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 Mysmhcarehub.com or call (844) 573-1532. 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 Tier 1 providers: $0 person / $0 family For Tier 2 providers: $1,500 person / $4,500 family For Tier 3 providers: $3,000 person / $9,000 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. For Tier 1 providers: All services are covered before you meet a deductible. For Tier 2 providers: Preventive care, imaging, diagnostic tests, emergency room care (all providers), emergency medical transportation (all providers), urgent care, home health care, outpatient mental health & substance abuse services, residential treatment facility, durable medical equipment, rehabilitation services, habilitation services and office visits 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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Tier 1 providers: $2,000 person / $4,000 family For Tier 2 providers: $6,000 person / $12,000 family For Tier 3 providers: Unlimited per person or 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?	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.

Is Preauthorization required?	Yes.	Preauthorization required for inpatient admissions, outpatient procedures, advanced imaging, diagnostic testing, durable medical equipment, physician office-based medical treatments or procedures, mental health and substance abuse treatment services, and other designated services. If required preauthorization is not obtained, covered benefits will be reduced by 50%. See the plan document for additional details regarding preauthorization requirements, exceptions, limitations, and penalties.
Will you pay less if you use a network provider?	Yes. See Mysmhcarehub.com or call (844) 573-1532 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
		Tier 1 smhCare Providers	Tier 2 Aetna CPII Providers	Tier 3 Non-Participating Providers	
		(You will pay the least)	(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	$10 copay/visit (office visits)/ 10% coinsurance (all other services)	$30 copay/visit (office visits)/ 30% coinsurance (all other services)	Deductible, then 60% coinsurance	Copay applies to the physician office visit only. Includes telemedicine. Preauthorization required for office procedures $2,400 or more. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Specialist visit	$35 copay/visit (office visits)/ 10% coinsurance (all other services)	$55 copay/visit (office visits)/ 30% coinsurance (all other services)	Deductible, then 60% coinsurance	
	Preventive care/ screening/ immunization	No Charge	No Charge	Deductible, then 60% coinsurance	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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 smhCare Providers	Tier 2 Aetna CPII Providers	Tier 3 Non-Participating Providers	
		(You will pay the least)	(You will pay the most)		
If you have a test	Diagnostic test (x-ray, blood work)	No Charge (SMH or ACH)/ $35 copay/visit (SMH Med Staff or ACH Office)/ $35 copay/visit (non-contrast CT scan of the heart with calcium scoring – SMHCS)/ Not Covered (non-contrast CT scan of the heart with calcium scoring – all other providers)/ No Charge (diagnostic physician services)	$50 copay/visit (Office or Freestanding Facility)/ $100 copay/visit (On Campus or Off Campus Outpatient Hospital)/ 30% coinsurance (diagnostic physician services)	Deductible, then 60% coinsurance	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 SMHCS.
	Imaging (CT/PET scans, MRIs)	$50 copay/visit (SMH or ACH)/ No Charge (diagnostic physician services)	$150 copay/visit (Office or Freestanding Facility)/ $300 copay/visit (On-Campus or Off-Campus Outpatient Hospital)/30% coinsurance (diagnostic physician services)	Deductible, then 60% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 smhCare Providers	Tier 2 Aetna CPII 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 Mysmhcarehub.com	Generic drugs	**SMH Rx Express:** $10 copay (30-day retail, 90-day retail & 90-day mail order)	**All Other Network Pharmacies:** $12 copay (30-day retail)/ $25 copay (90-day retail & 90-day mail order)	**Non-Participating Pharmacies:** Not Covered	Deductible does not apply. Covers up to a 90-day supply (retail prescription); 90-day supply (mail order prescription); 30-day supply (specialty drugs). The copay applies per prescription. There is no charge or deductible for preventive drugs. Mandatory generic provision applies. Specialty drugs must be obtained from the specialty pharmacy network. Step therapy provision applies.
	Preferred brand drugs	$40 copay (30-day retail, 90-day retail & 90-day mail order)	$40 copay (30-day retail)/ $80 copay (90-day retail & 90-day mail order)	Not Covered	
	Non-preferred brand drugs	$70 copay (30-day retail, 90-day retail & 90-day mail order)	$70 copay (30-day retail)/ $140 copay (90-day retail & 90-day mail order)	Not Covered	
	Specialty drugs	$100 copay (30-day retail)	$125 copay (30-day retail)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay/ occurrence (ambulatory surgery center)/ $150 copay (outpatient hospital)	$350 copay/ occurrence (ambulatory surgery center)/ Deductible, then 30% coinsurance (outpatient hospital)	Deductible, then 60% coinsurance	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	10% coinsurance	30% coinsurance	Deductible, then 60% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 smhCare Providers	Tier 2 Aetna CPII 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 copay/visit (emergency services)/ $250 copay/visit (non-emergency services)/ No Charge (physician's services)	$250 copay/visit (emergency services)/ $250 copay/visit (non-emergency services)/ No Charge (physician's services)	$250 copay/visit (emergency services)/ $250 copay/visit (non-emergency services)/ No Charge (physician's services)	Tier 2 and Tier 3 providers are paid at the Tier 1 provider level of benefits. Copay is waived if admitted to the hospital.
