program provided by Navitus.</p>
	<u>Specialty drugs</u>	\$100 <u>copay</u> (30-day retail)	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Deductible, then \$600 <u>copay</u> /occurrence	Not Covered	<p><u>Preauthorization</u> required for certain surgeries. If you don't get <u>preauthorization</u>, benefits could be reduced by 50% of the total cost of the service. See your <u>plan</u> document for a detailed listing.</p>
	Physician/surgeon fees	Deductible, then 15% <u>coinsurance</u>	Not Covered	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$200 <u>copay</u> /visit	\$200 <u>copay</u> /visit	Non-participating <u>providers</u> paid at the SMH <u>provider</u> level of benefits. <u>Copay</u> is waived if admitted to the hospital.
	<u>Emergency medical transportation</u>	\$100 <u>copay</u> /trip	\$100 <u>copay</u> /trip	Non-participating <u>providers</u> paid at the SMH <u>provider</u> level of benefits.
	<u>Urgent care</u>	\$35 <u>copay</u> /visit	Not Covered	<u>Copay</u> applies per visit regardless of what services are rendered. <u>Copay</u> waived if sent to and treated in the <u>emergency room</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
		SMH/GCPN Providers (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Deductible, then \$750 <u>copay</u> /admission	Not Covered	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	Deductible, then 15% <u>coinsurance</u>	Not Covered	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No Charge (office visit)/\$35 <u>copay</u> /visit (SMH partial <u>hospitalization</u> & intensive outpatient)/\$60 <u>copay</u> /visit (partial <u>hospitalization</u> & intensive outpatient)/No Charge (all other outpatient)	Not Covered	<u>Preauthorization</u> required for inpatient, partial <u>hospitalization</u> , and intensive outpatient. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service. Includes telemedicine.
	Inpatient services	Deductible, then \$750 <u>copay</u> /admission (facility charge)/ Deductible, then 15% <u>coinsurance</u> (professional fees)	Not Covered	
<b>If you are pregnant</b>	Office visits	No Charge (\$50 <u>copay</u> for initial visit)	Not Covered	<u>Preauthorization</u> required for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service. <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 counts towards the mother's expense.
	Childbirth/delivery professional services	Deductible, then 15% <u>coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	Deductible, then \$750 <u>copay</u> /admission	Not Covered	

 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
		SMH/GCPN Providers (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	\$35 <u>copay</u> /visit	Not Covered	Limited to 60 visits per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
	<u>Rehabilitation services</u>	\$35 <u>copay</u> /visit	Not Covered	Physical, speech/hearing & occupational therapy limited to a combined maximum of 30 visits per year. Massage therapy limited to 30 visits per year and requires a prescription and medical management approval. Includes telemedicine.
	<u>Habilitation services</u>	\$35 <u>copay</u> /visit	Not Covered	Covered to age 19 for physical, speech/hearing & occupational therapy. Includes telemedicine.
	<u>Skilled nursing care</u>	Deductible, then \$750 <u>copay</u> /admission	Not Covered	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
	<u>Durable medical equipment</u>	Deductible, then 15% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> required for any item in excess of \$2,000. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
	<u>Hospice services</u>	No Charge	Not Covered	Bereavement counseling is not covered. <u>Hospice services</u> limited to 60 days per lifetime.
<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:

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> .)		
<ul style="list-style-type: none"><li>• Bereavement counseling</li><li>• Cosmetic surgery</li><li>• Dental care (Adult &amp; Child)</li><li>• Glasses (Adult &amp; Child)</li></ul>	<ul style="list-style-type: none"><li>• Infertility treatment</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>• Routine eye care (Adult &amp; Child)</li><li>• Routine foot care (except for metabolic or peripheral vascular disease)</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"><li>• Acupuncture (15 visits or \$600, whichever is less; combined with chiropractic &amp; holistic care)</li><li>• Bariatric surgery (for morbid obesity only – 1 surgical procedure per lifetime)</li></ul>	<ul style="list-style-type: none"><li>• Chiropractic care (15 visits or \$600, whichever is less; combined with acupuncture &amp; holistic care)</li><li>• Hearing aids (to age 18 – \$2,600 per year and limited to one pair of hearing aids every 3 years)</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Weight loss programs (for morbid obesity only)</li></ul>

**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 SMH Health Care, Inc. at (941) 917-9000. 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 SMH Health Care, Inc. at (941) 917-9000 or Meritain Health, Inc. at (800) 925-2272.

### 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, kwijigo 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 plan's overall deductible \$500
- Primary care physician copayment \$0
- Hospital (facility) copayment \$750
- Other coinsurance 15%

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	\$500
Copayments	\$1,300
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,960</b>

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

- The plan's overall deductible \$500
- Specialist copayment \$50
- Hospital (facility) copayment \$600
- Other coinsurance 15%

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	\$500
Copayments	\$1,500
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,060</b>

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

- The plan's overall deductible \$500
- Specialist copayment \$50
- Hospital (facility) copayment \$200
- Other coinsurance 15%

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	\$300
Copayments	\$800
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,100</b>