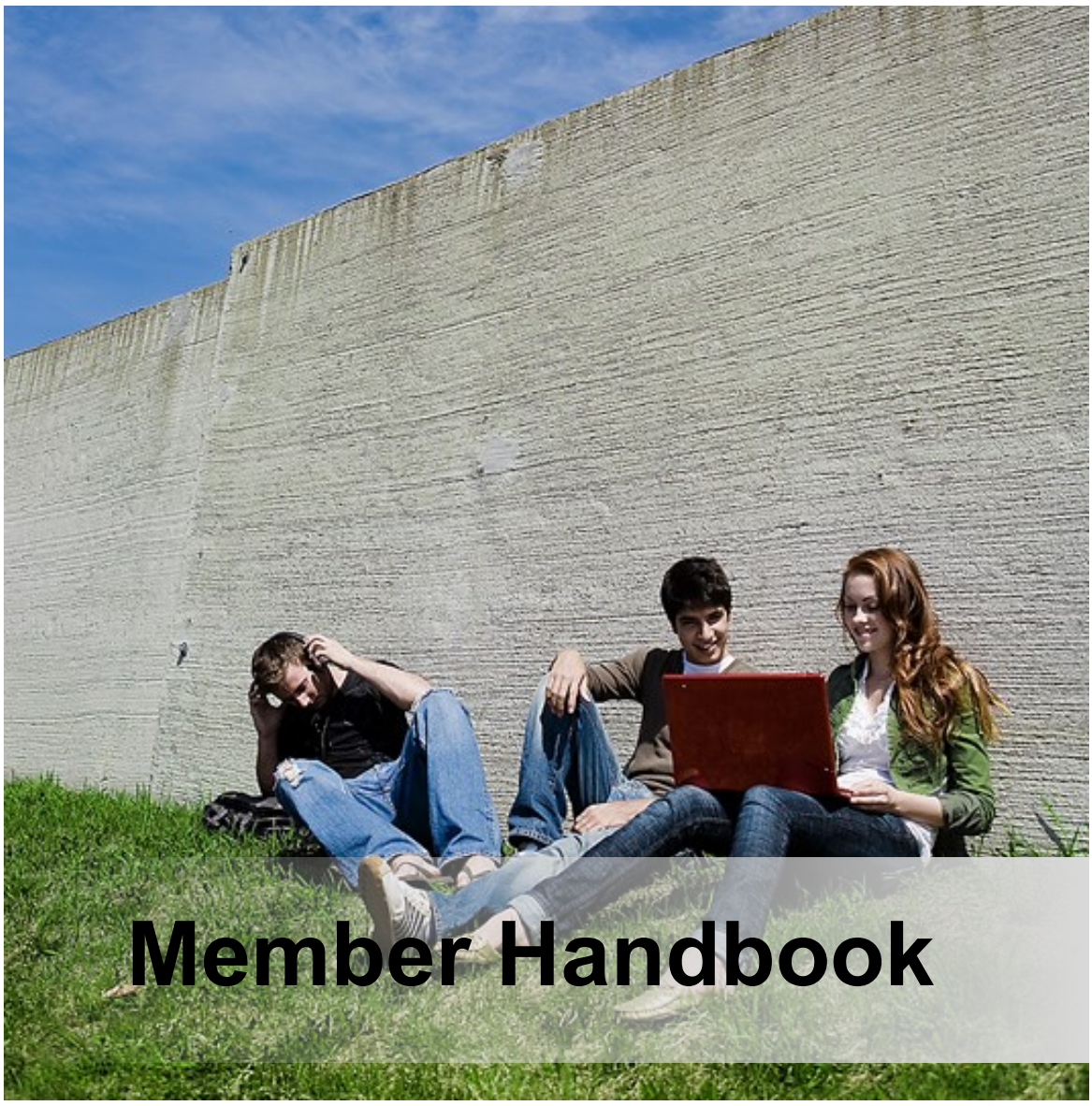
SIHO Marketplace



Member Handbook

Information about your health benefits

Table of Contents

Welcome

Welcome and thank you for selecting SIHO Insurance Services to be your partner in health care. It is our pleasure to provide you with access to the quality medical care you need and the personal service you deserve.

The purpose of this booklet is to provide you the information and resources to help you understand your policy.

ABOUT SIHO

SIHO Insurance Services is a leader in innovative health benefit solutions for businesses of all sizes, offering a wide range of products and services including third-party administration, fully insured plans, wellness programs, flexible spending plan administration and a full line of consumer-directed health plans.

SIHO was formed in 1987 through the cooperative efforts of local physicians, hospitals, and employers who were concerned about the rising cost of health care. Today, SIHO is a regional leader in health care delivery systems and insurance products for more than 100,000 members in more than 600 companies of all sizes. SIHO's network includes more than 30,000 medical providers and 180 hospital facilities. The main office is located in Columbus, Indiana.

