




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](http://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 <a href="#">deductible</a> ?	Tier 1 Inspire Network <a href="#">Provider</a> : \$2,000 Individual / \$4,000 Family Tier 2 SIHO Network <a href="#">Provider</a> : \$3,500 Individual / \$7,000 Family Tier 3 Out-of-Network <a href="#">Provider</a> : \$3,500 Individual / \$7,000 Family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , the overall family <a href="#">deductible</a> must be met before the plan begins to pay.  <b>Tier 1 and Tier 2 <a href="#">deductible</a> amounts cross apply but do NOT cross apply to the Tier 3 <a href="#">deductible</a>, and vice versa.</b>
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Preventive Care services are NOT subject to the <a href="#">deductible</a> .	This <a href="#">plan</a> covers certain preventive services without cost-sharing and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="http://www.siho.org">www.siho.org</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Tier 1 Inspire Network <a href="#">Provider</a> : \$4,750 Individual / \$9,500 Family Tier 2 SIHO Network <a href="#">Provider</a> : \$7,000 Individual / \$14,000 Family Tier 3 Out-of-Network <a href="#">Provider</a> : \$7,000 Individual / \$14,000 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.  <b>Tier 1 and Tier 2 <a href="#">out-of-pocket limit</a> amounts cross apply but do NOT cross apply to the Tier 3 <a href="#">out-of-pocket limit</a>, and vice versa.</b>
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premium</a> , <a href="#">Balance Billed</a> Charges, Precertification Penalties, and Services this <a href="#">Plan</a> does not cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.siho.org">www.siho.org</a> or call 1-800-443-2980 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider</a> network. You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan</a> 's network. You will pay the most if you use an out-of-network <a href="#">provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider</a> 's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your network <a href="#">provider</a> might use an out-of-network <a href="#">provider</a> for some services. Check with your <a href="#">provider</a> before you get services.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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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 Inspire Network Provider (You will pay the least)	Tier 2 SIHO Network Provider (You will pay more)	Tier 3 Non-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Chiropractic Annual Maximum: 30 visits
	<a href="#">Preventive care/screening/immunization</a>	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	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a> or by calling 855-524-0381.	Generic drugs	20% <a href="#">coinsurance</a>		Not Covered	Retail up to a 30-day supply. Mail Order up to 90-day supply.
	Preferred brand drugs	20% <a href="#">coinsurance</a>		Not Covered	Prescription Drugs listed on the High Deductible Health Plan - Health Savings Account Preventive Therapy Drug List will be covered at the appropriate <a href="#">coinsurance</a> and not subject to the annual <a href="#">deductible</a> .
	Non-preferred brand drugs	20% <a href="#">coinsurance</a>		Not Covered	
	<a href="#">Specialty drugs</a>	20% <a href="#">coinsurance</a>		Not Covered	Covered under the Pharmacy Benefit. <a href="#">Preauthorization</a> is required. Failure to obtain <a href="#">preauthorization</a> from the plan will result in a 10% penalty up to \$500 per claim.

**Plan Type: HDHP**

\* For more information about limitations and exceptions, see the plan or policy document at [www.siho.org](http://www.siho.org).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Inspire Network Provider (You will pay the least)	Tier 2 SIHO Network Provider (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% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	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% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	<a href="#">True Emergent:</a> 20% <a href="#">coinsurance</a>  <a href="#">Non-Emergent:</a> 20% <a href="#">coinsurance</a>	<a href="#">True Emergent:</a> 20% <a href="#">coinsurance</a>  <a href="#">Non-Emergent:</a> 30% <a href="#">coinsurance</a>	<a href="#">True Emergent:</a> 20% <a href="#">coinsurance</a>  <a href="#">Non-Emergent:</a> 40% <a href="#">coinsurance</a>	<a href="#">True Emergent</a> ER services will apply to the Tier 1 benefit level.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">True Emergent</a> Ambulance charges will apply to the Tier 1 benefit level. This includes non-emergent transportation from one facility to another facility.
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. Failure to obtain <a href="#">preauthorization</a> from the plan will result in a 10% penalty up to \$500 per claim.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Inspire Network Provider (You will pay the least)	Tier 2 SIHO Network Provider (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% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required for ABA Therapy and Intensive Outpatient Program (IOP). Failure to obtain <a href="#">preauthorization</a> from the plan will result in a 10% penalty up to \$500 per claim.
	Inpatient services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	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% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Dependent Daughter Maternity is Covered.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Calendar Year Maximum: 100 Visits. <a href="#">Preauthorization</a> is required. Failure to obtain <a href="#">preauthorization</a> from the plan will result in a 10% penalty up to \$500 per claim.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for Speech Therapy. Failure to obtain <a href="#">preauthorization</a> from the plan will result in a 10% penalty up to \$500 per claim.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Calendar Year Maximum: 60 Days. <a href="#">Preauthorization</a> is required. Failure to obtain <a href="#">preauthorization</a> from the plan will result in a 10% penalty up to \$500 per claim.

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Inspire Network Provider (You will pay the least)	Tier 2 SIHO Network Provider (You will pay more)	Tier 3 Non-Network Provider (You will pay the most)	
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required for purchases over \$1,000 and on all rentals. Failure to obtain <a href="#">preauthorization</a> from the plan will result in a 10% penalty up to \$500 per claim.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Calendar Year Maximum: 3 months outpatient; 6 months inpatient. <a href="#">Preauthorization</a> is required. Failure to obtain <a href="#">preauthorization</a> 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](#).)**

<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric Surgery</li> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing Aids</li> <li>• Infertility Treatment</li> <li>• Long-Term Care</li> <li>• Non-Emergency Care When Traveling Outside The U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private Duty Nursing</li> <li>• Routine Eye Care (Adult)</li> <li>• Weight Loss Programs</li> </ul>
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**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

<ul style="list-style-type: none"> <li>• Chiropractic Care</li> </ul>	<ul style="list-style-type: none"> <li>• Morbid Obesity (Calendar Year Maximum \$1,000)</li> </ul>	<ul style="list-style-type: none"> <li>• TMJ</li> </ul>
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**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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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](http://www.HealthCare.gov) or call 1-800-318-2596.

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**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 1-800-443-2980.

**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 (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, kwijigo holne' (410) 786-5110.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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#### Plan Type: HDHP

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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](#) \$2,000
- [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*)  
 Prescription drugs

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,260</b>

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

- The [plan's](#) overall [deductible](#) \$2,000
- [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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,820</b>

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

- The [plan's](#) overall [deductible](#) \$2,000
- [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*)  
 Prescription drugs

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,300</b>