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 **$400** person / **$1,000** family Out-of-network 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 **$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. More information about **prescription drug coverage** is available at www.navitus.com/	Generic drugs	$5.00 at Retail Pharmacy, $10.00 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. Certain over-the counter drugs (those with a prescription counterpart) are covered at $0 copay for store brands (private label) or $5 copay for Brand names.
	Preferred brand drugs	$17.50 at Retail Pharmacy, $35.00 at Mail Service Pharmacy.		
	Non-preferred brand drugs	$35.00 at retail pharmacy, $70.00 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

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 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
	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 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.