HOW TO CONTACT US

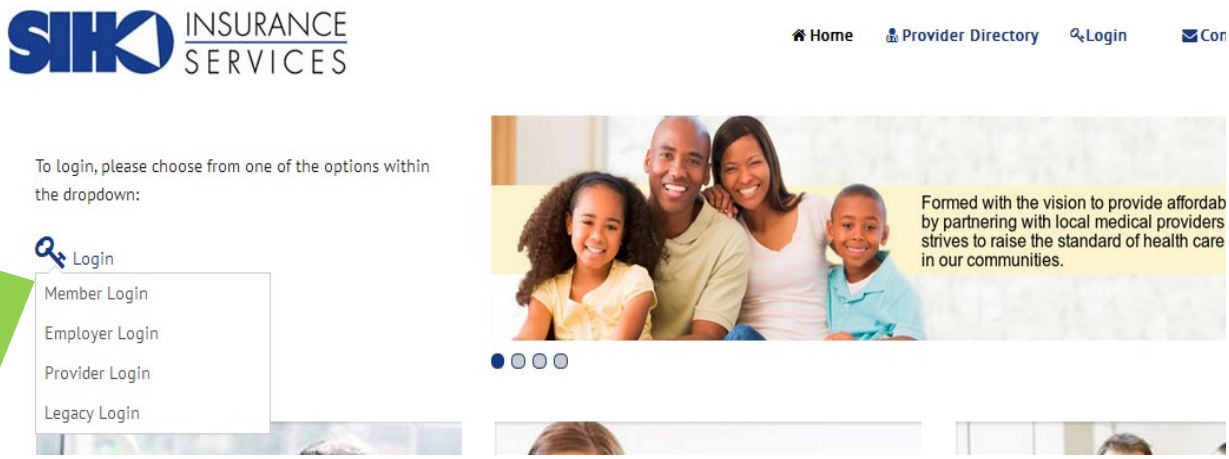
SIHO is available to answer your questions over the phone, in-person and on-line. In order to assist you 24 hours a day, information about SIHO Marketplace Plans is available on our website: http://www.siho.org/Marketplace. For any questions, contact SIHO Member Services by:

Phone:	844.378.7103
Email:	MemberSolutions@SIHO.org
Mail:	SIHO Member Services P.O. Box 1787 Columbus, IN 47202-1787
Walk-in Service:	417 Washington Street, Columbus, IN 47201

Logging onto the Web Portal

(View claims and eligibility information, print off temporary ID cards and request new cards)

Select Member Login to access the Member Web Portal. If you are new to the site, follow the on-screen instructions to create a username and password.



Logging onto the Provider Directory

You will receive the highest benefits from an in-network provider. To determine if your provider is in-network:

Log on to: http://www.siho.org/marketplace, click the Provider Lookup Tab and click on the Marketplace Logo.

Click the drop-down menu next to the Provider Name, select Begins With and enter the last name and zip code of the provider you are searching; if there are too many results, you can select the Specialty.

If you are unable to determine if your provider is in-network, you may call 844.378.7103 for assistance.

ID CARDS

The ID cards you receive in the mail will be the source of information used to receive medical care and prescription drugs. Office visit and prescription copays are listed on the front of the card. The card will include the name(s) of all people covered under the plan.

If you lose your ID card, you may log onto the portal to print off a temporary card and request a new card.

Member Rights and Responsibilities

As a SIHO member you have certain rights and responsibilities.

You have the right to:

- Be treated with dignity and respect.
- Receive coverage for the medical benefits that are covered under your Summary Plan Description.
- Receive the understandable information you need about your health benefit plan, including information about services that are covered and not covered and any costs that you will be responsible for paying.
- Have access to a current list of in-network doctors, hospitals and places you can receive care.
- Have your health information kept confidential by SIHO. SIHO adheres to all federal, state and accreditation regulations regarding confidentiality and the release of your personal health information.
- Participate in your health care. You have the right to receive information from your provider in language that you can understand.
- Be Heard. Our complaint-handling process is designed to hear and act upon your complaint, provide a courteous, prompt response, and guide you through our grievance process if you do not agree with our decision.
- Make recommendations regarding our policies that affect your rights and responsibilities. If you have recommendations, please call Member Services at the toll-free number on your ID card.

You have the **responsibility** to:

- Treat all health care professionals and staff with courtesy and respect.
- Review and understand the information that you receive from SIHO. Please call Member Services at the toll-free number on your ID card if you have questions or concerns.
- Show your ID card each time you receive services.
- Schedule an annual appointment with your doctor. You should ask questions and follow your doctor's advice.
- Provide complete and honest information to your doctor.
- Know what medicines you take and why you take them.
- Pay all copays, deductibles and co-insurance for which you are responsible.
- Keep all scheduled appointments and notify the provider office if you need to cancel.
- Notify SIHO with any changes in family size, address or phone number.
- Voice your opinions, concerns or complaints to SIHO Member Services at the toll-free number listed on your ID card.
- Contact healthcare.gov with any changes: marital status, have a baby, adopt or place a child for adoption, income, receive Medicare or Medicaid, change addresses, disability status, gain or lose a dependent, or other changes that effect income or household size.

