



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) 925-2272 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	For Tier 1 <u>providers</u> : \$0 person / \$0 family For Tier 2 <u>providers</u> : \$1,500 person / \$4,500 family For Tier 3 <u>providers</u> : \$3,000 person / \$9,000 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> .
Are there services covered before you meet your <u>deductible</u>?	Yes. For Tier 2 <u>providers</u> : <u>Preventive care</u> , <u>emergency medical transportation</u> (all <u>providers</u>), <u>emergency room care</u> (all <u>providers</u> – <u>emergency only</u>), <u>urgent care</u> (Tier 1 only), <u>hospice services</u> , <u>rehabilitation services</u> (Tier 1 only), <u>primary care provider</u> and <u>specialist</u> 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 www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For Tier 1 <u>providers</u> : \$4,000 person / \$8,000 family For Tier 2 <u>providers</u> : \$5,000 person / \$10,000 family For Tier 3 <u>providers</u> : Unlimited per person or 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.
What is not included in the <u>out-of-pocket limit</u>?	<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> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.gulfcoastprovider.net/Members/FindProvider or call (866) 260-0305 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.

Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
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 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
		Tier 1 SMH Providers	Tier 2 Aetna CPHI Providers	Tier 3 Non-Participating Providers	
		(You will pay the least)	(You will pay the most)		
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No Charge/visit /15% <u>coinsurance</u> (all other services)	\$0 copay (first visit per year)/\$50 <u>copay</u> /visit (all other office visits)/ 30% <u>coinsurance</u> (all other services)	60% <u>coinsurance</u>	<u>Copay</u> applies to the physician office visit only. Includes telemedicine. <u>Preauthorization</u> required for office procedures \$2,000 or more. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit (office visit)/ 15% <u>coinsurance</u> (all other services)	\$100 <u>copay</u> /visit (office visit)/ 30% <u>coinsurance</u> (all other services)	60% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>screening</u> / immunization	No Charge	No Charge	60% <u>coinsurance</u>	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.
If you have a test	<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)	30% <u>coinsurance</u>	60% <u>coinsurance</u>	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	30% <u>coinsurance</u>	60% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 SMH Providers	Tier 2 Aetna CPH Providers	Tier 3 Non-Participating Providers	
		(You will pay the least)	(You will pay the most)		
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 <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)	\$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 & 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 Access Guidance Services provided by Navitus.
	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)	
	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)	
	<u>Specialty drugs</u>	\$100 <u>copay</u> (30-day retail)		Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$350 <u>copay</u> / occurrence	30% <u>coinsurance</u>	60% <u>coinsurance</u>	<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.
	Physician/surgeon fees	15% <u>coinsurance</u>	30% <u>coinsurance</u>	60% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 SMH Providers	Tier 2 Aetna CPHI Providers	Tier 3 Non-Participating Providers	
		(You will pay the least)	(You will pay the most)		
If you need immediate medical attention	Emergency room care	\$250 <u>copay</u> /visit (emergency services)/ \$250 <u>copay</u> /visit (non-emergency services)	\$250 <u>copay</u> /visit (emergency services)/ \$250 <u>copay</u> /visit (non-emergency services)	\$250 <u>copay</u> /visit (emergency services)/ \$250 <u>copay</u> /visit (non-emergency services)	Tier 2 and Tier 3 <u>providers</u> are paid at the Tier 1 provider level of benefits. <u>Copay</u> is waived if admitted to the hospital.
	Emergency medical transportation	\$100 <u>copay</u> /trip	\$100 <u>copay</u> /trip	\$100 <u>copay</u> /trip	Tier 2 and Tier 3 <u>providers</u> are paid at the Tier 1 <u>provider</u> level of benefits.
	Urgent care	\$35 <u>copay</u> /visit	\$35 <u>copay</u> /visit	\$30 <u>copay</u> /visit, then 60% <u>coinsurance</u>	<u>Copay</u> applies per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copay</u> /visit	30% <u>coinsurance</u>	60% <u>coinsurance</u>	<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	15% <u>coinsurance</u>	30% <u>coinsurance</u>	60% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge (office visit)/No Charge (SMH partial <u>hospitalization</u> & intensive outpatient)/\$35 <u>copay</u> /visit (partial <u>hospitalization</u> & intensive outpatient)/No Charge (all other outpatient)	\$0 <u>copay</u> (first visit per year)/ \$50 <u>copay</u> /visit (office visits, partial <u>hospitalization</u> & intensive outpatient, and all other outpatient)	60% <u>coinsurance</u> (office visits and all other outpatient)/ Not Covered (partial <u>hospitalization</u> & intensive outpatient)/	<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 from a Tier 1 or Tier 2 provider
	Inpatient services	\$500 <u>copay</u> /admission (facility charge)/15% <u>coinsurance</u> (professional fees)	30% <u>coinsurance</u>	60% <u>coinsurance</u>	<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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 SMH Providers	Tier 2 Aetna CPII Providers	Tier 3 Non-Participating Providers	
		(You will pay the least)	(You will pay the most)		
If you are pregnant	Office visits	No Charge (\$50 <u>copay</u> for initial visit)	\$50 <u>copay</u> , then 30% <u>coinsurance</u>	60% <u>coinsurance</u>	<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 Tier 1 or Tier 2 <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	15% <u>coinsurance</u>	30% <u>coinsurance</u>	60% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$500 <u>copay</u> /admission	30% <u>coinsurance</u>	60% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$35 <u>copay</u> /visit	30% <u>coinsurance</u>	60% <u>coinsurance</u>	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 (massage therapy)/ \$35 <u>copay</u> /visit (all other therapies)	30% <u>coinsurance</u>	60% <u>coinsurance</u>	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 from a Tier 1 or Tier 2 provider.
	<u>Habilitation services</u>	\$35 <u>copay</u> /visit	30% <u>coinsurance</u>	60% <u>coinsurance</u>	Covered to age 19 for physical, speech/hearing & occupational therapy. Includes telemedicine from a Tier 1 or Tier 2 provider.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 SMH Providers	Tier 2 Aetna CPII Providers	Tier 3 Non-Participating Providers	
		(You will pay the least)	(You will pay the most)		
	<u>Skilled nursing care</u>	\$500 <u>copay</u> /admission	30% <u>coinsurance</u>	60% <u>coinsurance</u>	Limited to 90 days per year if not at SMHCS facilities. <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>	15% <u>coinsurance</u>	30% <u>coinsurance</u>	60% <u>coinsurance</u>	<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	30% <u>coinsurance</u>	60% <u>coinsurance</u>	Bereavement counseling is not covered. <u>Hospice services</u> limited to 60 days per lifetime.
If your child needs dental or eye care	Children’s eye exam	Not Covered	Not Covered	Not Covered	Not Covered
	Children’s glasses	Not Covered	Not Covered	Not Covered	Not Covered
	Children’s dental check-up	Not Covered	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</u> services.)		
- Bereavement counseling - Cosmetic surgery - Dental care (Adult & Child) - Emergency room services for non-emergency services	- Glasses (Adult & Child) - Habilitation services - 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 <u>plan</u> 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, 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 Tier 1 pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Primary care physician copayment</u>	\$0
■ Hospital (facility) <u>copayment</u>	\$500
■ Other <u>coinsurance</u>	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:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,100
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,360

Managing Joe's Type 2 Diabetes

(a year of routine Tier 1 care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>copayment</u>	\$350
■ Other <u>coinsurance</u>	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:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,300
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,420

Mia's Simple Fracture

(Tier 1 emergency room visit and follow-up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>copayment</u>	\$250
■ Other <u>coinsurance</u>	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:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$900
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$940

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