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. Out-of-Network – Combined Outpatient Mental Health and Substance Abuse $500	For out-of-network outpatient services, you will have more out-of-pocket costs to share. Use of in-network providers will furnish you the best benefit with the least cost sharing.
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-ins.	……..None…….
	Specialist visit	$25 co-pay per visit	$25 co-pay per visit, plus deductible and 20% co-ins.	……..None…….
	Preventive care/screening/ immunization	0 co-pay per visit	Not covered	Certain preventative services and immunizations are covered, such as 3D 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 at 100%, of U&C Allowance.	……..None…….
	Imaging (CT/PET scans, MRIs) (out-patient hospital)	Co-pay $50 per day	$85 co-pay per day, plus deductible at 100%, of U&C Allowance.	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.EmpiRxhealth.com	Generic drugs	$5 per prescription co-pay for up to 30-day supply	Same as in-network, but paid by plan reimbursement. Call EmpiRx Health at 1-877-241-7123 for details.	Maintenance medication (90 days) is $10.00 per prescription for 90-day supply. Call EmpiRx Health at 1-877-241-7123
	Preferred brand drugs	$35 per prescription co-pay for up to 30-day supply	Same as in-network, but paid by plan reimbursement. Call EmpiRx Health at 1-877-241-7123 for details.	Maintenance medication (90 days) is $70.00 per prescription for 90-day supply. Call EmpiRx Health at 1-877-241-7123
	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 EmpiRx Health at 1-877-241-7123 for details.	Maintenance medication (90 days) is $120.00 per prescription for 90-day supply. Call EmpiRx Health at 1-877-241-7123
	Specialty drugs	$35 or $60 per prescription for 30-day supply	Same as in-network, but paid by plan reimbursement.	Call EmpiRx Health at 1-877-241-7123 for details.

[* For more information about limitations and exceptions, see the Plan Document as amended 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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 co-pay	$85 per day copay plus deductible; payable at 100% of U&C Allowance.	……..None……..
	Physician/surgeon fees	$25 per visit	$25 plus deductible and 20% co-insurance of U&C Allowance.	……..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/Ambulance	Subject to $70 co-pay	Subject to $70 co-pay up to U&C Allowance.	
	Urgent care	$35 per visit	$45 per visit, plus deductible and 20% co-insurance of U&C Allowance.	……..None…….
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 per admission co-pay	$500 per admission co-pay plus any charges over allowed U&C amount.	Pre-notification required for hospitalizations (except childbirth). Out-of-network facilities may balance bill for charges over allowed amount.
	Physician fees (treatment, consultations, 2nd opinion, etc.)	$0 co-pay per doctor, per physician's visit	$0 co-pay, plus 20% co-insurance of U&C Allowance up to Out-of-Network maximum.	Out-of-network providers may balance bill for charges over U&C allowed amount.

[* For more information about limitations and exceptions, see the Plan Document as amended 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)	
If you need mental health, behavioral health, or substance abuse services	Mental/ Behavioral health Outpatient services	$25 per visit up to 100 visits per calendar year	$25 co-pay per visit, 20% of allowable amount, after $500 out-of-network deductible up to 60 visits per calendar year.	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	QUANTUM Health PPO; 100% up to 100 days/ CY *$100 co-pay per admission.	50% of allowable amount, after $500 co-pay, 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	20% of allowable amount up to 60 visits per calendar year.	Limit includes 20 visits for family members.
	Substance abuse disorder Inpatient services	$0	50% of allowable amount after $500 co-pay.	Inpatient limit is 4 weeks per confinement; 6 weeks per year.
If you are pregnant	Office visits	$25 co-pay per visit	$25 per visit, plus deductible and 20% co-insurance of U&C Allowance.	……..None……..
	Childbirth/delivery facility services	$100 per admission co-pay - Covered 100%	100% U&C, $500 co-pay per admission	……..None……..
If you need help recovering or have other special health needs	Home health care	$0	All charges in excess of allowed U&C amount	Benefit limited to 180 days per calendar year. Pre-notification required.
	Rehabilitation services	$100 if confined to a facility	$500 co-pay and all charges in excess of allowed U&C amount.	Benefit limited to 100 days per calendar year. Pre-notification required.
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	$100 if confined to a facility	$500 co-pay and all charges in excess of allowed U&C amount.	Benefit limit is 180 days per calendar year. Pre-notification required.

[* For more information about limitations and exceptions, see the Plan Document as amended 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)	
	Durable medical equipment	$25 co-pay	$500 deductible and 20% co-insurance of U&C Allowance.	……..None……..
	Hospice services	$0	You will pay all charges in excess of allowed U&C 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.)

- Acupuncture
- Eye Exams(routine; adult and child)
- Hearing Aids
- Weight Loss Programs
- Cosmetic Surgery
- Glasses(adult and child)
- Dental Care (adult and child)
- Habilitation Services
- Routine Foot Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your Plan Document.)

- Bariatric Surgery – mandatory second surgical opinion required.
- Non-emergency when travelling outside the U.S,
- Chiropractic care (pre-certification required)
- Private Duty Nursing (after first 48 hours of service). No benefit when confined to a facility.
- Artificial Insemination and all assisted Reproductive Technology-3 cycle lifetime maximum. (See In-Network, Out-of-Network, Center of Excellence and Specialty Pharmacy for various benefit levels.

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: [New York State Department of Health: http://www.health.ny.gov;]. 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: [Your School District Health Plan Representative].

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.

[* For more information about limitations and exceptions, see the Plan Document as amended 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
Copayment	$150
Hospital (facility) copayment	$100
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	$250
Coinsurance	
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$250**

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

The plan's overall deductible	$0
Copayments	$450
Hospital (facility) copayment	0%
Other coinsurance	0%

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	**$7,100**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$450
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$450**

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

The plan's overall deductible	$0
Copayments	$100
Hospital (facility) copayment	$100
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	**$6,219.72**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

The plan would be responsible for the other costs of these EXAMPLE covered services.