
 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, contact INDECS Corporation at 888-446-3327. 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 or call 1-888-446-3327 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$ 1,000 Individual; \$3,000 Family.	For out-of-network services, you must pay all the costs up to the deductible amount before this plan begins to pay for covered services. The deductible starts over every Jan. 1. See chart on page 2 on how you pay after meeting the deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive Care and some in-network services are covered before you meet your deductible	
Are there other deductibles for specific services?	\$ Yes	There is a \$500 deductible for each pre-certified out of network hospital admission.
What is the out-of-pocket limit for this plan ?	\$7,150 Individual; \$14,300 Family (Medical & Prescription combined out-of-pocket)	The out-of-pocket limit is the most you could pay during a coverage period of 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 ?	Premiums, penalty for failure to obtain pre-certification, balance-billed charges, services the plan doesn't cover.	Even though you pay for these services, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.indecscorp.com or call 800-810-2583 for assistance in locating an in network provider.	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 receive services.
Do you need a referral	No	You can see the specialist you choose without permission from this plan.

 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	\$25 co-pay per visit	\$25 co-pay per visit, plus deductible and 20% co-insurance	*****None*****
	Specialist visit	\$25 co-pay per visit	\$25 co-pay per visit, plus deductible and 20% co-insurance	*****None*****
	Preventive care / screening / immunization	0 co-pay per visit	Not covered	Certain preventative services and immunizations are covered, such as mammograms and well child visits. See Plan document for details on other specific benefits.
If you have a test	Diagnostic test (x-ray, blood work) (out-patient hospital)	Co-pay \$50 per day	\$85 co-pay per day, plus deductible and 20% co-insuranceNone.....
	Imaging (CT/PET scans, MRIs) (out-patient hospital)	Co-pay \$50 per day	\$85 co-pay per day, plus deductible and 20% co-insurance	Some tests require pre-certification/ pre-notification. See plan document for details.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Generic drugs	\$5 per prescription co-pay for up to 30-day supply	Same as in-network, but paid by plan reimbursement. Call CVS Caremark at 1-844-345-2792 for details.	Mail order is \$10.00 per prescription for 90-day supply. Covers up to a 30 day supply (retail subscription); 90 day supply (mail order prescription)
	Preferred brand drugs	\$35 per prescription co-pay for up to 30-day supply	Same as in-network, but paid by plan reimbursement. Call CVS Caremark at 1-844-345-2792 for details.	Mail order is \$70.00 per prescription for 90-day supply. Covers up to a 30 day supply (retail subscription); 90 day supply (mail order prescription)
	Non-preferred brand drugs	\$60 per prescription co-pay for up to 30-day supply	Same as in-network, but paid by plan reimbursement. Call CVS Caremark at 1-844-345-2792 for details.	Mail order is \$120.00 per prescription for 90-day supply. Covers up to a 30 day supply (retail subscription); 90 day supply (mail order prescription)

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)	
	Specialty drugs	\$35 or \$60 per prescription for 30-day supply	Same as in-network, but paid by plan reimbursement.	Call CVS Caremark Specialty Pharmacy at 1-800-237-2767 for details on specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$50 co-pay	\$85 per day, subject to copay, deductible and 20% co-insurance.None.....
	Physician/surgeon fees	\$25 per visit	\$25 plus deductible and 20% co-insurance.None.....
If you need immediate medical attention	Emergency room care	Co-pay of \$100 per visit.	100% of U&C after Co-pay of \$120 per visit.	One \$100 per admission co-pay applies if patient is admitted from the ER.
	Emergency medical transportation	Subject to deductible and 20% co-insurance after Plan pays first \$50 of allowed amount.	Subject to deductible and 20% co-insurance after Plan pays first \$50 of allowed amount.	Total reimbursement for volunteer ambulance is \$50 per year.
	Urgent care	\$35 per visit	\$45 per visit, plus deductible and 20% co-insurance.None.....
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 per admission co-pay	\$500 per admission deductible plus any charges over allowed amount.	Pre-notification required for hospitalizations (except childbirth). Out-of-network facilities may balance bill for charges over allowed amount.
	Physician/surgeon fees	\$25 per doctor, per visit	\$25 co-pay, plus deductible and 20% co-insurance to Out-of-Network maximum.	Out-of-network providers may balance bill for charges over allowed amount

