

 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, call 888-267-4445 or visit https://portal.90degreebenefits.com . For general definitions of common terms, such as <u>allowed amount</u> , <u>balance billing</u> , <u>coinsurance</u> , <u>copayment</u> , <u>deductible</u> , <u>provider</u> , or other <u>underlined</u> terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 888-267-4445 to request a copy.		
Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier I – Preferred \$250 Individual/\$750 Family Tier II – Network / Out-of-Area \$500 Individual/\$1,000 Family Tier III - Non-Network \$3,000 Individual/Unlimited Family	Any amount that is applied toward fulfilling Tier I and Tier II Deductible amounts will cross apply and fulfill both requirements on a reciprocal basis. Any amounts applied towards Tier III Deductible amount will accumulate separately.
Are there services covered before you meet your deductible?	Yes. Network Preventive Care.	This plan covers some items and services even if you haven't yet met the deductible amount.
Are there other deductibles for specific services?	Yes. Prescription: \$250 Individual/\$500 Family Dental: \$50 Individual/\$150 Family	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Tier I – Preferred \$750 Individual/\$2,250 Family Tier II – Network / Out-of-Area \$1,500 Individual/\$3,000 Family Tier III - Non-Network \$25,000 Individual/Unlimited Family Prescription Drug: \$1,000 Individual/\$2,000 Family	Any amount that is applied toward fulfilling Tier I and Tier II Out-of-Pocket amounts will cross apply and fulfill both requirements on a reciprocal basis. Any amounts applied towards Tier III Out-of-Pocket amount will accumulate separately. In addition, each Plan Year satisfaction of a new Out-of-Pocket amounts will be required.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain pre-certification 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. Call 888-267-4445 or visit https://portal.90degreebenefits.com for a list of participating providers.	You pay more if you use a provider in Tier II (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. You don't need a referral to see a specialist.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I Preferred	Tier II Network / Out-of-Area	Tier III Non-Network	
		(You will pay the least)		(You will pay the most)	
If you visit a health care provider's office or clinic	<u>Primary care visit to treat an injury or illness</u>	\$10 copay per visit deductible waived	\$20 copay per visit deductible waived	30% coinsurance after deductible	<u>Telehealth/Lab/X-Ray:</u> Tier I: \$10 Copay Tier II: \$20 copay Tier III: 30% coinsurance after deductible <u>Office Surgery:</u> Tier 1: 10% coinsurance after deductible Tier 2: 10% coinsurance after deductible Tier 3: 30% coinsurance after deductible <u>Allergy Injections/Allergy Serum/Allergy Testing:</u> Tier I & II: 20% coinsurance after deductible Tier 3: 30% coinsurance after deductible <u>Chiropractic Services:</u> Tier I & II: \$20 copay deductible waived Tier III: 30% coinsurance after deductible Limited to \$1,500 plan year maximum
	<u>Specialist visit</u>	\$10 copay per visit deductible waived	\$20 copay per visit deductible waived	30% coinsurance after deductible	
	<u>Preventive care/screening/immunization</u>	No charge	No charge	30% coinsurance after deductible	
If you have a test	<u>Diagnostic test (x-ray, blood work)</u>	5% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	<u>Independent Laboratory:</u> Tier I: 5% coinsurance after deductible Tier II: 10% coinsurance after deductible Tier III: 30% coinsurance after deductible
	<u>Imaging (CT/PET scans, MRIs)</u>	5% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	Pre-certification is required, call 855-236-3376. Failure to pre-certify will result in a penalty of \$200.

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		Tier I Preferred	Tier II Network / Out-of-Area	Tier III Non-Network	
		(You will pay the least)		(You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com Or call Express Scripts at 1-800-334-8134	<u>Generic copay</u>	Retail: \$0 copay deductible waived Mail Order: \$0 copay deductible waived			Retail – Limited to a 30-day supply per refill. Mail Order – Limited to a 90-day supply per refill.
	<u>Brand name copay</u>	Retail: The lessor of \$150 copay or 20% coinsurance after deductible Mail Order: The lessor of \$150 copay or 18% coinsurance after deductible			Prescription Deductible: \$250 Individual/\$500 Family Prescription Out-of-Pocket Maximum: \$1,000 Individual/\$2,000 Family (cumulative)
	<u>Specialty copay</u>	Retail: Not Applicable Mail Order: 20% coinsurance after deductible			Once the prescription Out-of-Pocket is met the Plan will pay 100% of covered prescriptions.
If you have outpatient surgery	<u>Facility fee (e.g., ambulatory surgery center)</u>	10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	Pre-certification is required, call 855-236-3376. Failure to pre-certify will result in a penalty of \$200.
	<u>Surgeon fees</u>	10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	None.
If you need immediate medical attention	<u>Emergency room care</u>	Facility: \$75 copay deductible waived Professional Fees: 10% coinsurance after deductible	Facility: 10% coinsurance after deductible Professional Fees: 10% coinsurance after deductible	Facility: 10% coinsurance after deductible (Tier II deductible and out-of-pocket maximum apply) Professional Fees: 10% coinsurance after deductible (Tier II deductible and out-of-pocket maximum apply)	If admitted, copay waived, and pre-cert required. Call 855-236-3376. Failure to pre-certify will result in a penalty of \$200.
	<u>Emergency medical transportation</u>	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	Pre-certification is required for air ambulance, call 855-236-3376. Failure to pre-certify will result in a penalty of \$200.
	<u>Urgent care</u>	\$30 copay deductible waived	\$30 copay deductible waived	30% coinsurance after deductible	None.