Policy Details

LIMITATIONS ON POLICY

The rights of Enrollees and obligations of SIHO and Participating Providers are subject to the following limitations:

CIRCUMSTANCES BEYOND HEALTH PLAN'S CONTROL

Neither SIHO nor any Participating Provider will be responsible for providing Covered Benefits if circumstances outside SIHO's control render the provision of Covered Benefits impracticable. These circumstances include, but are not limited to: unplanned computer system or power outages, labor unrest, complete or partial destruction of facilities, major disaster, epidemic, war, riot, civil insurrection, disability of a significant part of Participating Provider's personnel, or similar causes. SIHO will make a good faith effort to arrange for alternative methods to provide the Covered Benefits.

REFUSAL OF TREATMENT

Certain Enrollees may, for personal reasons, refuse to accept procedures or treatment recommended by Participating Providers. A Participating Provider may regard Enrollee's refusal as incompatible with continuing the provider-patient relationship and an obstruction of proper Medical Care. If an Enrollee refuses to accept treatment or procedures recommended by a Participating Provider, the Enrollee may consult with another Participating Provider of his or her choosing. If, after having adequate time to consider treatment alternatives, the Enrollee refuses to accept that Participating Provider's recommended course of treatment or procedures and both the Participating Providers and SIHO believe that no medically acceptable alternative exists, the Enrollee will be so advised. If the Enrollee still refuses to accept a recommended treatment or procedure, then neither the Participating Providers nor SIHO will have further responsibility to provide or arrange for treatment of the condition. This provision does not affect the Health Plan's obligation to provide Coverage for medically acceptable treatments for the condition otherwise covered by the Health Plan.

MEDICAL NON-COMPLIANCE

It is expected that the Enrollee will follow the advice of the Provider rendering or arranging services. If the Enrollee is receiving health services in a harmful or abusive quantity or manner or with harmful frequency, as determined by SIHO, the Enrollee may be required to select a single Participating Physician and a single Participating Hospital (with which the single Participating Physician is affiliated) to provide and coordinate all future health services. If the Enrollee fails to make the required selection of a Participating Physician and a single Participating Hospital within thirty-one (31) days of written notice of the need to do so, then SIHO shall designate the required single Participating Physician and Participating Hospital for the Enrollee. In the case of a medical condition which, as determined by SIHO, either requires or could benefit from special services, the Enrollee may be required to receive covered health services through a single Participating Provider designated by SIHO. Following selection or designation of a single Participating Provider, coverage is contingent upon all health services being provided by or through written referral of the designated Participating Provider.

Authorization & Appeals

PRE-AUTHORIZATION

SIHO requires that the following services be pre-certified:

1. Any inpatient admission (long term acute/sub-acute/rehab/skilled nursing facilities)
2. Mental health and substance abuse, intensive outpatient programs or partial hospitalizations
3. Home health care
4. Durable Medical Equipment (purchase over $750 and all rentals)
5. Hospice care
6. Transplant evaluations and procedures
7. Specialty drugs, excluding insulin
8. Oncology services (chemotherapy and radiation)
9. Applied Behavioral Analysis therapy
10. Dialysis
11. Speech therapy
12. Procedures performed with a letter of necessity from a physician

Members are responsible for obtaining precertification for services from a non-network provider. Failure to obtain precertification could result in a reduction of benefits for that service or procedure up to a penalty of fifty percent (50%) of the Prevailing Rate.

APPEALS PROCESS

There are two ways to appeal any charge(s) on your statement:

1 Mail your request, along with any other supporting documents to:

SIHO Appeals Coordinator
P.O. Box 1787
Columbus, IN 47202-1787

SIHO will send an acknowledgement notice for all member initiated written requests within 3 business days of receipt of the appeal request.

SIHO will notify the member within 30 business days after receiving the written request.

2 If a member is dissatisfied with the decision, he/she may file an External Review of Grievance/Appeal within 120 days after receiving the notice for the initial review, to the listed address. A decision will be reached within 15 business days from the filing date for a standard appeal or within 72 hours for an expedited appeal.

SIHO Insurance Services Comprehensive Preventive Health Benefit

These benefits are fully compliant with the Affordable Care Act (PPACA).

