**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.indecscorp.com or by calling call 1-888-446-3327.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$0** person / **$0** family In-network<br>**$400** person / **$1,000** family Out-of-network<br>Does not apply to copayments and services listed below as "No Charge" unless noted otherwise in Limitations & Exceptions column. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document 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 don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. **$2,940** Medical, **$4,410** Rx per person / **$5,880** Medical, **$8,820** Rx family In-network<br>**$1,000** person / **$1,000** family Out-of-network | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Penalties, deductibles, premiums, balance-billed charges, and health care this plan doesn't cover. | 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?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of **preferred providers,** see www.provider.bcbs.com. If you are unsure which network list to select, please call 1-800-810-2583. | 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 terms 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 on page 6. See your policy or plan document 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 In-network **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 | $18 Copay per visit | 20% Coinsurance | Maximum 3 Copays per day |
| | Specialist visit | $18 Copay per visit | 20% Coinsurance | Maximum 3 Copays per day |
| | Other practitioner office visit | $18 Copay per visit office visit & manipulations; No charge x-rays Chiropractic care; Not covered Acupuncture | 20% Coinsurance Chiropractic care; Not covered Acupuncture | none |
| | Preventive care/screening/ immunization | No charge | Not covered to age 19; 20% Coinsurance from age 19 | Deductible Waived Out-of-network from age 19 |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $18 Copay per visit | 20% Coinsurance | Maximum 3 Copays per day |
| | Imaging (CT/PET scans, MRIs) | $18 Copay per visit | 20% Coinsurance | Maximum 3 Copays per day; Prior authorization is required or benefit reduces by $250 per occurrence |

| 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 drugs to treat your illness or condition.**<br><br>More information about **prescription drug coverage** is available at www.navitus.com/ | Generic drugs | $6.00 at Retail Pharmacy, $9.00 at Mail Service Pharmacy. | | Use of mail order for maintenance drugs as defined by the Pharmacy Benefit Manager is mandatory after one refill at retail pharmacy.<br>Certain over-the counter drugs (those with a prescription counterpart) are covered at $0 copay for store brands (private label) or $6 copay for Brand names. |
| | Preferred brand drugs | $18.00 at Retail Pharmacy, $27.00 at Mail Service Pharmacy. | | |
| | Non-preferred brand drugs | $45.00 at retail pharmacy, $67.50 at Mail Service Pharmacy. | | |
| | Specialty drugs | See above. | See above. | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $18 Copay per visit | $18 Copay per visit | Deductible Waived Out-of-network; Facility benefits do not apply to Annual Maximum |
| | Physician/surgeon fees | No charge | 20% Coinsurance | none |
| **If you need immediate medical attention** | Emergency room services | $50 Copay per visit | $50 Copay per visit True ER; 20% Coinsurance Non-true ER | Deductible Waived Out-of-network True ER; Facility benefits do not apply to Annual Maximum True ER |

| 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 |
|---|---|---|---|---|
| | Emergency medical transportation | No charge hospital owned ambulance True ER; 20% Coinsurance professional and volunteer ambulance and hospital owned Non-true ER | No charge hospital owned ambulance True ER; 20% Coinsurance professional and volunteer ambulance and hospital owned Non-true ER | Deductible Waived Out-of-network hospital owned ambulance True ER; hospital owned ambulance True ER does not apply to Annual Maximum |
| | Urgent care | $18 Copay per visit | 20% Coinsurance | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge up to 365 day Maximum; 20% Coinsurance after Maximum benefit | No charge up to 365 day Maximum; 20% Coinsurance after Maximum benefit | Deductible Waived Out-of-network 365 day Maximum per spell of illness then deductible applies; Facility benefits do not apply to Annual Maximum; Prior authorization is required or benefit reduces by $250 per admission |
| | Physician/surgeon fee | No charge | No charge | ——————none—————— |

| 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 mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | Psychiatrist up to $40 payment per visit, no copay. Psychologist, LCSW, MSSW $27 Copay per visit. | Psychiatrist or psychologist 20% Coinsurance after deductible to benefit limit of $40. | Facility benefits do not apply to Annual Maximum; Prior authorization is required or benefit reduces by $250 per occurrence. |
| | Mental/Behavioral health inpatient services | No charge up to 120 day Maximum benefit; Additional 30 days 20% Coinsurance after Maximum benefit | No charge up to 120 day Maximum benefit; Additional 30 days 20% Coinsurance after Maximum benefit | Deductible Waived Out-of-network up to 120 day Maximum benefit per calendar year then deductible applies included in hospital spell of illness Maximum; 30 Maximum days per calendar year after 120 day Maximum benefit is met; facility benefits do not apply to Annual Maximum; Prior authorization is required or benefit reduces by $250 per admission |
| | Substance use disorder outpatient services | $18 Copay per visit; No charge other outpatient services | 20% Coinsurance | 60 Maximum visits per calendar year; facility benefits do not apply to Annual Maximum; Prior authorization is required or benefit reduces by $250 per occurrence |
| | Substance use disorder inpatient services | 20% Coinsurance | 20% Coinsurance | 7 Maximum weeks benefit per calendar year; facility benefits do not apply to Annual Maximum; Prior authorization is required or benefit reduces by $250 per admission |
| **If you are pregnant** | Prenatal and postnatal care | No charge | 20% Coinsurance | ——————none—————— |
| | Delivery and all inpatient services | No charge | 20% Coinsurance | ——————none—————— |

| 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 | Deductible Waived Out-of-network; 365 day Maximum per spell of illness combined with Inpatient hospital; 3 visits equals 1 benefit day; Facility benefits do not apply to Annual Maximum; Prior authorization is required or benefit reduces by $250 per occurrence |
| | Rehabilitation services | $18 Copay per visit; 20% Coinsurance Hospital therapy after 6 months of Inpatient stay PT | $18 Copay per visit Hospital therapy within 6 months; 20% Coinsurance after 6 months PT; 20% Coinsurance OT/ST | Deductible Waived Out-of-network Hospital therapy within 6 months PT |
| | Habilitation services | Not covered | Not covered | none |
| | Skilled nursing care | No charge | No charge | Deductible Waived Out-of-network; 150 Maximum days per spell of illness; Facility benefits do not apply to Annual Maximum |
| | Durable medical equipment | No charge | 20% Coinsurance | none |
| | Hospice service | No charge | No charge | Deductible Waived Out-of-network; Facility benefits do not apply to Annual Maximum |
| **If your child needs dental or eye care** | Eye exam | Not covered | Not covered | none |
| | 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 for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Long-term care
- Routine eye care (adult)
- Routine foot care
- Weight loss programs

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

- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

## 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 1-800-826-9781. 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: UMR at 1-800-826-9781. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

*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 also will 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** $7,250
- **Patient pays** $290

**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:**

| | |
|---|---|
| Deductibles | $0 |
| Copays | $90 |
| Coinsurance | $0 |
| Limits or exclusions | $200 |
| **Total** | **$290** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $1,100
- **Patient pays** $4,300

**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:**

| | |
|---|---|
| Deductibles | $0 |
| Copays | $310 |
| Coinsurance | $0 |
| Limits or exclusions | $0 |
| **Total** | **$310** |

# Questions and answers about Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Costs are based on individual coverage benefit levels.
- 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.
- Prescription drug costs (Prescriptions) shown in the Coverage Examples reflect information provided by the Plan's Prescription Benefits Manager.

## 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.