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?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. The plan does not have a 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?	Not Applicable	The plan does not have an out-of-pocket limit on your expenses.
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	Not covered	Not covered
	Specialist visit	Not covered	Not covered
	Preventive care/screening/ immunization	No charge	Limited to preventive services as defined by PPACA. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. The plan pays up to 125% of Medicare allowed. You must pay the portion of provider charges not covered by the plan. Covered laboratory services paid under the BCBSAL fee schedule.
f you have a test	Diagnostic test (x-ray, blood work)	Not covered	Not covered
	Imaging (CT/PET scans, MRIs)	Not covered	
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	Limited to PPACA required preventive care medications and supplies. All other drugs are not covered.
	Preferred brand drugs (Tier 2)	Not covered (certain PPACA required medications may be covered at no charge)	
	Non-preferred brand drugs (Tier 3)	Not covered (certain PPACA required medications may be covered at no charge)	
	Specialty drugs (Tier 4)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered
	Physician/surgeon fees	Not covered	Not covered
If you need immediate	Emergency room care	Not covered	Not covered

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
medical attention	Emergency medical transportation	Not covered	
	Urgent care	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered
	Physician/surgeon fees	Not covered	Not covered
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered
	Inpatient services	Not covered	
If you are pregnant	Office visits	Not covered	Not covered
	Childbirth/delivery professional services	Not covered	
	Childbirth/delivery facility services	Not covered	
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered
	Rehabilitation services	Not covered	Not covered
	Habilitation services	Not covered	Not covered
	Skilled nursing care	Not covered	Not covered
	Durable medical equipment	Not covered	Not covered
	Hospice services	Not covered	Not covered
If your child needs dental or eye care	Children's eye exam	Not covered	Not Covered – Vision exams for children may be covered under the preventive services.
	Children's glasses	Not covered	Not covered
	Children's dental check-up	Not covered	None

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
- Chiropractic Care
- Emergency Medical Transportation (ambulance)
- Emergency Room Care
- Cosmetic Surgery
- Dental Care
- Diagnostic Tests and Imaging
- Habilitation Services
- Hearing Aids
- Home Health Care
- Hospice
- Infertility Treatment
- Inpatient Services
- Long Term Care
- Mental Health, Behavioral Health, And Substance Abuse Treatment
- Non-Emergency Care When Traveling Outside The U.S.
- Non- Preventive Care Services
- Outpatient Surgery
- Primary Care And Specialist Visits, Except For Covered Preventive Care
- Private Duty Nursing
- Rehabilitation Services
- Routine Eye Care (Adult)
- Routine Foot Care
- Skilled Nursing Care
- Weight Loss Programs
- Specialty Drugs

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

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? No.
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	$0
Specialist copayment	$0
Hospital (facility) coinsurance	n/a
Other coinsurance	n/a

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,300
The total Peg would pay is	**$12,300**

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 copayment	$0
Hospital (facility) coinsurance	n/a
Other coinsurance	n/a

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$5,400
The total Joe would pay is	**$5,400**

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

The plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) coinsurance	n/a
Other coinsurance	n/a

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,800
The total Mia would pay is	**$2,800**

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

For more information about limitations and exceptions, see the plan or policy document at www.90degreebenefits.com