Wellness Exam:

Men - One per year
Women - One per year with family physician, one per year with OB/GYN, if needed

CHILDHOOD IMMUNIZATIONS

Vaccine	AGE >	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months	2-3 years	4-6 years	7-10 years	11-12 years	13-18 years
Diphtheria, Tetanus, Pertussis				DTap	DTap	DTap		DTap				DTap		TDap	
Human Papillomavirus														HPV 3 Doses	
Meningococcal											MCV				
Influenza						Influenza (yearly)									
Pneumococcal				PCV	PCV	PCV	PCV				PPSV				
Hepatitis A							Hep A 2 Doses				Hep A Series				
Hepatitis B		Hep B	Hep B			Hep B							Hep B Series		
Inactivated Poliovirus				IPV	IPV	IPV						IPV			
Measles, Mumps, Rubella							MMR					MMR			
Varicella							Varicella					Varicella			
Rotavirus				RV	RV	RV									
Haemophilus Influenzae Type B				HIB	HIB	HIB	HIB								

Note: Preferred age for vaccine is indicated where specific vaccine is listed in the **colored box**.

SERVICES FOR CHILDREN

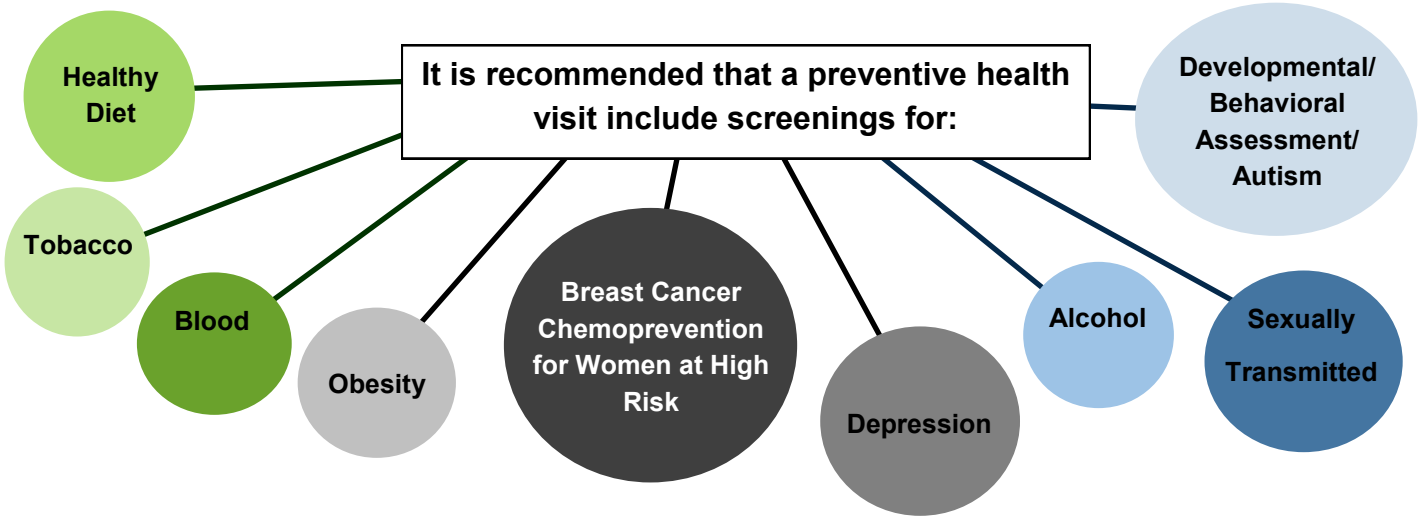
• Gonorrhea preventative medication for eyes • Hearing Screening • Hemoglobinopathies (sickle cell) • Congenital Hypothyroidism Phenylketonuria (PKU)	Newborns	Developmental/ Behavioral Assessment/Autism	All Ages
Fluoride Supplement	Children without fluoride in water source	Hematocrit or He-moglobin Screening	All Ages
Iron Supplementation	6-12 months at high risk	Lead Screening	For children at risk of exposure
HIV Screening	Age 12 and above	Tuberculin Testing	For children at high risk of tuber-culosis
Visual Acuity	Up to Age 5	Dyslipidemia Screening	Children at risk of lipid disorders
Oral Dental Screening	During PHB visit	Height, Weight and Body Mass Index measurements	Through Age 17
Urinalysis	4-6 years & 12-16 years	Medical History	All Children throughout development

Bacteriuria	Lab test
Hepatitis B	Lab test
Iron Deficiency Anemia Screening	Lab test
Gestational Diabetes Screening (between 24 & 28 weeks)	Lab test
Rh Incompatibility	Lab test
Syphilis Screening	Lab test
Breast Feeding Interventions*	Counseling, Support & Supplies
Nicotine*	Counseling
Folic Acid	Women capable of becoming pregnant

SERVICES FOR ALL WOMEN

Domestic Violence Screening & Counseling	Annually
Contraceptive Methods*	Covered unless religious exemption applies

