# CITY OF COLUMBUS

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 1/1/2017-12/31/2017**

**Coverage for:** Single/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 your employer or by calling SIHO 1-800-443-2980

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **Inspire & SIHO: $750** single / **$1,500** family<br>**Out of Network: $750** single / **$1,500** family<br>Inspire and SIHO Deductibles cross apply. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **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. |
| **Is there an out–of–pocket limit on my expenses?** | **Inspire & SIHO: $4,750** single / **$9,500** family<br>**Out of Network: $4,750** single / **$9,500** family<br>Inspire and SIHO Coinsurance cross apply. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Precertification Penalties, Premiums, Balance Billed Charges and Healthcare this Plan does not cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. See www.siho.org **or call 1-800-443-2980** for a list of participating providers. Please refer to your ID card for the appropriate network | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |

**Questions:** Call 1-800-443-2980 or visit us at www.siho.org.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/sbc or call 1-800-443-2980 to request a copy.

| | | |
|---|---|---|
| | information | |
| **Do I need a referral to see a specialist?** | No. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**. |

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** fo if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

| Common Medical Event | Services You May Need | Your cost if you use an In-network Provider | Your cost if you use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | none |
| | Specialist visit | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | none |
| | Other practitioner office visit | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | Chiropractic calendar year maximum: 30 visits. |
| | Preventive care/screening/immunization | No Charge | No Charge | Based on SIHO's Comprehensive Preventive Guidelines. Preventive Dental Services are covered at no cost. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | Lab tests performed at Prompt Med, CRH Lab at Sandcrest or any provider sending specimen to CRH are paid at 100% |

| Common Medical Event | Services You May Need | Your cost if you use an In-network Provider | Your cost if you use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Imaging (CT/PET scans, MRIs) | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | none |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.siho.org. | Generic drugs | $10 copay retail; $25 copay mail order | Not Covered | Retail up to 30 day supply; Mail Order up to 90 day supply |
| | Preferred brand drugs | $30 copay retail; $60 copay mail order | Not Covered | Retail up to 30 day supply; Mail Order up to 90 day supply |
| | Non-preferred brand drugs | $50 copay retail; $120 copay mail order | Not Covered | Retail up to 30 day supply; Mail Order up to 90 day supply |
| | Specialty drugs | 20% coinsurance | N/A | Covered under Major Medical. Prior authorization required. Failure to obtain precertification will result in a 10% penalty up to $500 per claim. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | Select Outpatient Procedures may require Prior authorization. Failure to obtain precertification will result in a 10% penalty up to $500 per claim. |
| | Physician/surgeon fees | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | none |
| **If you need immediate medical attention** | Emergency room services | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | Non-Emergent use of Emergency Room will be subject to a $150 facility copayment |
| | Emergency medical transportation | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | none |
| | Urgent care | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | none |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | Prior authorization required. Failure to obtain precertification will result in a 10% penalty up to $500 per claim. |

| Common Medical Event | Services You May Need | Your cost if you use an In-network Provider | Your cost if you use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Physician/surgeon fee | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | ——————none—————— |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | Prior authorization required for ABA Therapy and Intensive Outpatient Program (IOP). Failure to obtain precertification will result in a 10% penalty up to $500 per claim. |
| | Mental/Behavioral health inpatient services | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | Prior authorization required for Inpatient and Partial Hospitalization (PHP). Failure to obtain precertification will result in a 10% penalty up to $500 per claim. |
| | Substance use disorder outpatient services | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | Prior authorization required for Intensive Outpatient Program (IOP). Failure to obtain precertification will result in a 10% penalty up to $500 per claim. |
| | Substance use disorder inpatient services | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | Prior authorization required for Inpatient and Partial Hospitalization (PHP). Failure to obtain precertification will result in a 10% penalty up to $500 per claim. |
| **If you are pregnant** | Prenatal and postnatal care | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | Dependent daughters are **not** covered. |
| | Delivery and all inpatient services | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | Dependent daughters are **not** covered. |

| Common Medical Event | Services You May Need | Your cost if you use an In-network Provider | Your cost if you use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | No charge | No charge | Prior authorization required. Failure to obtain precertification will result in a 10% penalty up to $500 per claim. Calendar year maximum: 100 visits |
| | Rehabilitation services | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | Prior authorization required for Speech Therapy. Failure to obtain precertification will result in a 10% penalty up to $500 per claim. |
| | Habilitation services | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | ——————none—————— |
| | Skilled nursing care | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | Prior authorization required. Failure to obtain precertification will result in a 10% penalty up to $500 per claim. Calendar year maximum: 60 days |
| | Durable medical equipment | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | Prior authorization required on all purchases over $750 and all rentals. Failure to obtain precertification will result in a 10% penalty up to $500 per claim. |
| | Hospice service | Inspire: 20% coinsurance<br>SIHO: 30% coinsurance | 40% coinsurance | Prior authorization required. Failure to obtain precertification will result in a 10% penalty up to $500 per claim. Bereavement counseling covered at the same benefit. Calendar year maximum: 3 months outpatient, 6 months inpatient. |
| **If your child needs dental or eye care** | Eye exam | Not Covered | Not Covered | ——————none—————— |
| | Glasses | Not Covered | Not Covered | ——————none—————— |

| Common Medical Event | Services You May Need | Your cost if you use an In-network Provider | Your cost if you use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Dental check-up | No Charge | No Charge | Preventive Dental exams, x-rays and cleanings covered - limited to 2 per year. |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Infertility Treatment
- Dental care (Adult)
- Long Term Care
- Routine eye care (Adult)
- Weight loss programs
- Non-Emergency care when traveling outside the U.S.
- Hearing Aids

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Morbid Obesity ($1000 Calendar year maximum)
- TMJ

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at [contact number]. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov."

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the Appeals Coordinator in writing P.O. Box 1787 Columbus, IN 47202 or verbally by calling 1-800-443-2980.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,290
- **Patient pays** $2,250

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $750 |
| Co-pays | $0 |
| Co-insurance | $1,350 |
| Limits or exclusions | $150 |
| **Total** | **$2,250** |

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,500
- **Patient pays** $1,900

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $750 |
| Co-pays | $380 |
| Co-insurance | $690 |
| Limits or exclusions | $80 |
| **Total** | **$1,900** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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