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?	For Network Provider: Select Health Network/Encircle/Trinity $750 Individual / $1,500 Family Non-Network Provider: $2,000 Individual / $4,000 Family *Network and Non-Network deductible do not cross-apply.	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.
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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For Network Provider: Select Health Network/Encircle/Trinity $2,000 I5ndividual / $4,000 Family Non-Network Provider: $5,000 Individual / $10,000 Family *Network and Non-Network out-of-pocket limit do not cross-apply.	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. Network and Non-Network out-of-pocket limit do not cross-apply
What is not included in the out-of-pocket limit?	Premiums, Balance Billing Charges, Precertification Penalties, Referral Penalties, Non-Network Transplant Services, Healthcare 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.selecthealthnetwork.com, http://www.trinity-health.org/, 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?	Yes. A Select Health Network provider must submit a referral request to see an Encircle provider or a 30% reduction in benefits will apply.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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 *A referral is required to see an Encircle provider or a 30% reduction in benefits will apply.
		Network Provider Select Health Network/Encircle/Trinity (You will pay the least)	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	Office Visit: $20 copayment All Other Services: 10% coinsurance after deductible	50% coinsurance after deductible	In-Network: Office copayment includes X-Rays and Labs performed and billed in the office. All other services are subject coinsurance after deductible. Labs sent to an outside laboratory are subject to 10% coinsurance after deductible. Chiropractic Services provided by an Out-of-Network Provider and/or Encircle provider will be paid at the In-Network level with no penalty.
	Specialist visit	Office Visit: $40 copayment All Other Services: 10% coinsurance after deductible	50% coinsurance after deductible	
	Preventive care/screening/ immunization	No Charge	Not Covered	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 Saint Joseph Health System Comprehensive Preventive Health Benefit (PHB) guidelines.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	50% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required PET, MRA, and MRI scans. Failure to obtain Preauthorization will result in a penalty of 30% per occurrence.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *A referral is required to see an Encircle provider or a 30% reduction in benefits will apply.
		Network Provider Select Health Network/Encircle/Trinity (You will pay the least)	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.siho.org.	Generic drugs	Retail: $10 copayment (including Specialty drugs) Mail Order: $15 copayment (including Specialty drugs)	Retail: 50% coinsurance no deductible (minimum $40 per prescription order) Mail Order: Not Covered	Retail covers up to a 30-day supply. Mail covers up to a 90-day supply. Orally Administered Cancer Chemotherapy: $0 copayment Asthma Supplies: $0 copayment Specialty drugs are covered under the pharmacy benefit if received through the Pharmacy. Preauthorization is required for Specialty drugs. Failure to obtain Preauthorization will result in a penalty of 30% per occurrence.
	Preferred brand drugs	Retail: $30 copayment (including Specialty drugs) Mail Order: $45 copayment (including Specialty drugs)	Retail: 50% coinsurance no deductible (minimum $40 per prescription order) Mail Order: Not Covered	
	Non-preferred brand drugs	Retail: $50 copayment (including Specialty drugs) Mail Order: $60 copayment (including Specialty drugs)	Retail: 50% coinsurance no deductible (minimum $40 per prescription order) Mail Order: Not Covered	
	Specialty drugs	Retail: See Copayments Above Mail Order: See Copayments Above	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *A referral is required to see an Encircle provider or a 30% reduction in benefits will apply.
		Network Provider Select Health Network/Encircle/Trinity (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required for select outpatient procedures. Failure to obtain Preauthorization will result in a penalty of 30% per occurrence.
	Physician/surgeon fees	10% coinsurance after deductible	50% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	Facility: $250 copayment Physician: 0% coinsurance, deductible waived	Facility: $250 copayment Physician: 0% coinsurance, deductible waived	Non-Emergent services in the ER are not covered. Copayment waived if admitted directly from emergency room.
	Emergency medical transportation	0% coinsurance, deductible waived	0% coinsurance, deductible waived	Any charges incurred at Non-Network provider due to True Emergency will apply as In-Network. Non-Emergent Ambulance services are not covered.
	Urgent care	Office Visit: $40 copayment All Other Services: 10% coinsurance after deductible	50% coinsurance after deductible	In-Network: Office copayment includes X-Rays and Labs performed and billed in the office. All other services are subject coinsurance after deductible. Labs sent to an outside laboratory are subject to 10% coinsurance after deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required. Failure to obtain Preauthorization will result in a penalty of 30% per occurrence.
	Physician/surgeon fees	10% coinsurance after deductible	50% coinsurance after deductible	

