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 healthcare 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?	In-Network Provider: $4,000 Individual / $8,000 Family Out-of-Network Provider: $5,500 Individual / $11,000 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. **In-network and out-of-network deductible amounts do not cross-apply.**
Are there services covered before you meet your deductible?	Yes. In Network: 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. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible.
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?	In-Network Provider: $7,500 Individual / $15,000 Family Out-of-Network Provider: $22,500 Individual / $45,000 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 not cross-apply.**
What is not included in the out-of-pocket limit?	Premium, Balance Billing Charges, Precertification Penalties, and 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.Cigna.com 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.

Important Questions	Answers	Why This Matters:
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 healthcare provider's office or clinic	Primary care visit to treat an injury or illness	$15 copayment All Other Services: 20% coinsurance after deductible	50% coinsurance after deductible	Injections, Surgery, MRI/MRA/CAT scans, Ultrasounds, X-rays, and Labs performed in the office are covered under the office visit copayment.
	Specialist visit	$30 copayment All Other Services: 20% coinsurance after deductible	50% coinsurance after deductible	
	Preventive care/screening/ immunization	No Charge	50% coinsurance after deductible	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. See www.siho.org for a list of PHB services.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible Independent Lab Services: No Charge	50% coinsurance after deductible Independent Lab Services: 50% coinsurance after deductible	Preauthorization may be required for Genetic Testing. Failure to obtain Preauthorization may result in a $500 penalty.
	Imaging (CT/PET scans, MRIs)	20% 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
		Network Provider (You will pay the least)	Out-of-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 NWPHarma.com or 1-877-867-0943.	Generic drugs	**Preferred Pharmacy** Retail & Mail Order 30-Day Supply: $15 copayment Retail & Mail Order 31-91-Day Supply: $38 copayment **Non-Preferred Pharmacy Walgreens** Retail 30-Day Supply: 50% coinsurance no deductible Retail 31-91-Day Supply: 50% coinsurance no deductible Mail Order 1-91-Day Supply: Not Covered	Not Covered	Specialty drugs are limited to a 30-day supply. Preauthorization for Specialty drugs is required before exploration of Patient Assistance Program eligibility. If the patient is not eligible for Patient Assistance, will return to plan with Tier 4 copay which is listed above. Northwind is authorized to fill one time while Patient Assistance Programs are being explored.
	Preferred Brand drugs	**Preferred Pharmacy** Retail & Mail Order 30-Day Supply: $50 copayment Retail & Mail Order 31-91-Day Supply: $150 copayment **Non-Preferred Pharmacy Walgreens** Retail 30-Day Supply: 50% coinsurance no deductible Retail 31-91-Day Supply: 50% coinsurance no deductible Mail Order 1-91-Day Supply: Not Covered	Not Covered	
	Non-Preferred drugs	**Preferred Pharmacy** Retail & Mail Order 30-Day Supply: $150 copayment Retail & Mail Order 31-91-Day Supply: $450 copayment **Non-Preferred Pharmacy Walgreens** Retail 30-Day Supply: 50% coinsurance no deductible Retail 31-91-Day Supply: 50% coinsurance no deductible Mail Order 1-91-Day Supply: Not Covered		
	Specialty drugs	No charge after deductible	Not Covered	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required for select outpatient procedures. Failure to obtain Preauthorization may result in a $500 penalty.
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	Facility: $250 copayment, per visit, then 20% coinsurance after deductible Physicians: 20% coinsurance after deductible		True Emergent ER services will apply to the Tier 1 benefit level.
	Emergency medical transportation	20% coinsurance after deductible		True Emergent Ambulance charges will apply to the Tier 1 benefit level. Non-Emergent Ambulance services are Not Covered.
	Urgent care	$75 copayment All Other Services: 20% coinsurance after deductible	50% coinsurance after deductible	Injections, Surgery, MRI/MRA/CAT scans, Ultrasounds, X-rays, and Labs performed in the office are covered under the office visit copayment.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required for Inpatient. Failure to obtain Preauthorization may result in a $500 penalty.
	Physician/surgeon fees	20% 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $15 copayment IOP and PHP: $15 copayment	50% coinsurance after deductible	Mental Health and Substance Therapy Services Performed in an Office Setting include evaluation/interview, therapy/counseling, testing, and medication management.
	Inpatient services	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required. Failure to obtain Preauthorization may result in a $500 penalty.
If you are pregnant	Office visits	$15 copayment	50% coinsurance after deductible	Dependent Daughter Maternity is not Covered. However, preventive prenatal labs and preventive services are covered as required by the ACA.
	Childbirth/delivery professional services	20% coinsurance after deductible	50% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	50% coinsurance after deductible	Plan Year Maximum: 120 visits Maximum does not apply to Home Infusion Therapy. Preauthorization is required. Failure to obtain Preauthorization may result in a $500 penalty.
	Rehabilitation services	Office Setting: $30 copayment Outpatient & Free-Standing Facility: 20% coinsurance after deductible	50% coinsurance after deductible	Physical and Occupational Therapy Plan Year Maximum: 60 Visits Combined Speech Therapy Plan Year Maximum: 30 Visits ABA Therapy is Covered.
	Habilitation services			

* 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)	
	Skilled nursing care	20% coinsurance after deductible	50% coinsurance after deductible	Skilled Nursing Plan Year Maximum: 150 visits Preauthorization is required. Failure to obtain Preauthorization may result in a $500 penalty.
	Durable medical equipment	20% coinsurance after deductible	50% coinsurance after deductible	None
	Hospice services	No Charge	No Charge	None
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
- Dental Care
- Hearing Aids
- Infertility
- Long-Term Care
- The Non-Emergency Care When Traveling Outside the U.S.
- Routine Eye Care
- Routine Foot Care

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

- Bone Anchored Hearing Aids
- Chiropractic Care (Annual Maximum: 12 visits)
- Cochlear Implants
- Private-duty nursing (Outpatient only)

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 grievance for any reason to your plan. For more information about your rights, this notice, or

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

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 1-800-443-2980.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-443-2980.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-443-2980.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-443-2980.

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

number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 2

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	**$4,000**
Specialist copayment	**$15**
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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$4,000
Copayments	$10
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,770**

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

The plan's overall deductible	**$4,000**
Specialist copayment	**$15**
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	$900
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

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

The plan's overall deductible	**$4,000**
Specialist copayment	**$15**
Hospital (facility) copayment	**$250**
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)*

Total Example Cost	**$3,000**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,100
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,400**

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