**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: $1,250 Individual / $2,500 Family<br>Tier 2 SIHO Network Provider: $2,000 Individual / $4,000 Family<br>Tier 3 Out-of-Network Provider: $2,000 Individual / $4,000 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.<br>**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<br>Tier 2 SIHO Network Provider: $7,000 Individual / $14,000 Family<br>Tier 3 Out-of-Network Provider: $7,000 Individual / $14,000 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.<br>**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 **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 | Chiropractic Annual Maximum: 30 visits |
| | 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 | All office and outpatient labs will be paid at 100%, deductible waived, when provided at, or billed by Columbus Regional Hospital or a Columbus Regional Health Care Physician.<br><br>Preauthorization is required for genetic testing Failure to obtain preauthorization from the plan will result in a 10% penalty up to $500 per claim. |
| | 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**<br>More information about **prescription drug coverage** is available at www.optumrx.com or by calling 855-524-0381. | Generic drugs | Retail:<br>$10 copayment<br><br>Mail Order:<br>$25 copayment | | Not Covered | Retail: Up to a 30-day supply<br>Mail Order: Up to 90-day supply |
| | Preferred brand drugs | Retail:<br>$30 copayment<br><br>Mail Order:<br>$60 copayment | | Not Covered | |
| | Non-preferred brand drugs | Retail:<br>$50 copayment<br><br>Mail Order:<br>$120 copayment | | Not Covered | |
| | Specialty drugs | Generic:<br>$10 copayment<br><br>Preferred brand drugs:<br>$30 copayment<br><br>Non-preferred brand drugs:<br>$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<br><br>Non-Emergent: $150 copayment, then 20% coinsurance | True Emergent: 20% coinsurance<br><br>Non-Emergent: $150 copayment, then 30% coinsurance | True Emergent: 20% coinsurance<br><br>Non-Emergent: $150 copayment, then 40% coinsurance | True Emergent: ER services will apply to the Tier 1 benefit level. |
| | Emergency medical transportation | True Emergent: 20% coinsurance<br><br>Non-Emergent: 20% coinsurance | True Emergent: 20% coinsurance<br><br>Non-Emergent: 30% coinsurance | True Emergent: 20% coinsurance<br><br>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 Intensive Outpatient Program (IOP) and Partial Hospitalization (PHP). 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 and 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 | |
| **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 and ABA 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 |
|---|---|---|---|---|---|
| | | 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) | |
| | 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 $1,000 and 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 |

## 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



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

**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 wwww.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 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 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 800-443-2980.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-443-2980.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 800-443-2980.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-443-2980.

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

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* 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 | $1,250 |
| 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

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,250 |
| Copayments | $10 |
| Coinsurance | $1,900 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,220** |

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

| | |
|---|---|
| The plan's overall deductible | $1,250 |
| 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** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,250 |
| Copayments | $300 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,770** |

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

| | |
|---|---|
| The plan's overall deductible | $1,250 |
| 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

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,250 |
| Copayments | $10 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,460** |

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