ADULT IMMUNIZATIONS		ADULTS LABS		ADULT PROCEDURES/SERVICES	
Tetanus, Diphtheria, Pertussis	Every 10 years after age 18	Lipid Panel	Yearly	Bone Density Scan	Every 3 years age 60 or older
Human Papillomavirus	To age 26	Total Serum Cholesterol	Yearly	Mammogram	Baseline women - once between 35-40
Meningococcal	To age 55	PSA, men over 50	Yearly	Mammogram	Yearly for women over 40
Influenza	Every year	Pap Smear/Thin Prep Pap Test	Yearly	BRCA (letter of medical necessity required)	Women genetically at high risk of breast cancer
Pneumococcal	Every 5 years after age 50	Fecal Occult Testing	Yearly after age 50	Sigmoidoscopy	Every 3 years after age 50
Hepatitis A	All ages	FBS (Fasting Blood Sugar)	Yearly	Colonoscopy	Every 10 years after age 50
Hepatitis B	From ages 18-25	Hgb A1C	Yearly	Barium Enema	Yearly after age 50
Shingles	Once after age 60	HIV Testing	Yearly	Abdominal Ultrasound	For men who have smoked - one time between ages 65-75
Measles, Mumps and Rubella*	Once after age 19 (up to two vaccinations per lifetime)	Human Papillomavirus DNA Testing	Every 3 years beginning at age 30	Aspirin for Men	Ages 45 - 79
		Syphilis Screening	Yearly	Aspirin for Women	Ages 55 - 79
		Chlamydia Infection Screening	Yearly		
		Gonorrhea Screening	Yearly		



COUNSELING SERVICES

Counseling services are provided for obesity, alcohol misuse, tobacco use*, healthy diet, Sexually Transmitted Infections, and HIV.

The **SIHO Preventive Health Benefit Guidelines** are developed and periodically reviewed by SIHO's Quality Management Committee, a group of local physicians and health care providers. The QMC reviews routine care services from the American Academy of Family Practice Standards, American College of OB/GYN Standards, Center for Disease Control Recommendations, American Cancer Society Recommendations, American Academy of Pediatric Standards and U.S. Preventive Services Task Force Recommendations.

These recommendations were combined with input from local physicians and the standard Preventive Health Benefit was developed. These standards and recommendations are reviewed every one to two years, and the benefits are updated as needed.

Please note that your physician may recommend additional tests or screenings not included in this benefit. Routine screenings that are not listed in this brochure are generally not covered, and you may be financially responsible for those charges.

***Please contact SIHO Member Services at (844) 378-7103 for specific coverage information.**

Helpful Information

TIPS BEFORE A HEALTH CARE APPOINTMENT

1. If you need medical advice quickly, call your provider's office; sometimes, symptoms can be managed at home and don't need an appointment.
2. Research your condition or symptoms: your insurance company, health care websites and your provider are good sources of information.
3. Bring a list of questions about: your condition, symptoms, medications, allergies, etc.
4. Make lists to bring for your visit: ex. questions to ask, current medicines you take
5. If possible, bring a family member or friend to take notes and/or ask questions.

TIPS DURING A HEALTH CARE APPOINTMENT

- Make lists to bring for your visit: ex. questions to ask, current medicines you take
- Ask questions if there is anything you don't understand.
- Take notes about what your provider says.
- Repeat the information back to the provider, to make sure you understand what was said.
- If a family member or friend is with you, have them repeat the information back to the provider.

CLINICAL PRACTICE GUIDELINES

- Any SIHO Clinical Staff member may author a Proposed Clinical Practice Guideline and will consult with a SIHO Clinical Expert on any area outside their primary expertise.
- After collaboration with an expert, the Medical Director receives the guideline for review and revision.
- After approval, it is sent to the Quality Management Committee and Medical Management Director for approval; if approved, it is eligible to be used by the Medical Management Staff.
- All Clinical Practice Guideline will be reviewed and/or revised annually per URAC accreditation standards.

Helpful Information

If you have a large medical bill, contact your local provider or facility. They can work with you to set up a payment plan or help you apply for assistance.

HOW TO APPLY FOR ASSISTANCE

Option 1: Visit your county Family and Social Services Administration Office (8 a.m.—4:30, Monday—Friday).

BARTHOLOMEW	BROWN	DECATUR
2330 Poshard Dr., Columbus	121 Locust Dr., Nashville	905 W. Keegan's Way, Suite 4, Greensburg

JACKSON	JENNINGS	SCOTT
1406 E. Tipton St., Seymour	1171 N. State St., North Vernon	1048 W. Community Way, Scottsburg

Option 2: Call **800.403.0864** to apply by phone (may take up to 1 hour).

Option 3: Apply online at: **https://www.ifcem.com/CitizenPortal/application.do#**

(Click on Apply for Health Coverage, SNAP, and/or Cash Assistance online)

Free/Sliding Scale Clinics (listed by county):

http://www.needhelppayingbills.com/html/indiana_free_health_care_clini.html

Questions?

