This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.siho.org or by calling 800-443-2980.

Important Questions	Answers		Why this Matters:
What is the overall deductible?	**In-Network:** Individual: **$2,000** Family: **$4,000** Out-of-network applies to in-network amount and vice-versa	**Out-of-Network:** Individual: **$4,000** Family: **$8,000** Out-of-network applies to in-network amount and vice-versa	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your plan document/SPD to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.		You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	**In-Network:** Individual: **$3,000** Family: **$6,000** Out-of-network applies to in-network amount and vice-versa	**Out-of-Network:** Individual: **$4,000** Family: **$8,000** Out-of-network applies to in-network amount and vice-versa	The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Penalties for failing to follow precertification		Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	Yes, $2,000,000.		The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. See www.siho.org for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed below (see Excluded Services & Other Covered Services). See your plan document/SPD for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	No Charge	--------none--------
	Specialist visit	No Charge	No Charge	--------none--------
	Other practitioner office visit	No Charge	No Charge	Chiropractor - Annual maximum limit is 12 visits.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Preventive care/screening/immunization	No Charge	No Charge	Based on SIHO's Comprehensive Preventive Guidelines. Deductible does not apply
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	No Charge	--------none--------
	Imaging (CT/PET scans, MRIs)	No Charge	No Charge	--------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	$10 co-payment after deductible has been met / prescription (retail and mail order)	No Charge	Covers up to a 30-day supply (retail prescriptions). Covers up to a 90-day supply (mail order prescriptions).
	Preferred brand drugs	$30 copayment after deductible has been met / prescription (retail) $75 copayment / prescription (mail order)	No Charge	Covers up to a 30-day supply (retail prescriptions). Covers up to a 90-day supply (mail order prescriptions).
	Non-preferred brand drugs	$60 co-payment after deductible has been met / prescription (retail) $180 co-payment / prescription (mail order)	No Charge	Covers up to a 30-day supply (retail prescriptions). Covers up to a 90-day supply (mail order prescriptions).
	Specialty drugs	$200 co-payment after deductible has been met for prescription (retail)/ $200 co-payment prescription (mail order)	Not Covered	Precertification is required.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	No Charge	--------none--------
	Physician/surgeon fees	No Charge	No Charge	--------none--------
If you need immediate medical attention	Emergency room services	No Charge	No Charge	--------none--------
	Emergency medical transportation	No Charge	No Charge	--------none-------
	Urgent care	No Charge	No Charge	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	No Charge	Precertification required. Payment will be reduced by $500 if precertification is not obtained.
	Physician/surgeon fee	No Charge	No Charge	--------none--------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	No Charge	--------none--------
	Mental/Behavioral health inpatient services	No Charge	No Charge	Precertification required at first visit. Payment will be reduced by $500 if precertification is not obtained.
	Substance use disorder outpatient services	No Charge	No Charge	--------none--------
	Substance use disorder inpatient services	No Charge	No Charge	Precertification required at first visit. Payment will be reduced by $500 if precertification is not obtained.
If you are pregnant	Prenatal and postnatal care	No Charge	No Charge	Dependent daughter maternity is covered.
	Delivery and all inpatient services	No Charge	No Charge	Precertification required. Payment will be reduced by $500 if precertification is not obtained.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	Precertification required. Payment will be reduced by $500 if precertification is not obtained. Annual maximum of 100 visits.
	Rehabilitation services	No Charge	No Charge	Check with plan for limitations that may apply based on type of therapy. Therapies included: cardiac rehabilitation, occupational, physical, speech and pulmonary/respiratory.
	Habilitation services	No Charge	No Charge	Each therapy service is limited to an annual maximum of 20 visits.
	Skilled nursing care	No Charge	No Charge	Precertification required. Payment will be reduced by $500 if precertification is not obtained. Annual maximum of 100 visits.
	Durable medical equipment	No Charge	No Charge	Precertification required on all rentals over and purchases over $500.
	Hospice service	No Charge	No Charge	Precertification required. Payment will be reduced by $500 if precertification is not obtained.
If your child needs dental or eye care	Eye exam	No Charge (Covered under Preventive Care)	No Charge (Covered under Preventive Care)	Deductible does not apply.
	Glasses	Not Covered	Not Covered	--------none--------
	Dental check-up	Not Covered	Not Covered	--------none--------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric Surgery
- Cosmetic Surgery
- Routine Foot Care
- Hearing Aids
- Infertility Treatment
- Weight Loss Programs
- Most Coverage Provided Outside the U.S.
- Non-Emergency Care while Traveling outside the U.S.
- Dental Care (Adult)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (for rehabilitation purposes)
- Chiropractic Care
- Routine Eye Care (Adult)
- Private Duty Nursing
- Long-term Care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **800-443-2980**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact a plan representative at: **800-443-2980** or visit us at **www.siho.org.** 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.

Additionally, a consumer assistance program may be available in your state to help you with your appeal. Visit www.dol.gov/ebsa/healthreform. Under "Internal Claims and Appeals and External Review", select *Consumer Assistance Programs* for contact information of those states currently offering programs to assist consumers in filing an appeal.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby

(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,390
- **Patient pays** $3,150

Sample care costs:

Sample care costs	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Patient pays	
Deductibles	$2,000
Copays	$0
Coinsurance	$1,000
Limits or exclusions	$150
Total	**$3,150**

These amounts assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not notified the plan, your costs may be higher. For more information, contact 800-443-2980 or visit us at www.siho.org.

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,320
- **Patient pays** $3,080

Sample care costs:

Sample care costs	
Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Patient pays	
Deductibles	$2,000
Copays	$160
Coinsurance	$840
Limits or exclusions	$80
Total	**$3,080**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact 800-443-2980 or visit us at www.siho.org.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles, copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.