	Emergency medical transportation	$125 copay/trip (ground)/ $250 copay/trip (air)	$125 copay/trip (ground)/ $250 copay/trip (air)	$125 copay/trip (ground)/ $250 copay/trip (air)	Tier 2 and Tier 3 providers are paid at the Tier 1 provider level of benefits.
	Urgent care	$25 copay/visit	$60 copay/visit	Deductible, then $120 copay/visit, then 60% coinsurance	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)	$250 copay/admission	Deductible, then 30% coinsurance	Deductible, then 60% coinsurance	Preauthorization required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Deductible, then 60% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/visit (office visit)/ $15 copay/visit (ABA therapy)/ No Charge (partial hospitalization & intensive outpatient; and all other outpatient)	$30 copay/visit (office visit)/ $20 copay/visit (ABA therapy)/ $40 copay (partial hospitalization & intensive outpatient)/30% coinsurance (all other outpatient)	Not Covered (partial hospitalization & intensive outpatient)/ Deductible, then 60% coinsurance (office visits, ABA therapy, and all other outpatient)	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. Residential treatment center limited to 180 days per year.
	Inpatient services	$250 copay/admission (facility charges)/ 10% coinsurance (professional fees)	$250 copay/ admission (facility charges for substance abuse treatment & residential treatment center)/	Deductible, then 60% coinsurance (facility charges and professional fees for mental disorders & substance abuse	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 smhCare Providers	Tier 2 Aetna CPII Providers	Tier 3 Non-Participating Providers	
		(You will pay the least)	(You will pay the most)		
			Deductible, then 30% coinsurance (facility charges for mental disorders)/ 30% coinsurance (professional fees)	treatment)/ Not Covered (residential treatment center)	
If you are pregnant	Office visits	No Charge ($35 copay for initial visit)	$55 copay/visit	Deductible, then 60% coinsurance	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 Tier 1 or Tier 2 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	Deductible, then 30% coinsurance	Deductible, then 60% coinsurance	
	Childbirth/delivery facility services	$250 copay/admission	Deductible, then 30% coinsurance	Deductible, then 60% coinsurance	
If you need help recovering or have other special health needs	Home health care	$35 copay/visit	$50 copay/visit	Deductible, then 60% coinsurance	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	$25 copay/visit (SMH or ACH only)	$40 copay/visit (non-facility)/ $80 copay/visit (facility)	Deductible, then 60% coinsurance	Physical, speech/hearing, and occupational therapy are limited to a combined maximum of 30 visits per year. Additional visits are allowed if medically necessary. Includes telemedicine from a Tier 1 or Tier 2 provider. Massage therapy is only covered at Healthfit Powered by SMH locations and is subject to a copay. Coverage is limited to 30 visits per year and requires a prescription from a physician.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 smhCare Providers	Tier 2 Aetna CPII Providers	Tier 3 Non-Participating Providers	
		(You will pay the least)	(You will pay the most)		
	Habilitation services	$25 copay/visit (SMH or ACH only)	$40 copay/visit (non-facility)/ $80 copay/visit (facility)	Deductible, then 60% coinsurance	Covered to age 19 for physical, speech/hearing & occupational therapy. Includes telemedicine from a Tier 1 or Tier 2 provider.
	Skilled nursing care	$250 copay/admission	$200 copay/day (up to 10 days)/ No Charge (days 10-180)	Not Covered	Limited to 180 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.
	Durable medical equipment	10% coinsurance	30% coinsurance	Deductible, then 60% coinsurance	Preauthorization required for any item in excess of $1,500. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Hospice services	No Charge	Deductible, then 30% coinsurance	Deductible, then 60% coinsurance	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	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 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)**
- **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 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 Tier 1 pre-natal care and a hospital delivery)

The plan's overall deductible	**$0**
Primary care physician copayment	**$0**
Hospital (facility) copayment	**$250**
Other coinsurance	**10%**

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	$800
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$960

Managing Joe's Type 2 Diabetes
(a year of routine Tier 1 care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist copayment	**$35**
Hospital (facility) copayment	**$200**
Other coinsurance	**10%**

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	$900
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,000

Mia's Simple Fracture
(Tier 1 emergency room visit and follow-up care)

The plan's overall deductible	**$0**
Specialist copayment	**$35**
Hospital (facility) copayment	**$250**
Other coinsurance	**10%**

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	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$820

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