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, www.90degreebenefits.com. 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.healthcare.gov/sbc-glossary/ or call 1-800-558-7798 to request a copy

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,250/Individual or $9,750/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care , prescription drugs 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.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,250/Individual or $9,750/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?	Penalties for non-compliance with plan provisions; premiums, balance-billing 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?	Not applicable.	This plan does not use a provider network. You can receive covered service from any provider.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/office visit; deductible does not apply	Chiropractic care: 18 visits/year
	Specialist visit	$50 copay/office visit; deductible does not apply	
	Preventive care/screening/ immunization	No charge	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.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Labs performed during network office visit are included in office visit copay
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.elixirsolutions.com	Generic drugs (Tier 1)	No charge (retail/mail order)	Must use participating pharmacy. Non-participating pharmacies are NOT covered. Certain ACA preventive care, contraceptives and smoking deterrents are covered at no charge. Covers up to a 30-day supply (retail); 90-day supply (Retail90 or mail order).
	Preferred brand drugs (Tier 2)	$35 or 25%* copay/prescription (30-day) $87.50 or 25%* copay/ prescription (90-day); deductible does not apply (*whichever is greater)	
	Non-preferred brand drugs (Tier 3)	$75 or 25%* copay/ prescription (30-day) $187.50 or 25%* copay/ prescription (90-day); deductible does not apply (*whichever is greater)	
	Specialty drugs (Tier 4)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay/; deductible does not apply	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500.
	Physician/surgeon fees	$150 copay/; deductible does not apply	None
If you need immediate medical attention	Emergency room care	$400 copay/visit; deductible does not apply	None
	Emergency medical transportation	0% coinsurance	
	Urgent care	$50 copay/ visit; deductible does not apply	
If you have a hospital	Facility fee (e.g., hospital	0% coinsurance	Preauthorization is required. If you don't get

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
stay	room)		preauthorization, benefits could be reduced by $500.
	Physician/surgeon fees	0% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/office visit; deductible does not apply All other: 0% coinsurance	Preauthorization is required for outpatient and inpatient services. If you don't get preauthorization, benefits could be reduced by $500.
	Inpatient services	0% coinsurance	
If you are pregnant	Office visits	$30 copay/office visit; deductible does not apply	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	60 days/year. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500.
	Rehabilitation services	0% coinsurance	Physical, speech, occupational, cardiac rehabilitation: 35 visits/ year, combined.
	Habilitation services	0% coinsurance	
	Skilled nursing care	0% coinsurance	25 days/year. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500.
	Durable medical equipment	0% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500.
	Hospice services	0% coinsurance	15 visit/days per lifetime.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered
	Children's glasses	Not covered	Not covered
	Children's dental check-up	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
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care except for certain oral surgeries or treatment to sound natural teeth required when due to injury.
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Private Duty Nursing, except as covered under home health
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Chiropractic Care
- Non-emergency care when traveling outside the U.S. unless the Plan Member traveled outside of the U.S. for purpose of obtaining medical services, supplies, or drugs.

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. 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: 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.
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 1-800-558-7798.

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** **$3,250**
- **Specialist copay** **$40**
- **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,250
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,310**

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

- **The plan's overall deductible** **$3,250**
- **Specialist copay** **$40**
- **Hospital (facility) coinsurance** **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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$30
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,250**

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

- **The plan's overall deductible** **$3,250**
- **Specialist copay** **$40**
- **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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,100**

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