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, call 1-800-443-2980 or visit us at www.siho.org. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-443-2980 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For Inspire & SIHO Provider: $1,500 Individual / $3,000 Family For Out-of-Network Provider: $1,500 Individual / $3,000 Family **Inspire and SIHO Deductibles cross apply.**	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes.	This plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.siho.org.
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 Inspire & SIHO Provider: $4,750 Individual / $9,500 Family For Out-of-Network Provider: $4,750 Individual / $9,500 Family **Inspire and SIHO Coinsurance cross apply.**	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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, Balance Billed Charges, Precertification Penalties, and Services this Plan does not 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.siho.org or call 1-800-443-2980 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. 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
		Inspire Network (You will pay the least)	SIHO Network (You will pay more)	Non-Network 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	20% coinsurance	30% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	30% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No Charge	No Charge	No Charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.siho.org	Generic drugs	20% coinsurance		Not Covered	Retail up to a 30-day supply. Mail Order up to 90-day supply. IRS Preventive Drugs covered at 20% no deductible.
	Preferred brand drugs	20% coinsurance		Not Covered	
	Non-preferred brand drugs	20% coinsurance		Not Covered	
	Specialty drugs	20% coinsurance		Not Covered	Covered under the Major Medical Benefit. Preauthorization is required. Failure to obtain preauthorization from the plan will result in a 10% penalty up to $500 per claim.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	40% coinsurance	Select Outpatient Procedures may require Pre-certification. Failure to obtain prior authorization from the plan will result in a 10% penalty up to $500 per claim.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	30% coinsurance	40% coinsurance	True Emergency: 20% coinsurance all tiers and charges incurred at Non-Network provider will apply as In-Network benefits.

* For more information about limitations and exceptions, see the plan or policy document at www.siho.org.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Inspire Network (You will pay the least)	SIHO Network (You will pay more)	Non-Network Provider (You will pay the most)	
	Emergency medical transportation	20% coinsurance	30% coinsurance	40% coinsurance	True Emergency: 20% coinsurance all tiers and charges incurred at Non-Network provider will apply as In-Network benefits.
	Urgent care	20% coinsurance	30% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	40% coinsurance	Preauthorization is required. Failure to obtain preauthorization from the plan will result in a 10% penalty up to $500 per claim.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	40% coinsurance	Preauthorization required for ABA Therapy and Intensive Outpatient Program (IOP). Failure to obtain preauthorization from the plan will result in a 10% penalty up to $500 per claim.
	Inpatient services	20% coinsurance	30% coinsurance	40% coinsurance	Precertification required for Inpatient. Partial Hospitalization (PHP) & Residential Treatment (RES). Failure to obtain prior authorization from the plan will result in a 10% penalty up to $500 per claim.
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	40% coinsurance	Dependent Daughter Maternity is Covered.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	40% coinsurance	Calendar Year Maximum: 100 Visits. Preauthorization is required. Failure to obtain preauthorization from the plan will result in a 10% penalty up to $500 per claim.
	Rehabilitation services	20% coinsurance	30% coinsurance	40% coinsurance	Preauthorization is required for Speech Therapy. Failure to obtain preauthorization from the plan will result in a 10% penalty up to $500 per claim.
	Habilitation services	20% coinsurance	30% coinsurance	40% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at www.siho.org.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Inspire Network (You will pay the least)	SIHO Network (You will pay more)	Non-Network Provider (You will pay the most)	
	Skilled nursing care	20% coinsurance	30% coinsurance	40% coinsurance	Calendar Year Maximum: 60 Days. Preauthorization is required. Failure to obtain preauthorization from the plan will result in a 10% penalty up to $500 per claim
	Durable medical equipment	20% coinsurance	30% coinsurance	40% coinsurance	Preauthorization required for purchases over $750 & on all rentals. Failure to obtain preauthorization from the plan will result in a 10% penalty up to $500 per claim.
	Hospice services	20% coinsurance	30% coinsurance	40% coinsurance	Calendar Year Maximum: 3 months outpatient; 6 months inpatient. Preauthorization is required. Failure to obtain preauthorization from the plan will result in a 10% penalty up to $500 per claim. Bereavement counseling covered at the same benefit.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	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.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care When Traveling Outside The U.S.
- Private Duty Nursing
- Routine Eye Care (Adult)
- Weight Loss Programs

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

- Chiropractic Care
- Morbid Obesity (Calendar Year Maximum $1,000)
- TMJ

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or

www.cciio.cms.gov. 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 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: Appeals Coordinator in writing at P.O. Box 1787 Columbus, IN 47202 or verbally by calling 1-800-443-2980.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 (410) 786-5110.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (410) 786-5110.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** (410) 786-5110.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (410) 786-5110.

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

* For more information about limitations and exceptions, see the plan or policy document at www.siho.org.

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	$1,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$2,527
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,087**

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

The plan's overall deductible	$1,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$1,437
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,992**

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

The plan's overall deductible	$1,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,885**

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

Discrimination is Against the Law

Current Health Solutions and/or the plan sponsors for which it administers employee welfare and benefits plans ("Current Health Solutions and/or the Plans it administers") comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Current Health Solutions and/or the Plans it administers do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Current Health Solutions (both for itself and/or on behalf of the Plans it administers):

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, please contact the Compliance contact for Current Health Solutions by mail at 417 Washington Street, Columbus, IN 47201, by phone at (844) 255-7120 or TTY (800) 743-3333.

If you believe that Current Health Solutions and/or the Plans it administers have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the above Compliance contact. You can file a grievance in person or by mail, or email as indicated above. If you need help filing a grievance the Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at http://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services

English: ATTENTION: Our Member Services department has free language interpreter services available for non-English speakers. Call 800.443.2980 (TTY: 800.743.3333)

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800.443.2980 (TTY: 800.743.3333).

Chínese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800.443.2980 (TTY: 800.743.3333).

Burmese:

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက်
စီစဉ်ဆောင်ရွက်ပေးပါမည်။

ဖုန်းနံပါတ် 800.443.2980 (TTY: 800.743.3333) သို့ ခေါ်ဆိုပါ။

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800.443.2980 (TTY: 800.743.3333).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800.443.2980 (ATS : 800.743.3333).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800.443.2980 (TTY: 800.743.3333).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800.443.2980 (TTY: 800.743.3333).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800.443.2980 (TTY: 800.743.3333)번으로 전화해 주십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800.443.2980 (телетайп: 800.743.3333).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800.443.2980 (رقم هاتف الصم والبكم: 800.743.3333).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 800.443.2980 (TTY: 800.743.3333) पर कॉल करें।

Pennsylvania Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 800.443.2980 TDD/TTY 800.743.3333 uffrufe.

Dutch: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 800.443.2980 (TDD/TTY 800.743.3333).

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800.443.2980 (TTY: 800.743.3333) 'ਤੇ ਕਾਲ ਕਰੋ।

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 800.443.2980（TTY: 800.743.3333）まで、お電話にてご連絡ください。