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?	**Health Risk Assessment Participants:** $500 Individual/ $1,000 Family	**Non-Participants:** $1,000 Individual/ $2,000Family	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. **In-Network and Out-of-Network deductible amounts do cross apply.**
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your 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.
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?	**Health Risk Assessment Participants:** Tier 1: $2,000 Individual/ $4,000 Family Tier 2: $2,500 Individual/ $5,000 Family Tier 3: $3,500 Individual/ $7,000 Family	**Non-Participants:** Tier 1: $2,500 Individual/ $5,000 Family Tier 2: $3,000 Individual/ $6,000 Family Tier 3: $4,000 Individual/ $8,000 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. **In-Network and Out-of-Network out-of-pocket limit amounts do cross apply.**
	RX Out-of-Pocket: $2,000 Individual / $4,000 Family.		
What is not included in the out-of-pocket limit?	Premiums, Balance Billing Charges, Preauthorization Penalties, Non-Emergent Emergency Room Penalty and Healthcare this Plan does not cover.		Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
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 (such as lab work). 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
		Network Provider (You will pay the least)	Out-of-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	Tier 1 & 2: 20% coinsurance after deductible	50% coinsurance after deductible	In-Network: Copayment applies to office visit only. All other services are subject to deductible and coinsurance.
	Specialist visit	Tier 1 & 2: 20% coinsurance after deductible	50% coinsurance after deductible	
	Preventive care/screening/ immunization	Tier 1 & 2: No Charge deductible waived	No Charge, deductible waived	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. This plan follows Open Door Health Services Comprehensive Preventive Health Benefit (PHB) guidelines. See www.siho.org for a list of PHB services.
If you have a test	Diagnostic test (x-ray, blood work)	Facility Charges: Tier 1:10% coinsurance after deductible Tier 2: 30% coinsurance after deductible Physician Charges: Tier 1 & 2: 20% coinsurance after	50% coinsurance after deductible	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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		deductible		
	Imaging (CT/PET scans, MRIs)	Facility Charges: Tier 1:10% coinsurance after deductible Tier 2: 30% coinsurance after deductible Physician Charges: Tier 1 & 2: 20% coinsurance after deductible	50% coinsurance after deductible	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.truescripts.com or 844-257-1955.	Generic drugs	1-30 Day Supply: $5 copayment 31-90 Day Supply: $12 copayment	1-30 Day Supply: $5 copayment 31-90 Day Supply: $12 copayment	RX Out-of-pocket limit: $2,000 individual / $4,000 family *1-30 Day Supply – Step Therapy trigger drugs will be exempt from the $100 RX Maximum *31-90 Day Supply – Step Therapy trigger drugs will be exempt from the $200 RX Maximum Preauthorization is required for Specialty drugs. Specialty drugs are limited to a 30 Day supply or less.
	Preferred brand drugs	1-30 Day Supply: 20% coinsurance or $20 copayment (whichever is greater) up to a $100* max 31-90 Day Supply: 20% coinsurance or $40 copayment (whichever is greater) up to a $200* max	1-30 Day Supply: 20% coinsurance or $20 copayment (whichever is greater) up to a $100* max 31-90 Day Supply: 20% coinsurance or $40 copayment (whichever is greater) up to a $200* max	
	Non-preferred brand drugs	1-30 Day Supply: 20% coinsurance or $20 copayment (whichever is greater) up to a $100* max 31-90 Day Supply: 20% coinsurance or $40 copayment (whichever is greater) up	1-30 Day Supply: 20% coinsurance or $20 copayment (whichever is greater) up to a $100* max 31-90 Day Supply: 20% coinsurance or $40 copayment	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		to a $200* max	(whichever is greater) up to a $200* max	
	Specialty drugs	Specialty Tier 1: 20% coinsurance or $20 copayment (whichever is greater) Specialty Tier 2: 50% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Tier 1:10% coinsurance after deductible Tier 2: 30% coinsurance after deductible	50% coinsurance after deductible	None
	Physician/surgeon fees	Tier 1 & 2: 20% coinsurance after deductible	50% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	True Emergency: Facility & Physician Charges at Greene Co. Hospital: 10% coinsurance after deductible All Other Hospitals: Facility Charges: Tier 1 & Tier 2: 10% coinsurance after deductible Physician Charges: Tier 1 & Tier 2: 20% coinsurance after deductible Non-Emergent:	True Emergency: Facility Charges: 10% coinsurance after deductible Physician Charges: 20% coinsurance after deductible Non-Emergent: Facility & Physician Charges: 50% coinsurance after deductible	True Emergent ER services will apply to the In-network benefit level. Copayment waived if admitted from ER. Non-Emergent Emergency room services will be subject to $150 penalty per occurrence.

