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, https://portal.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 http://www.healthcare.gov/sbc-glossary or call 1-888-267-4445 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible?	Tier 1: Network	Tier 2: Non-Network	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.
Per Person (One Member Only)	$1,500	$5,000	
Per Family (Two or More Members):	$4,500	$15,000	
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. 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 deductible for specific services.
What is the out-of-pocket limit for this plan?	Tier 1: Network	Tier 2: Non-Network	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.
Per Person (One Member Only)	$6,350	$12,700	
Per Family (Two or More Members):	$12,700	$25,400	
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), 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. To locate an In-Network provider, please visit http://90degreedirectory.com or call 888-267-4445.		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.

Important Questions	Answers	Why This Matters:
⚠ 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
		Tier 1: Network (You will pay the least)	Tier 2: Non-Network (You will Pay the most)	
If you visit a health care provider's office or clinic	Primary Care Physician (PCP): visits to treat an injury or illness	$35 co-pay per visit, deductible waived	50% after deductible	Therapeutic Injections and Allergy Testing, per visit: Tier 1: $35 co-pay/Specialist: $50 co-pay Tier 2: 50% after deductible/Specialists: N/A Allergy Injections and Serum, per visit: Tier 1: $35 co-pay, then 20% coinsurance, deductible waived/Specialist: $50 co-pay Tier 2: 50% after deductible/Specialists: N/A
	Specialist Office Visits:	$50 co-pay per visit	N/A	
	Office Surgery,	$250 co-pay, then 20% coinsurance, per visit deductible waived	50% after deductible	
	Preventive care & Screening/ immunization	No Charge	50% after deductible	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. United States Preventive Services Task Force (USPSTF). http://www.uspreventiveservicestaskforce.org
If you have a test	Diagnostic Testing: x-ray and blood work	$35 co-pay per visit, deductible waived	50% after deductible	Independent Laboratory & Professional Component: Tier 1: 20% coinsurance, deductible waived Tier 2: 50% coinsurance, deductible waived
	Specialist	$50 co-pay per visit	N/A	
	Diagnostic Imaging: Outpatient CT and PET scans and MRIs	20% coinsurance per visit, deductible waived	50% coinsurance, deductible waived	Vascular studies provided by Methodist (TexSan) Facility; TIN 74-2730328 will be covered at 100% of allowed changes for In-Network.
	High Cost Imaging: Outpatient/Independent Physician & Facility	$250 co-pay, then 20% coinsurance per visit deductible waived	50% after deductible	MRI, PET, CT, Myelogram, Cardiac Stress Test, Bone Scan, Ultrasounds (non-obstetrical) and Angiography

