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.dol.gov/ebsa/healthreform or call 1-800-277-9476 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** Individual/**$2,000** Family for White River Health System Providers **$1,500** Individual/**$3,750** Family for All Other Providers	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. COVID-19 testing and treatment performed in office or outpatient setting. Preventive care, physician office services, Emergency Room Facility services, Urgent care services, Out-Patient or Rehabilitative and Habilitative Therapies that are WRHS Providers 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, but see the chart starting on page 2 for other costs for services this **plan** covers.
What is the out-of-pocket limit for this plan?	**$3,000** Individual/**$6,000** Family for White River Health System Providers **$5,500** Individual/**$9,000** Family for All Other Providers	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?	Premiums, balance-billed charges, health care this plan doesn't cover, penalties for failure to obtain pre-authorization for services and amounts over the	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

	Maximum Allowable Charge.	
Will you pay less if you use a network provider?	No. There is no Network.	None
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 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
		White River Health System Providers	All Other Providers	
If you visit a health care provider's office or clinic	Primary Care visit to treat an injury or illness	$30 copayment	$50 copayment	Home visits are treated the same as an office visit. Copayment waived if treatment is for COVID-19.
	Specialist visit	10% coinsurance	30% coinsurance	
	Preventive care/screening/immunization	No charge	No charge	None
If you have a test	Diagnostic test (laboratory and blood work)	10% deductible waived	20% coinsurance	COVID-19 testing in any setting except In-patient, there is no cost-sharing.
	Diagnostic test Imaging (CT/PET scans, MRI MRA's, and X-rays)	10% deductible waived	20% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.MyMaxCareRx.com	Generic Drugs	25% coinsurance with a minimum of $5 and a maximum of $15 (retail)	Not covered	When a medication cost is $750 or more, per 30-day supply the member pays 25% coinsurance.
	Preferred Brand Name Drugs	25% coinsurance with a minimum of $30 and a maximum of $50 (retail)	Not covered	When a medication cost is $750 or more, per 30-day supply the member pays 25% coinsurance.
	Non-Preferred Brand Name Drugs	25% coinsurance with a minimum of $45 and a maximum of $75 (retail)	Not covered	When a medication cost is $750 or more, per 30-day supply the member pays 25% coinsurance.
	Specialty drugs	Based on category of prescription drug listed above	Not covered	When a medication cost is $750 or more, per 30-day supply the member pays 25% coinsurance.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		White River Health System Providers	All Other Providers	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	None
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance after $100 copayment	10% coinsurance after $100 copayment (Non-Emergency use of Emergency room is not covered)	Copayment waived if treatment is for COVID-19 or if you are admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$30 copayment	$50 copayment	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Pre-certification is required within 48 hours after an emergency. Call 1-800-373-4454. Failure to follow this procedure may reduce reimbursement received from the Plan.
	Physician/surgeon fee	10% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	20% coinsurance	None
	Inpatient services	10% coinsurance	20% coinsurance	None
	Office visits	10% coinsurance	20% coinsurance	None
If you are pregnant	Office visits-1ST office visit only	$30 copayment	20% coinsurance	Copayment applies to initial office visit only.
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	Pre-certification is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay.
If you need help recovering or have other special health	Home health care	10% coinsurance	20% coinsurance	None
	Rehabilitation services	10% coinsurance	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		White River Health System Providers	All Other Providers	
needs	Habilitation services	10% coinsurance	20% coinsurance	None
	Skilled nursing care	10% coinsurance	20% coinsurance	None
	Durable medical equipment	10% coinsurance	20% coinsurance	Covered up to purchase price
	Hospice services	10% coinsurance	20% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Except as required by ACA
	Children's glasses	Not Covered	Not Covered	Except as required by ACA
	Children's dental check-up	Not Covered	Not Covered	Except as required by ACA

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 (Adult)
- Experimental treatment
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic Care
- Hearing Aids

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the **plan** at (807) 262-6580. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, 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 the plan at 1-800-277-9476. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Does this Coverage 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 Coverage Meet the Minimum Value Standard? 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: 1-800-277-9476

Spanish (Español): Para obtener asistencia en Español, llame al
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa
Chinese (中文): 如果需要中文的幫助，请拨打这个号码
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'

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	$1,000
▪ PCP copayment	$30
▪ Hospital (facility) *coinsurance*	90%
▪ Other *coinsurance*	90%
This EXAMPLE event includes services like:	
Primary care physician office visits (*prenatal care)*	
Childbirth/Delivery Professional Services	
Childbirth/Delivery Facility Services	
Diagnostic tests (*ultrasounds and blood work)*	
Specialist visit *(anesthesia)*	
Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$30
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,130**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
▪ The plan's overall deductible	$1,000
▪ PCP copayment	$30
▪ Hospital (facility) *coinsurance*	90%
▪ Other *coinsurance*	90%
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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$520
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$720**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
▪ The plan's overall deductible	$1,000
▪ Specialist copayment	90%
▪ Hospital (facility) *coinsurance*	90%
▪ Other *coinsurance*	90%
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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$100
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1.180**