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?	Tier 1 Inspire Network Provider: $750 Individual / $1,500 Family Tier 2 SIHO Network Provider: $1,500 Individual / $3,000 Family Tier 3 Out-of-Network Provider: $1,500 Individual / $3,000 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. **Tier 1 and Tier 2 deductible amounts cross apply but do NOT cross apply to the Tier 3 deductible, and vice versa.**
Are there services covered before you meet your deductible?	Yes. Preventive Care services and Home Healthcare are NOT subject to the 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 and Home Health 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 deductible for specific services.
What is the out-of-pocket limit for this plan?	Tier 1 Inspire Network Provider: $4,750 Individual / $9,500 Family Tier 2 SIHO Network Provider: $6,000 Individual / $12,000 Family Tier 3 Out-of-Network Provider: $6,000 Individual / $12,000 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 limit until the overall family out-of-pocket limit has been met. **Tier 1 and Tier 2 out-of-pocket limit amounts cross apply but do NOT cross apply to the Tier 3 out-of-pocket limit, and vice versa.**
What is not included in the out-of-pocket limit?	Premium, Balance Billed Charges, Preauthorization 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
		Tier 1 - Inspire Network (You will pay the least)	Tier 2 - SIHO Network (You will pay more)	Tier 3 – 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	
	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	Lab tests performed at Prompt Med, CRH Lab at Sandcrest or any provider sending specimen to CRH are paid at 100%. This does Not apply to labs performed directly at CRH.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	40% coinsurance	None

* 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
		Tier 1 - Inspire Network (You will pay the least)	Tier 2 - SIHO Network (You will pay more)	Tier 3 – Non-Network Provider (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.optumrx.com or by calling 855-524-0381.	Generic drugs	Retail: $10 copayment Mail Order: $25 copayment		Not Covered	Retail: Up to a 30-day supply Mail Order: Up to 90-day supply
	Preferred brand drugs	Retail: $30 copayment Mail Order: $60 copayment		Not Covered	
	Non-preferred brand drugs	Retail: $50 copayment Mail Order: $120 copayment		Not Covered	
	Specialty drugs	Generic: $10 copayment Preferred brand drugs: $30 copayment Non-preferred brand drugs: $50 copayment		Not Covered	Covered under the Pharmacy Benefit. Preauthorization is required. Failure to obtain preauthorization from the plan may result in a 10% penalty up to $500 per claim.

* 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
		Tier 1 - Inspire Network (You will pay the least)	Tier 2 - SIHO Network (You will pay more)	Tier 3 – Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	40% coinsurance	Select Outpatient Procedures may require Preauthorization. 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	
If you need immediate medical attention	Emergency room care	True Emergent: 20% coinsurance Non-Emergent: 20% coinsurance	True Emergent: 20% coinsurance Non-Emergent: 30% coinsurance	True Emergent: 20%coinsurance Non-Emergent: 40% coinsurance	True Emergent: ER services will apply to the Tier 1 benefit level.
	Emergency medical transportation	True Emergent: 20% coinsurance Non-Emergent: 20% coinsurance	True Emergent: 20% coinsurance Non-Emergent: 30% coinsurance	True Emergent: 20% coinsurance Non-Emergent: 40% coinsurance	True Emergent Ambulance charges will apply to the Tier 1 benefit level. This includes non-emergent transportation from one facility to another facility.
	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

* 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
		Tier 1 - Inspire Network (You will pay the least)	Tier 2 - SIHO Network (You will pay more)	Tier 3 – Non-Network Provider (You will pay the most)	
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	Preauthorization required for Inpatient. Partial Hospitalization (PHP) & Residential Treatment (RES). Failure to obtain preauthorization 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	

* 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
		Tier 1 - Inspire Network (You will pay the least)	Tier 2 - SIHO Network (You will pay more)	Tier 3 – Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	No Charge	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	
	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	Precertification 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	None
	Children's dental check-up	Not Covered	Not Covered	Not Covered	None

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

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	$750
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	$750
Copayments	$40
Coinsurance	$2,520
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,370**

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

The plan's overall deductible	$750
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	$750
Copayments	$700
Coinsurance	$585
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,090**

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

The plan's overall deductible	$750
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	$750
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,135**

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