Common Medical Event	Services You May Need	What You Will Pay Tier 1: Network (You will pay the least)	What You Will Pay Tier 2: Non-Network (You will Pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at** www.maxorplus.com **Maxor Plus Customer Service: 800-687-0707**	Prescription Drugs	Retail 30-days	Mail Order: 90-days	Retail: 30-days All Brands: $499 plan costs or less per refill: Greater of $35 or 50% with a maximum of $100 per refill All Brands: $500 plan costs or more per refill: Greater of $10 & 20% coinsurance
	Generic drugs: $499 plan cost or less per refill	$10 co-pay	$20 co-pay	
	Generic drugs: $500 plan cost or more per refill	$10 co-pay & 10% coinsurance	$20 co-pay & 10% coinsurance	
	Specialty Generic:	$20 co-pay	N/A	Mail Order: 90 days All Brands: $499 plan costs or less per refill: Greater of $70 or 50% with a maximum of $250 per refill All Brands: $500 plan costs or more per refill: Greater of $20 & 20% coinsurance
	Specialty Brand	Greater of $70 or 50% with a maximum of $750 per refill	N/A	
If you have outpatient surgery	Outpatient Hospital: Surgery & Ambulatory Surgery Center	$250 co-pay, 20% coinsurance, per visit deductible waived	50% after deductible	Diagnostic Colonoscopies will be paid 100% after $250 co-pay for In-Network. Precertification is required. Call 855-236-3376, Valenz Health. Failure to get precertification, benefits could be reduced by $500 of the total cost of services.
If you need immediate medical attention	True Emergency Room: Hospital Facility Services	$250 co-pay, 20% coinsurance, deductible waived	250 co-pay, 20% coinsurance, deductible waived	If admitted within 24 hours co-pay will be waived. Precertification is required. Call 855-236-3376, Valenz Health. Failure to get precertification, benefits could be reduced by $500 of the total cost of services.
	True Emergency Room: Hospital Professional Services	20% deductible waived	20% deductible waived	
	Emergency medical transportation: Ground and Air	20% after deductible	50% after deductible	None
	Non-Emergency Room: Hospital Facility Services	$1,000 co-pay, 20% coinsurance after deductible	50% coinsurance after deductible	Non-Emergency Room: Hospital Professional Services Tier 1: 20% coinsurance after deductible Tier 2: 50% coinsurance after deductible
	Urgent care	$35 co-pay, deductible waived, per visit	50% coinsurance after deductible	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Tier 1: Network (You will pay the least)	Tier 2: Non-Network (You will Pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 co-pay, 20% coinsurance, deductible waived per visit	50% after deductible	Precertification is required. Call 855-236-3376, Valenz Health. Failure to get precertification, benefits could be reduced by $500 of the total cost of services.
	Physician & Surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	Assistant Surgeon will be limited to 25% of the Usual and Customary fee.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$250 co-pay, 20% coinsurance, deductible waived per visit	50% coinsurance after deductible	Diagnostic colonoscopies will be paid 100% after $250 co-pay for In-Network.
	Inpatient services	20% coinsurance after deductible	50% coinsurance after deductible	None.
If you are pregnant	Office visits: Childbirth & Delivery Professional services	20% coinsurance after deductible	50% coinsurance after deductible	Cost sharing does not apply for certain Network Prenatal & Preventive services required by PPACA. 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.).
	Childbirth & Delivery Facility Services	20% coinsurance after deductible	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	0% coinsurance, deductible waived	50% after deductible	*Limited to 120 visits per calendar year.
	Rehabilitation services: Cardiac	$250 co-pay, 20% coinsurance after deductible	50% after deductible	Physical Therapy (Office) & Occupational Therapy (Outpatient): Tier 1: $35 co-pay, 20% coinsurance, deductible waived per visit Tier 2: 50% after deductible per visit
	Habilitation services	0% coinsurance deductible waived	50% after deductible	Precertification is required. Call 855-236-3376, Valenz Health. Failure to get precertification, benefits could be reduced by $500 of the total cost of services.

Common Medical Event	Services You May Need	What You Will Pay Tier 1: Network (You will pay the least)	What You Will Pay Tier 2: Non-Network (You will Pay the most)	Limitations, Exceptions, & Other Important Information
	Skilled nursing care	0% coinsurance deductible waived	50% coinsurance, Deductible waived	*Limited to 60 visits per calendar year. Precertification is required. Call 855-236-3376, Valenz Health. Failure to get precertification, benefits could be reduced by $500 of the total cost of services.
	Durable medical equipment: Includes DME Supplies	20% after deductible	50% after deductible	None.
	Hospice services	0% coinsurance after deductible	50% after deductible	*Bereavement counseling covered within 6 months of death. *$20,000 lifetime maximum Precertification is required. Call 855-236-3376, Valenz Health. Failure to get precertification, benefits could be reduced by $500 of the total cost of services.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Coverage limited as required by PPACA.
	Children's glasses	No Charge	No Charge	Not a covered service under this Plan.
	Children's dental check-up	No Charge	No Charge	

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.)		
• Bariatric surgery • Long-Term Care • Substance use disorder • Gene Therapy	• Non-emergency care when traveling outside the U.S. • Mental/Behavioral Health • Acupuncture • Cosmetic surgery	• Routine foot care • Weight loss programs • Dental Care (adult) • Orphan Drugs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Hearing aids ($1,000 combined for both ears every 36 months) • Infertility Treatment diagnostic testing only	• Chiropractic Care (calendar year maximum to 20)	• Private duty nursing when clinical eligibility is met • Routine eye care (adult) eye exam and glaucoma testing only

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 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: 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.
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 [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

About these Coverage Examples:

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

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*	$1,500
Specialists *co-pay*	$50
Hospital (facility) *[coinsurance]*	20%
Other *[coinsurance]*	20%

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	$1,500
Copayments	$550
Coinsurance	$3,834
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$5,884**

Managing Joe's Type 2 Diabetes

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

The plan's overall *deductible*	$1,500
Specialist *co-pay*	$50
Hospital (facility) *[coinsurance]*	20%
Other *[coinsurance]*	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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$50
Coinsurance	$1,458
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,008**

Mia's Simple Fracture

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

The plan's overall *deductible*	$1,500
Specialist *co-pay*	$50
Hospital (facility) *[coinsurance]*	20%
Other *[coinsurance]*	20%

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	$1,500
Copayments	$285
Coinsurance	$365
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,150**

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