




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, [insert contact information]. 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 [www.indecscorp.com.com](http://www.indecscorp.com.com) or call 1-888-446-3327 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	INN: \$0 Ind/\$0 Family OON: \$400 Ind/\$1,000 Family	Calendar year, embedded deductible.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No other deductibles.	
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$7,900 individual / \$15,800 family; for <a href="#">out-of-network</a> providers \$400 individual / \$400 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> , <a href="#">pre-certification penalty</a> , charges and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-800-810-2583 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	No referral required.

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness and telehealth	\$18 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a> after deductible No benefit	None
	Teladoc	\$10 <a href="#">copay</a>	No benefit	
	<a href="#">Specialist</a> visit	\$18 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a> after deductible	None
	<a href="#">Preventive care/screening</a> /immunization	No charge	20% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. Preventive mammography, gyn, PAP, colon cancer screening & all preventive child care In-Network ONLY, no OON benefit.
If you have a test	Outpatient Hospital <a href="#">Diagnostic test</a> (x-ray, blood work)	\$18 <a href="#">copay</a>	\$18 <a href="#">copay</a> 100% deductible waived	None
	Imaging (CT/PET scans, MRIs)	\$18 <a href="#">copay</a>	\$18 <a href="#">copay</a> 100% deductible waived	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.navitus.com">www.navitus.com</a> .	Generic drugs (Tier 1)	\$5 <a href="#">copay</a> /prescription (retail)		Non-participating pharmacy requires payment up front. Member must submit claim to Pharmacy Benefits Manager. Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	\$17.50 <a href="#">copay</a> / prescription (retail)		
	Non-preferred brand drugs (Tier 3)	\$35 <a href="#">copay</a>		
	<a href="#">Mail Order</a>	\$10/\$35/\$70	No benefit.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$18 <a href="#">copay</a>	\$18 <a href="#">copay</a> <a href="#">Deductible waived</a>	
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a> after deductible	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$50 <a href="#">copay</a>	\$50 <a href="#">copay</a> , deductible waived	None

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.indecscorp.com](http://www.indecscorp.com).]

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)	
	<a href="#">Emergency medical transportation</a> Volunteer or Professional Hospital owned	20% <a href="#">coinsurance</a> No cost	20% <a href="#">coinsurance</a> after deductible No cost	
	<a href="#">Urgent care</a>	\$18 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a> after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	No cost	20% <a href="#">coinsurance</a> after deductible	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced up to 365 days.
	Physician/surgeon fees	No cost	20% <a href="#">coinsurance</a> after deductible	
If you need mental health, behavioral health, or substance abuse services	<a href="#">Alcohol Treatment</a> Outpatient services	No cost	No cost, deductible waived	60 visit calendar yr limit.
	Inpatient/ partial hospitalization	No cost No cost	No cost up to Plan's Usual & Customary, deductible waived No cost up to Plan's Usual & Customary, deductible waived	<a href="#">Preauthorization</a> is required. 7 week calendar yr max combined (Two partial days count as one in-patient day.)
	<a href="#">Substance Abuse</a> Outpatient services	\$18 <a href="#">copay</a>	20% <a href="#">coinsurance</a> after deductible	60 visit calendar yr combined max (20 visits can be used for family members' counseling).
	Inpatient/ partial hospitalization	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> after deductible	<a href="#">Preauthorization</a> is required. 7 week calendar yr max combined (Two partial days count as one in-patient day.)
	<a href="#">Mental Health</a> Outpatient Psychiatrist  PHD, LCSW, MSSW Telemedicine (PHD, LCSW, MSSW)	Allowance above max payment of \$40. \$27 <a href="#">copay</a> \$40 <a href="#">copay</a>	20% plus allowance above \$40 max payment. No benefit No benefit	

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)	
	Inpatient/Partial Hospitalization	No cost	No cost, deductible waived	First 120 days (Two days partial hospitalization count as one inpatient day.)
	Inpatient/Partial Hospitalization	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> after deductible	Additional 30 days (Two days partial hospitalization count as one inpatient day.)
If you are pregnant	Office visits	No cost	20% <a href="#">coinsurance</a> after deductible	<a href="#">Cost sharing</a> does not apply for in-network <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No cost	20% <a href="#">coinsurance</a> after deductible	
	Childbirth/delivery facility services	No cost	20% <a href="#">coinsurance</a> after deductible	
If you need help recovering or have other special health needs	<a href="#">Home Health Care</a>	No cost	No cost	Three HHC visits equals one hospital day.
	<a href="#">Rehabilitation services (PT, OT, ST)</a>	\$18 <a href="#">copay</a>	20% <a href="#">coinsurance</a> after deductible	Out of network deductible waived if within 6 months of surgery.
	<a href="#">Skilled Nursing Facility</a>	No cost	No cost, deductible waived	<a href="#">Preauthorization</a> is required. 150 day maximum.
	<a href="#">Durable Medical Equipment</a>	No cost	20% <a href="#">coinsurance</a> after deductible	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<a href="#">Hospice services</a>	No cost	No cost	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult &amp; Child)</li> <li>• Infertility treatment</li> <li>• Acupuncture</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Glasses/contacts</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult &amp; child)</li> <li>• Routine foot care</li> <li>• Bariatric surgery</li> <li>• Hearing Aids</li> </ul>

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

- Infertility testing
- Genetic testing
- Chiropractic care
- Weight loss programs

**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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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](http://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: [insert applicable contact information from instructions].

**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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码[insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%

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*)

<b>Total Example Cost</b>	<b>\$14,118</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$0</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$72
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">copayment</a>	\$72

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a> *	\$0
<a href="#">Copayments</a>	\$154
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$154</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">ER copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$4,200</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a> *	\$0
<a href="#">Copayments</a>	\$50
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$52</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [insert].

\*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.