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 need mental health, behavioral health, or substance abuse services	Mental/ Behavioral health outpatient services Calendar Year Maximum Combined Counts (Network & Out-of-Network) Lifetime Outpatient Mental Health Maximum Combined Counts (Network & Out-of-Network)	\$25 per visit up to 100 visits per calendar year	\$25 co-pay per visit, 50% of allowable amount, after \$1,000 out-of-network deductible up to 30 visits per calendar year/60 visits lifetime.	Pre-notification & other limits apply to mental health and substance abuse benefits. Limits may be greater for severe, biologically based mental illness. See your plan document for details of benefits and potential penalties.
	Mental/ Behavioral health inpatient services	\$100 per admission up to 100 days per calendar year	50% of allowable amount, after \$500 deductible, and any charges over allowed amount for up to 30 days per calendar year.	See your plan document for a complete explanation of benefits and pre-certification requirements.
	Substance Abuse Disorder outpatient services	\$0 per visit up to 60 visits per calendar year	50% of allowable amount up to 60 visits per calendar year.	Limit includes 20 visits per family members.
	Substance Abuse Disorder inpatient services	\$100 co-pay per admission	50% of allowable amount after \$500 deductible	Limit is 4 weeks per confinement; 6 weeks per calendar year.
If you are pregnant	Office visits	\$25 co-pay per visit	\$25 per visit, plus deductible and 20% co-insuranceNone.....
	Childbirth/delivery professional services	Covered 100%	100% U&C, \$500 deductible per admissionNone.....
If you need help recovering or have other special health needs	Home health care	\$0	All charges in excess of allowed amount	Benefit limited to 180 days per calendar year. Pre-notification required.
	Rehabilitation services	\$100 co-pay if confined to a facility	\$500 deductible and all charges in excess of allowed amount.	Benefit limited to 100 days per calendar year.
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	\$100 co-pay if confined to a facility	\$500 deductible and all charges in excess of allowed amount.	Benefit limit is 180 days per calendar year. Pre-notification required.

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)	
	Durable medical equipment	Deductible and 20% co-insurance	Deductible and 20% co-insurance.None.....
	Hospice services	Inpatient \$100 co-pay	You will pay all charges in excess of allowed amount	Pre-notification required
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](#).)

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|--|--|---|
| <ul style="list-style-type: none"> • Acupuncture • Eye Exams(routine; adult and child) • Hearing Aids • Weight Loss Programs | <ul style="list-style-type: none"> • Cosmetic Surgery • Glasses(adult and child) • Assisted Reproductive Technology (IVF) | <ul style="list-style-type: none"> • Dental Care (adult and child) • Habilitation Services • Routine Foot Care |
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Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your [plan](#) document.)

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| <ul style="list-style-type: none"> • Bariatric Surgery – mandatory second surgical opinion required. • Non-emergency when travelling outside the U.S, | <ul style="list-style-type: none"> • Chiropractic care (pre-certification required) • Private Duty Nursing (after first 48 hours of service). No benefit when confined to a facility. |
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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 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: INDECS Corporation at 1-888-446-3327.

Does this plan provide Minimum Essential Coverage? [Yes]

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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](#).

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

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](#) [*cost sharing*] \$75
- Hospital (facility) [*cost sharing*] \$100
- Other [*cost sharing*] % 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	\$7,540
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$175
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$175

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](#) [*cost sharing*] \$950
- Hospital (facility) [*cost sharing*] \$0
- Other [*cost sharing*] 20%

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

Total Example Cost	\$5400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$950
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$950

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [*cost sharing*] \$525
- Hospital (facility) [*cost sharing*] \$100
- Other [*cost sharing*] \$360

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	\$3700
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$625
Coinsurance	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$685