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I Preferred	Tier II Network / Out-of-Area	Tier III Non-Network	
		(You will pay the least)		(You will pay the most)	
If you have a hospital stay	<u>Facility fee (e.g., hospital room)</u>	\$100 copay deductible waived	10% coinsurance after deductible	30% coinsurance after deductible	Pre-certification is required, call 855-236-3376. Failure to pre-certify will result in a penalty of \$200.
	<u>Surgeon fees</u>	10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	None.
If you need mental health, behavioral health, or substance abuse services	<u>Outpatient services</u>	<u>Office Visit:</u> \$10 copay per visit deductible waived <u>Outpatient Facility:</u> 10% coinsurance after deductible	<u>Office Visit:</u> \$20 copay per visit deductible waived <u>Outpatient Facility:</u> 10% coinsurance after deductible	<u>Office Visit:</u> 30% coinsurance after deductible <u>Outpatient Facility:</u> 30% coinsurance after deductible	None.
	<u>Inpatient services</u>	\$100 copay deductible waived	10% coinsurance after deductible	30% coinsurance after deductible	Pre-certification is required, call 855-236-3376. Failure to pre-certify will result in a penalty of \$200.
If you are pregnant	<u>Office visits</u>	\$10 copay per visit deductible waived	\$20 copay per visit deductible waived	30% coinsurance after deductible	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	<u>Childbirth/delivery professional services</u>	10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	
	<u>Childbirth/delivery facility services</u>	\$100 copay deductible waived	10% coinsurance after deductible	30% coinsurance after deductible	Pre-cert is required for inpatient stays longer than 48 hours for vaginal delivery or 96 hours for cesarean delivery, call 855-236-3376. Failure to pre-certify will result in a penalty of \$200 per admission.

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		Tier I Preferred	Tier II Network / Out-of-Area	Tier III Non-Network	
		(You will pay the least)		(You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	Limited to 120 visits per calendar year. Pre-cert is required, call 855-236-3376. Failure to pre-certify will result in a penalty of \$200.
	<u>Rehabilitation services</u>	5% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	<u>Occupational Therapy, Physical Therapy, and Speech Therapy:</u> 60 visits per Plan Year (Visits maximums will accrue on a separate basis for each therapy) Speech Therapy and Inpatient Rehabilitation requires pre-certification, call 855-236-3376. Failure to pre-certify will result in a penalty of \$200.
	<u>Habilitation services</u>	5% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	
	<u>Skilled nursing care</u>	10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	Maximum benefit of 170 days per plan year. Pre-cert is required, call 855-236-3376. Failure to pre-certify will result in a penalty of \$200.
	<u>Durable medical equipment</u>	10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	Pre-cert is required, call 855-236-3376. Failure to pre-certify will result in a penalty of \$200.
	<u>Hospice services</u>	10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	Bereavement counseling covered within 6 months of death.
If your child needs dental or eye care	<u>Children's eye exam</u>	No charge	No charge	No charge	For Dependent Children between the ages of 5 and 18, benefits will be available for one eye exam per Plan Year
	<u>Children's glasses</u>	No charge	No charge	No charge	For Dependent Children between the ages of 5 and 18, benefits will be available for either one pair of glasses, or a one-year supply of contacts, per Plan Year
	<u>Children's dental check-up</u>	No charge	No Charge	No charge	Dental deductible does not apply.

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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 <u>excluded services</u> .)		
<ul style="list-style-type: none">• Bariatric surgery• Infertility treatment (plan will pay to determine diagnosis only)	<ul style="list-style-type: none">• Foreign travel• Weight loss programs	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none">• Acupuncture (limited to \$1,500 per plan year)• Dental care - repair, restoration, and major dental repair (limited to \$1,500 per plan year)	<ul style="list-style-type: none">• Chiropractic treatment (limited to \$1,500 per plan year)• Hearing aids (coverage is limited to dependent children up to age 19)	<ul style="list-style-type: none">• Routine eye (maximum \$300 every 24 months combined)

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 available by calling 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. 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: 888-267-4445. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 888-267-4445.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-267-4445.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 888-267-4445.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 888-267-4445.

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

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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 <u>deductible</u>	\$500
■ <u>Specialist copay</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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	\$12,840
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$1,000
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,560

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$500
■ <u>Specialist copay</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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	\$7,460
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$750
Copayments	\$180
Coinsurance	\$570
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$1,560

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$500
■ <u>Specialist copay</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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	\$2,010
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$60
Coinsurance	\$160
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$720

The Deductible reflected in the examples illustrated above include/may include both medical and prescription expenses.

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