For any questions about these options or how your claim was processed, contact our **Marketplace Department: 844.378.7103**

Cost/Benefit Information of Selecting a Treatment

If you or a family member experience a catastrophic event: Premature Birth, Cancer, Transplant, Heart Disease or Back/Spinal Surgery, call Member Services at 844.378.7103 and ask to speak to the Medical Management Department. They will assist in directing you to the appropriate source of treatment and help you to contain costs.

Summary of Benefits & Coverage

As a result of the Affordable Care Act, there are ten benefits which all plans are required to contain. These ten benefits are:

1. Clinical care in a doctor's office
2. Wellness & preventative care (physicals, immunizations (shots)
3. Prenatal and postnatal care (given during pregnancy and after birth)
4. Prescription drugs
5. Pediatric services (for children, including vision coverage)
6. Hospital stays
7. Rehabilitation services (to recover from injury or illness and regain abilities
8. Lab tests
9. Emergency Room visits (plus ambulatory services)
10. Mental health and substance abuse treatment

COVERED SERVICES

Your member policy has the full list of covered services and limitations of coverage. You can access your policy by logging on the SIHO Marketplace website: www.siho.org/marketplace. To see the out-of-pocket cost associated with a specific service, please refer to your Summary of Benefits and Coverage (SBC).

OUT-OF-POCKET MAXIMUM

Your out-of-pocket maximum is the maximum amount you could pay for expenses of covered services during a year. The following charges do not apply to the out-of-pocket charges:

- Premiums
- Balanced-billed Charges
- Non-covered charges

DEDUCTIBLE

Your deductible is the amount you are required to pay. The amount of the deductible depends on the level of plan you selected (Bronze, Silver, Gold). Bronze plans have lower monthly premiums but have higher deductibles. Gold plans have higher monthly premiums but lower deductibles. You will need to pay for covered services until your deductible is reached. These services do not apply towards your deductible:

- Visits to your PCP, wellness and preventative care
- Generic prescriptions

When you receive medical services, you will pay your co-pay, if it applies. If your deductible has not been meet, you will be billed for the remaining amount, minus any co-pay or co-insurance.

Paying for Your Coverage

Every month, you will receive your premium statement. Here are the ways to pay your bill:

Mail in a check to our lockbox address (include your Subscriber # on the check):

SIHO Marketplace
P.O. Box 74008093
Chicago, IL 60674-8093

Pay with a credit card by calling **866.635.0774** and follow the telephonic instructions.

Log in to your online account at: https://siho.softheon.com/Marketplace/

We can accept your payment in person at our Columbus location (**we do not accept cash**).

What's Covered (Non emergencies are not covered out-of-network)

Emergency Services

Your SIHO Marketplace Plan provides coverage for emergency services, including:

- Ambulance
- Hospital Charges
- Physician Charges
- Supplies and Medicines used treating you

TYPE OF CARE NEEDED	WHAT YOU SHOULD DO
PREVENTATIVE CARE Annual physical | Immunizations (shots) | Cholesterol screening	**Make an appointment with your provider.**
OFFICE VISIT / URGENT CARE **This is for immediate, but not life-threatening care** Fever | Sore throat | Earache | Minor cuts | Minor injury	**Your provider will give you an appointment or provide you with further instructions.**
EMERGENCY CARE **This is for a serious medical condition** Severe injury, especially to the head | Major burns or bleeding Severe chest pain | Seizures | Difficulty breathing | Unconsciousness	**Call 911 or go to the nearest hospital.** At the hospital: • Give them your SIHO Marketplace ID card • Ask them to send a copy of your visit to your provider as soon as possible

What's Covered
Primary Care Physician

If you already have a primary care physician, he or she may already be included in our network. If you do not have a doctor, or need to find an in-network provider, we can assist you.

There are several groups of doctors who can be your PCP:

- Family Medicine
- General Practice
- Internal Medicine
- OB-GYN (women)
- Pediatrician (children)

Your PCP can coordinate your care from office visits and writing prescriptions to referrals to specialists and hospital care.

To search for a provider, please see the section on how to find an in-network physician on **page 4.**

What's Covered
Mental Health Services

Even everyday obstacles can become too much to bear at times. SIHO has included mental health and substance abuse benefits in our Marketplace Plans through SOLUTIONS, an employee assistance program. SOLUTIONS is a service of Centerstone of Indiana, which is a private, not-for-profit behavioral health organization. SOLUTIONS can be reached at: (812) 377-5074, (800) 766-0068 or solutions@centerstone.org

The enhanced mental health and substance abuse benefit offers behavioral health care assistance in the identification and resolution of problems that members face in their everyday lives, including marital, family, drug abuse, work and school-related, depression, stress and anxiety.