* 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 *A referral is required to see an Encircle provider or a 30% reduction in benefits will apply.
		Network Provider Select Health Network/Encircle/Trinity (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	New Avenues Midwest Behavioral Health Network: Office Visit: $20 copayment All Other Services: 10% coinsurance after deductible	50% coinsurance after deductible	In-Network: Copayment includes evaluation/interview, therapy/counseling, medication management, and testing in an office setting. Preauthorization is required for Intensive Outpatient and ABA Therapy. Failure to obtain Preauthorization will result in a penalty of 30% per occurrence.
	Inpatient services	New Avenues Midwest Behavioral Health Network: 10% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required for Inpatient, Residential Treatment (RES), and Partial Hospitalization (PHP). Failure to obtain Preauthorization will result in a penalty of 30% per occurrence.
If you are pregnant	Office visits	Office Visit: $20 copayment All Other Services: 10% coinsurance after deductible	50% coinsurance after deductible	In-Network: Office copayment includes X-Rays and Labs performed and billed in the office. All other services are subject coinsurance after deductible. Labs sent to an outside laboratory are subject to 10% coinsurance after deductible.
	Childbirth/delivery professional services	10% coinsurance after deductible	50% coinsurance after deductible	Dependent Daughter Maternity is covered.
	Childbirth/delivery facility services	10% coinsurance after deductible	50% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *A referral is required to see an Encircle provider or a 30% reduction in benefits will apply.
		Network Provider Select Health Network/Encircle/Trinity (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	50% coinsurance after deductible	Annual Maximum: 100 visits per calendar year. *Maximum does not include home infusion therapy or private duty nursing rendered in the home. Preauthorization is required. Failure to obtain Preauthorization will result in a penalty of 30% per occurrence.
	Rehabilitation services	$30 copayment	50% coinsurance after deductible	Annual Maximum: 60 visits each for Physical and Occupational Therapy. 20 visits for Speech Therapy. When services are rendered in the home, Home health care service limits apply. Preauthorization is required for Occupational, Physical, and Speech Therapy after the first 12 treatments. No Preauthorization is required for evaluation. Failure to obtain Preauthorization will result in a penalty of 30% per occurrence.
	Habilitation services	$30 copayment	50% coinsurance after deductible	
	Skilled nursing care	10% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required. Failure to obtain Preauthorization will result in a penalty of 30% per occurrence.
	Durable medical equipment	10% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required on purchases over $750 and on all rentals. Failure to obtain Preauthorization will result in a penalty of 30% per occurrence.
	Hospice services	10% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required. Failure to obtain Preauthorization will result in a penalty of 30% per occurrence.
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
- Infertility Treatment
- Long-term Care
- Non-Emergency Care When Traveling Outside The U.S.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Bariatric Surgery (Limit of one surgery per lifetime and a $125,000.00 lifetime max)
- Chiropractic Care (Annual Maximum: 12 Visits)
- Skilled Nursing

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 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.**
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.

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 copayment	$40
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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$280
Coinsurance	$970
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	$750
Specialist copayment	$40
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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$940
Coinsurance	$190
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,940**

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

The plan's overall deductible	$750
Specialist copayment	$40
Hospital (facility) copayment	$250
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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$560
Copayments	$490
Coinsurance	$1
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,050**

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