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 or call 1-888-446-3327 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	INN: $0 Ind/$0 Family OON: $400 Ind/$1,000 Family	Calendar year, embedded deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary 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. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No other deductibles.	
What is the out-of-pocket limit for this plan?	For network providers $2,540 individual / $5,080 family; for out-of-network providers $400 individual / $400 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 limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing, pre-certification penalty, 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.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call 1-800-810-2583 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?	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 provider's office or clinic	Primary care visit to treat an injury or illness and telehealth	$18 copay/visit	20% coinsurance after deductible No benefit	None
	Teladoc	$10 copay	No benefit	
	Specialist visit	$18 copay/visit	20% coinsurance after deductible	None
	Preventive care/screening/ immunization	No charge	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan 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 Diagnostic test (x-ray, blood work)	$18 copay	$18 copay 100% deductible waived	None
	Imaging (CT/PET scans, MRIs)	$18 copay	$18 copay 100% deductible waived	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.navitus.com**.	Generic drugs (Tier 1)	$5 copay/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 copay / prescription (retail)		
	Non-preferred brand drugs (Tier 3)	$35 copay		
	Mail Order	$10/$35/$70	No benefit.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$18 copay	$18 copay Deductible waived	
	Physician/surgeon fees	No charge	20% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	$50 copay	$50 copay, deductible waived	None

[* For more information about limitations and exceptions, see the plan or policy document at 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)	
	Emergency medical transportation Volunteer or Professional Hospital owned	 20% coinsurance No cost	 20% coinsurance after deductible No cost	
	Urgent care	$18 copay/visit	20% coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	No cost	20% coinsurance after deductible	Preauthorization is required. If you don't get preauthorization, benefits could be reduced up to 365 days.
	Physician/surgeon fees	No cost	20% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Alcohol Treatment 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	Preauthorization is required. 7 week calendar yr max combined (Two partial days count as one in-patient day.)
	Substance Abuse Outpatient services	$18 copay	20% coinsurance after deductible	60 visit calendar yr combined max (20 visits can be used for family members' counseling).
	Inpatient/ partial hospitalization	20% coinsurance	20% coinsurance after deductible	Preauthorization is required. 7 week calendar yr max combined (Two partial days count as one in-patient day.)
	Mental Health Outpatient Psychiatrist PHD, LCSW, MSSW Telemedicine (PHD, LCSW, MSSW)	Allowance above max payment of $40. $27 copay $40 copay	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% coinsurance	20% coinsurance after deductible	Additional 30 days (Two days partial hospitalization count as one inpatient day.)
If you are pregnant	Office visits	No cost	20% coinsurance after deductible	Cost sharing does not apply for in-network preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No cost	20% coinsurance after deductible	
	Childbirth/delivery facility services	No cost	20% coinsurance after deductible	
If you need help recovering or have other special health needs	Home Health Care	No cost	No cost	Three HHC visits equals one hospital day.
	Rehabilitation services (PT, OT, ST)	$18 copay	20% coinsurance after deductible	Out of network deductible waived if within 6 months of surgery.
	Skilled Nursing Facility	No cost	No cost, deductible waived	Preauthorization is required. 150 day maximum.
	Durable Medical Equipment	No cost	20% coinsurance after deductible	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	No cost	No cost	Preauthorization is required. If you don't get preauthorization, 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Infertility treatment
- Acupuncture
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Glasses/contacts
- Routine eye care (Adult & child)
- Routine foot care
- Bariatric surgery
- Hearing Aids

[* For more information about limitations and exceptions, see the plan or policy document at www.indecscorp.com.]

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Infertility testing	• Chiropractic care	• Weight loss programs
• Genetic testing		

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 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, kwiijigo 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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[* For more information about limitations and exceptions, see the plan or policy document at www.indecscorp.com.]

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	$0
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	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)*

Total Example Cost	**$14,118**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

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

The plan's overall deductible	$0
Specialist copayment	$72
Hospital (facility) coinsurance	0%
Other copayment	$72

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Durable medical equipment *(glucose mete*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$0
Copayments	$154
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$154**

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

The plan's overall deductible	$0
ER copayment	$50
Hospital (facility) coinsurance	0%
Other coinsurance	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)*

Total Example Cost	**$4,200**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$0
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$52**

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.