SIHO Marketplace Plans provide coverage for:

- Inpatient Mental Health Services
- Outpatient Mental Health Services
- Inpatient Substance Abuse Treatment
- Outpatient Substance Abuse Treatment

What's Covered
Maternity Services

COVERED SERVICES FOR PREGNANT MEMBERS

SIHO covers maternity services for Marketplace members. These services include prenatal care, delivery and postpartum care. For more information, contact Member Services at **812.378.7103** or toll-free **844.378.7103**. For high-risk pregnancies, call Member Services and ask to be transferred to Medical Management.

PRENATAL CARE

While you are pregnant, you will go to an OB/GYN doctor. At your first pregnancy visit, your doctor will:

- Perform a physical
- Predict the date of your baby's birth
- Review your medical history
- Perform genetic testing to screen for any problems that may be passed down to your baby

SCHEDULED DELIVERIES

SIHO recognizes and supports The American College of Obstetrics and Gynecology's recommendations for scheduled deliveries and federal standards. As a SIHO member who may be pregnant or become pregnant, we want you to know what SIHO health care providers are recommending about scheduled deliveries. Scheduled deliveries are when you and your health care provider pick the day to deliver your baby. This can be done by scheduling a C-section, or you can be admitted to the hospital and given IV medication to start your labor. If you have a vaginal delivery, your inpatient stay will be covered for up to 48 hours. If you have a Cesarean section, your inpatient stay will be covered for up to 96 hours.

SCHEDULED DELIVERIES RECOMMENDATIONS

- If there is no medical reason for you to deliver before your due date, it's best for you and your baby to wait for natural labor
- The American College of Obstetrics and Gynecologists recommend that scheduled deliveries without a medical reason should not occur before 39 weeks of pregnancy.
- If you must schedule your delivery, talk with your health care provider and make sure you are at least 39 weeks into your pregnancy.
- If you are planning a vaginal delivery, your doctor should check to make sure your cervix is beginning to open and is ready for delivery.

If your OB/GYN does not find any problems, you will see him or her regularly:

- One time every four weeks for the first 28 weeks
- One time every two or three weeks from week 28 through week 36
- After 36 weeks, one time every week until you have your baby
- If you have any special medical problems, your provider may want to see you more often.

What's Covered
Pediatric Vision

PEDIATRIC VISION BENEFIT SUMMARY

Taking care of your child's eyes with VSP includes a covered-in-full benefit outlined below. You'll have access to the highest quality vision care from a VSP doctor you can trust. Visit vsp.com/advantage to find a doctor who's right for your child an one who carries children's frames from our exclusive Otis & Piper™ Eyewear Collection.

VSP Doctor Network: VSP Advantage

BENEFIT	DESCRIPTION	COPAY (Your cost)	FREQUENCY
Your Coverage with a VSP Advantage Doctor			
WellVision Exam ®	A thorough eye exam that tests for childhood eye health and vision issues, like nearsightedness, amblyopia (lazy eye), and strabismus (crossed eyes)	$0	Every 12 months
Prescription Glasses			
Frames	Frames from our exclusive Otis & Piper Eyewear Collection	$0	Every 12 months
Lenses	• Single vision, lined bifocal, lined trifocal, or lenticular lenses • Polycarbonate, scratch-resistant coating, and UV protection	$0 included in prescription glasses	Every 12 months
Lens Options	20% - 25% off other lens options	N/A	Every 12 months
Contacts (Instead of glasses)	Contact lens exam and a minimum three-month's supply of contact lenses are covered in full. Ask your VSP doctor which contacts qualify for your child's plan.	$0	Every 12 months
Extra Savings and Discounts	Glasses and Sunglasses 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision Exam		
	Laser Vision Correction Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

VSP guarantees coverage from VSP doctors only. Coverage information is subject to change.

Pediatric Vision is only provided to subscribers under age 19.

What's Covered
Prescriptions

Prescription Drug

This coverage is an important part of any health plan. Marketplace Plans allow members to purchase prescription medications at a local retail pharmacy as well as through the mail order service.

Retail Services

A great way to get short-term medications is through your local pharmacy. Most national drugstore chains and independently owned pharmacies are contracted with SIHO.

Mail Order Service

Utilizing the Mail Order Service saves you time and money by receiving 90 days of medication for approximately the same cost as 75 days of medication from a participating retail pharmacy. Mail order service is the most convenient method of receiving maintenance medications. Once set up, your medicine will arrive automatically, saving you the time and trouble of visits to the pharmacy.

Birth Control

All birth control prescribed by your physician, including oral medication, injectable and other prescribed forms are covered under Marketplace Plans and are subject to the same copay as other prescription drugs.

Chantix™ Smoking Cessation Prescription

Chantix will be **only** covered at retail pharmacies with a **Brand Non-Formulary Copayment**.

Chantix (varenicline) is non-nicotine prescription medicine specifically developed to help adults quit smoking. Chantix contains no nicotine but targets the same receptors that nicotine does. Chantix is believed to block nicotine from these receptors. At the end of 12 weeks of using Chantix, 44% of those using the drug were able to quit smoking.