* 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Facility Charges Tier 1 & 2 :10% coinsurance after deductible Physician Charges: Tier 1 & Tier 2: 20% coinsurance after deductible		
	Emergency medical transportation	True Emergency: Tier 1 & Tier 2: 10% coinsurance after deductible Non-Emergent: Tier 1:10% coinsurance after deductible Tier 2: 30% coinsurance after deductible	True Emergency: 10% coinsurance after deductible Non-Emergent: 50% coinsurance after deductible	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	Facility Charges: Tier 1:10% coinsurance after deductible Tier 2: 30% coinsurance after deductible Tier 1 & 2: Physician Charges: 20% coinsurance after deductible	50% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Tier 1:10% coinsurance after deductible Tier 2: 30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required. Failure to obtain Preauthorization will result in 50% reduction penalty.
	Physician/surgeon fees	Tier 1 & 2: 20% coinsurance	50% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		after deductible		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Facility Charges: Tier 1:10% coinsurance after deductible Tier 2: 30% coinsurance after deductible Tier 1 & 2: Physician Charges: 20% coinsurance after deductible	50% coinsurance after deductible	Autism & ADD/ADHD: Covers office visits and any testing required for diagnosis but treatment is not covered.
	Inpatient services	Tier 1:10% coinsurance after deductible Tier 2: 30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required. Failure to obtain Preauthorization will result in 50% reduction penalty.
If you are pregnant	Office visits	Tier 1 & 2: 20% coinsurance after deductible	50% coinsurance after deductible	Dependent Daughter Maternity is Not Covered. Preventive pre-natal labs and preventive services are covered as required by the ACA. See www.siho.org for a list of PHB services.
	Childbirth/delivery professional services	Tier 1 & 2: 20% coinsurance after deductible	50% coinsurance after deductible	
	Childbirth/delivery facility services	Tier 1:10% coinsurance after deductible Tier 2: 30% coinsurance after deductible	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	Facility Charges: Tier 1:10% coinsurance after deductible Tier 2: 30% coinsurance after deductible	50% coinsurance after deductible	Annual Maximum: 100 visits

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Physician Charges: Tier 1 & 2: 20% coinsurance after deductible		
	Rehabilitation services	Facility Charges: Tier 1:10% coinsurance after deductible Tier 2: 30% coinsurance after deductible Physician Charges: Tier 1 & 2: 20% coinsurance after deductible	50% coinsurance after deductible	Annual Maximum: 20 visits combined for Physical, Occupational, and Chiropractic Therapy. Separate 20 visit limit for Speech Therapy.
	Habilitation services	Facility Charges: Tier 1:10% coinsurance after deductible Tier 2: 30% coinsurance after deductible Physician Charges: Tier 1 & 2: 20% coinsurance after deductible	50% coinsurance after deductible	
	Skilled nursing care	Facility Charges: Tier 1:10% coinsurance after deductible Tier 2: 30% coinsurance after deductible Physician Charges: Tier 1 & 2: 20% coinsurance after deductible	50% coinsurance after deductible	Annual Maximum: 90 days Preauthorization is required. Failure to obtain Preauthorization will result in 50% reduction penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	Facility Charges: Tier 1:10% coinsurance after deductible Tier 2: 30% coinsurance after deductible Physician Charges: Tier 1 & 2: 20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required on purchases over $1,000 and on all rentals. Failure to obtain Preauthorization will result in a penalty of 50% per occurrence.
	Hospice services	Facility Charges: Tier 1:10% coinsurance after deductible Tier 2: 30% coinsurance after deductible Physician Charges: Tier 1 & 2: 20% coinsurance after deductible	50% coinsurance after deductible	Inpatient Annual Maximum: 30 days Preauthorization is required. Failure to obtain Preauthorization will result in 50% reduction penalty.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	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
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids (Unless hearing loss is a result of an accidental injury)
- Infertility Treatment
- Long-Term Care
- The Non-Emergency Care When Traveling Outside the U.S.
- Private Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care (Unless necessary for metabolic (diabetes) or peripheral-vascular disease)
- 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 (Annual Maximum: 20 visits combined with Physical and Occupational
- Bariatric Surgery (Morbid Obesity Only; Lifetime Maximum of $50,000)

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

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

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: Appeals Coordinator in writing at P.O. Box 1787 Columbus, IN 47202 or verbally by calling 1-800-443-2980. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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, kwiijigo holne' (410) 786-5110.]

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

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	$500
Specialist copayment	20%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,060**

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

The plan's overall deductible	$500
Specialist copayment	20%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$500
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

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

The plan's overall deductible	$500
Specialist copayment	20%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$810**

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