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 or call (866) 260-0305. 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 or call Meritain Health, Inc. at (800) 318-2023 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For SMH/GCPN providers: $0 person/ $0 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. For SMH/GCPN providers: All services are 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 www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	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.
What is the out-of-pocket limit for this plan?	For SMH/GCPN providers: $4,000 person / $8,000 family (deductible, coinsurance & copays)	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?	Premiums, preauthorization penalty amounts, 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. See www.gulfcoastprovider.net/Members/FindProvider or call (866) 260-0305 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.	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
		SMH/GCPN Providers (You will pay the least)	Non-Participating 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	No Charge/visit /15% coinsurance (all other services)	Not Covered	Copay applies to the physician office visit only. Includes telemedicine. Preauthorization required for office procedures $2,000 or more. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Specialist visit	$50 copay/visit /15% coinsurance (all other services)	Not Covered	
	Preventive care/screening/ immunization	No Charge	Not Covered	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)	No charge (lab – SMH), $35 copay/visit (lab - all other lab providers) No charge (x-ray - SMH), $35 copay/visit (x-ray – all other x-ray providers) $35 copay/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 preauthorization, benefits could be reduced by 50% of the total cost of the service. See your plan for requirements. CT scan of the heart with calcium scoring only covered at SMH.
	Imaging (CT/PET scans, MRIs)	$100 copay/visit	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.navitus.com	Generic drugs	$8 copay (smhRxExpress 30-day retail)/$9 copay (30-day retail)/$16 copay (smhRxExpress 90-day retail)/$20 copay (90-day retail & mail order)	$9 copay (30-day retail)/ Not Covered (all other drugs)	$7,000 max per year with an additional $1,500 if RX case manager utilized. $1,000 per person deductible after benefit maximums reached; 50% coinsurance then applies with no script max; 40% coinsurance applies if pharmacy case manager utilized; 20% coinsurance applies if both pharmacy & chronic disease case manager utilized. Covers up to a 90-day supply (retail prescription); 90-day supply (mail order prescription); 30-day supply (specialty drugs). The copay applies per
	Preferred brand drugs	40% copay (30-day retail - $25 minimum/ $100 max per script)/(90-day retail & mail order - $50 minimum/$100 max per script)	40% copay (30-day retail - $25 minimum/ $100 max per script)/ Not Covered (all other drugs)	

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% copay (30-day retail - $35 minimum/ $100 max per script)/(90-day retail & mail order - $75 minimum/$100 max per script)	60% copay (30-day retail - $35 minimum/ $100 max per script)/ Not Covered (all other drugs)	prescription. There is no charge or deductible for preventive drugs. Mandatory generic provision applies. Specialty drugs must be obtained from the specialty pharmacy network. Maximums and per person deductible does not apply to specialty drugs). Step therapy provision applies. Some specialty drugs may be eligible for copay assistance through the Access Guidance Services provided by Navitus.
	Specialty drugs	$100 copay (30-day retail)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$350 copay/occurrence	Not Covered	Preauthorization required for certain surgeries. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. See your plan document for a detailed listing.
	Physician/surgeon fees	15% coinsurance	Not Covered	
If you need immediate medical attention	Emergency room care	$200 copay/visit	$200 copay/visit	Non-participating providers paid at the SMH provider level of benefits. Copay is waived if admitted to the hospital.
	Emergency medical transportation	$100 copay/trip	$100 copay/trip	Non-participating providers paid at the SMH provider level of benefits.
	Urgent care	$35 copay/visit	Not Covered	Copay applies per visit regardless of what services are rendered. Copay waived if sent to and treated in the emergency room.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/admission	Not Covered	Preauthorization required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	15% coinsurance	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge (office visit)/No Charge (SMH partial hospitalization & intensive outpatient)/$35 copay/visit (partial hospitalization & intensive outpatient)/No Charge (all other outpatient)	Not Covered	Preauthorization required for inpatient, partial hospitalization, and intensive outpatient. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. Includes telemedicine.
	Inpatient services	$500 copay/admission (facility charge)/15% coinsurance (professional fees)	Not Covered	

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)	
If you are pregnant	Office visits	No Charge ($50 copay for initial visit)	Not Covered	Preauthorization required for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. Cost sharing does not apply to preventive services from a participating provider. 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	No Charge	Not Covered	
	Childbirth/delivery facility services	$500 copay/admission	Not Covered	
If you need help recovering or have other special health needs	Home health care	$35 copay/visit	Not Covered	Limited to 60 visits per year. Preauthorization required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Rehabilitation services	$35 copay/visit	Not Covered	Physical, speech/hearing & occupational therapy limited to a combined maximum of 30 visits per year. Additional visits allowed if medically necessary. Massage therapy limited to 30 visits per year and requires a prescription and medical management approval. Includes telemedicine.
	Habilitation services	$35 copay/visit	Not Covered	Covered to age 19 for physical, speech/hearing & occupational therapy. Includes telemedicine.
	Skilled nursing care	$500 copay/admission	Not Covered	Limited to 90 days per year if not at SMHCS facilities. Preauthorization required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.

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)	
	Durable medical equipment	15% coinsurance	Not Covered	Preauthorization required for any item in excess of $2,000. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Hospice services	No Charge	Not Covered	Bereavement counseling is not covered. Hospice services limited to 60 days per lifetime.
If your child needs dental or eye care	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- **Bereavement counseling**
- **Cosmetic surgery**
- **Dental care (Adult & Child)**
- **Emergency room services for non-emergency services**
- **Glasses (Adult & Child)**
- **Infertility treatment**
- **Long-term care**
- **Non-emergency care when traveling outside the U.S.**
- **Routine eye care (Adult & Child)**
- **Routine foot care (except for metabolic or peripheral vascular disease)**

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

- **Acupuncture (15 visits or $600, whichever is less; combined with chiropractic & holistic care)**
- **Bariatric surgery (for morbid obesity only – 1 surgical procedure per lifetime)**
- **Chiropractic care (15 visits or $600, whichever is less; combined with acupuncture & holistic care)**
- **Hearing aids (to age 18 – $2,600 per year and limited to one pair of hearing aids every 3 years)**
- **Private-duty nursing**
- **Weight loss programs (for morbid obesity only)**

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, 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 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, kwiijigo 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	**$0**
Primary care physician copayment	**$0**
Hospital (facility) copayment	**$500**
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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,360

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	**$50**
Hospital (facility) copayment	**$350**
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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,420

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

The plan's overall deductible	**$0**
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*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$840

The **plan** would be responsible for the other costs of these EXAMPLE covered services.