Plan Type	Gold / Silver	Bronze	Silver HSA	Bronze HSA
RX—Member Pays: (Generic/Brand Name/ Non-Formulary)	$15 / $40 / $80	$25 / $50 / $100	Ded., 10%	Ded., 20%
Mail Order Prices: (Generic/Brand Name/ Non-Formulary)	$37.50 $100 $200	$62.50 $125 $250	Ded., 10% Ded., 10% Ded., 10%	Ded., 20% Ded., 20% Ded., 20%

*SIHO's formulary (preferred drug list) is established by our Pharmacy and Therapeutic Committee and is updated quarterly. The formulary list can be found at http://www.caremark.com/portal/asset/SIHO_DrugList.pdf

Your HIPAA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. This section provides an overview of those rights. You will receive from the Plan Administrator a separate "Notice of Privacy Provisions" which contains additional information about how your individually identifiable health information is protected and who you should contact with questions or concerns.

HIPAA applies to medical and prescription drug plans. These plans are commonly referred to as "HIPAA Plans" and are administered to comply with the applicable provisions of HIPAA.

Protected Health Information (PHI) is information created or received by the HIPAA Plans that relates to an individual's physical or mental health or condition (including genetic information as provided under the Genetic Information Nondiscrimination Act), the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper, or oral.

The Plan will comply with all privacy requirements defined in the HIPAA Privacy Policy and will use or disclose PHI only if the use or disclosure is permitted or required by HIPAA Regulations and any other applicable Federal, state, or local law.

The HIPAA Plans may disclose PHI to the Plan Sponsor only for limited purposes as defined in the HIPAA Privacy Rules. The Plan Sponsor agrees to use and disclose PHI only as permitted or required by HIPAA. PHI may be used or disclosed for Plan administration functions that the Plan Sponsor performs on behalf of the HIPAA Plans. Such functions include:

- Enrollment of eligible individuals
- Eligibility determinations
- Payment for coverage
- Claim payment activities
- Coordination of benefits
- Claim appeals.

If a Plan participant wants to exercise any of his or her rights concerning PHI, he or she should contact the specific Claims Administrator involved with the PHI in question. The Claims Administrator will advise the Plan participant of the procedures to be followed.

The Plan will require any agents, including subcontractors, to whom it provides PHI to agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. The Plan Sponsor will report to the Plan any use or disclosure of PHI it knows is other than as permitted by the Plan and HIPAA Regulations.

Your HIPAA Rights cont'd

Any HIPAA Plan will maintain policies and procedures that govern the HIPAA Plan's use and disclosure of PHI. These policies and procedures include provisions to restrict access solely to the previously listed positions/departments and only for the functions listed previously. The HIPAA Plan's policies and procedures will also include a mechanism for resolving issues of noncompliance.

In accordance with the Health Breach Notification Rule (16 CFR Part 18), the Plan sponsor agrees to notify both participants and the Federal Trade Commission of the use or disclosure of any PHI or electronic PHI provided for Plan Administration purposes that is inconsistent with the uses or disclosures provided for, or that represents a PHI Security Incident, of which the Plan Sponsor or any Business Associate of the Plan Sponsor becomes aware.

HIPAA also requires that participants automatically receive a certificate of creditable coverage within a reasonable period of time after coverage ceases (if not eligible for COBRA continuation coverage) or after COBRA coverage ends (including any grace period for non-payment of COBRA premiums). For participants who are eligible to elect COBRA continuation coverage, the certificate will be provided no later than 44 days after a qualifying event.

The standard certificate includes basic health plan participation information and a statement as to whether you and your covered dependent(s) had at least 18 months of coverage without a significant break (more than 63 days). If you or your dependent(s) had less than 18 months of coverage, the statement will include the date coverage began and ended as well as the date of any waiting period.

A certificate will never cover longer than an 18-month period without a 63-day break, which is the maximum creditable coverage that an individual would need under the pre-existing condition exclusion rules and the rules for access to the individual market. You automatically will receive the standard statement when coverage ends. A single certificate may be used for all Plan Participants in a family who are losing coverage at the same time.

To request another copy of the standard certificate and/or the alternative certificate, contact the Plan Administrator within 24 months after the end of a period of continuous coverage. Your certificate will be sent in a reasonable and prompt fashion or, alternatively, if all parties agree, the Plan Administrator may provide this information by phone.

SIHO Marketplace

SIHO INSURANCE SERVICES

www.siho.org/marketplace

844.378.7103

This document is only a brief description of benefits and services offered under these plans and is presented for informational purposes only. Our plans have exclusions, limitations and terms under which the contract may be continued in force or discontinued. For more information on these plans, contact your authorized SIHO agent/broker or contact SIHO at 800.443.2980.

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