

 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 888-673-7115 or visit <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 www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 888-673-7115 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$3,000 Individual / \$6,000 Family. Non-Network: \$9,000 Individual / \$18,000 Family	If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of members meets the overall family deductible. You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Network Provider: 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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: \$6,000 Individual / \$12,000 Family. Non-Network: \$18,000 Individual / \$36,000 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?	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 a provider visit www.mercyoptions.net (select Valenz as the employer).	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.

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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
		Network Provider	Non-Network Provider	
		(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>	20% coinsurance after deductible	50% coinsurance after deductible	<u>Office Therapeutic Injections, Office X-ray, Office Laboratory, Diagnostic Testing, All Other Office Related Services, Office Surgery, Office Allergy Injections and Serum, Office Allergy Testing:</u> Network Provider: 20% coinsurance after deductible Non-Network Provider: 50% coinsurance after deductible
	<u>Specialist visit</u>	20% coinsurance after deductible	50% coinsurance after deductible	
	<u>Preventive care/screening/immunization</u>	No Charge	50% coinsurance after deductible	
If you have a test	<u>Diagnostic test (x-ray, blood work)</u>	20% coinsurance after deductible	50% coinsurance after deductible	<u>Independent Lab:</u> Network Provider: 20% coinsurance after deductible Non-Network Provider: 50% coinsurance after deductible
	<u>Imaging (CT/PET scans, MRIs)</u>	20% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required, call 855-236-3376. Failure to pre-certify will result in a penalty of \$250.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Non-Network Provider	
		(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.southernscripts.net Or call Southernscripts at 800-710-9341.	<u>Generic drugs</u>	\$0 copay, after deductible	\$0 copay, after deductible	Retail - 30 day supply - copay applies to each 30 day supply. Mail Order - copay applies to each 31-90 day supply. <u>Specialty Drug Program:</u> For more information call HealthPlan Management Program at 417-893-8437. After 90 days covered through Specialty Drug Program (If qualified). If not qualified, revert to copay.
	<u>Preferred brand drugs</u>	\$0 copay, after deductible	\$0 copay, after deductible	
	<u>Non-preferred brand drugs</u>	\$0 copay, after deductible	\$0 copay, after deductible	
	<u>Specialty drugs</u>	\$0 copay, after deductible	\$0 copay, after deductible	
If you have outpatient surgery	<u>Facility fee (e.g., ambulatory surgery center)</u>	20% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required, call 855-236-3376. Failure to pre-certify will result in a penalty of \$250.
	<u>Physician/surgeon fees</u>	20% coinsurance after deductible	50% coinsurance after deductible	
If you need immediate medical attention	<u>Emergency room care</u>	20% coinsurance after deductible	20% coinsurance after deductible	If admitted, copay waived and pre-cert required. Call 855-236-3376. Failure to pre-certify will result in a penalty of \$250. <u>Ambulance (Air, Water, and Ambulance Transfers for non-emergency):</u> Pre-certification is required, call 855-236-3376. Failure to pre-certify will result in a penalty of \$250. <u>Surgery/Physical Therapy/Occupational Therapy, Allergy Injections, MRI, PET, BONE SCAN, Cardiac Stress Test, Radiation, Chemo, Dialysis:</u> Network Provider: 20% coinsurance after deductible Non-Network Provider: 50% coinsurance after deductible
	<u>Emergency medical transportation</u>	20% coinsurance after deductible	50% coinsurance after deductible	
	<u>Urgent care</u>	20% coinsurance after deductible	50% coinsurance after deductible	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Non-Network Provider	
		(You will pay the least)	You will pay the most)	
If you have a hospital stay	<u>Facility fee (e.g., hospital room)</u>	20% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required, call 855-236-3376. Failure to pre-certify will result in a penalty of \$250.
	<u>Physician/surgeon fees</u>	20% coinsurance after deductible	50% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	<u>Outpatient services</u>	20% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required, call 855-236-3376. Failure to pre-certify will result in a penalty of \$250.
	<u>Inpatient services</u>	20% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required, call 855-236-3376. Failure to pre-certify will result in a penalty of \$250.
If you are pregnant	<u>Office visits</u>	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.)
	<u>Childbirth/delivery professional services</u>			
	<u>Childbirth/delivery facility services</u>	20% coinsurance after deductible	50% coinsurance after deductible	Pre-cert is required for inpatient stays longer than 48 hours for vaginal delivery or 72 hours for cesarean delivery, call 855-236-3376. Failure to pre-certify will result in a penalty of \$250 per admission.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Non-Network Provider	
		(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>	20% coinsurance after deductible	50% coinsurance after deductible	Limited to 60 visits per calendar year. Pre-cert is required, call 855-236-3376. Failure to pre-certify will result in a penalty of \$250.
	<u>Rehabilitation services</u>	20% coinsurance after deductible	50% coinsurance after deductible	<u>Physical Therapy, Occupational Therapy, Speech Therapy:</u> Pre-cert is required, call 855-236-3376. Failure to pre-certify will result in a penalty of \$250. Maximum benefits per calendar year 40 visits per therapy.
	<u>Habilitation services</u>	20% coinsurance after deductible	50% coinsurance after deductible	<u>Chiropractic Services:</u> Network Provider: 20% coinsurance after deductible Non-Network Provider 50% coinsurance after deductible Maximum benefits per calendar year 26 visits.
	<u>Skilled nursing care</u>	20% coinsurance after deductible	50% coinsurance after deductible	Limited to 25 days per calendar year. Pre-cert is required, call 855-236-3376. Failure to pre-certify will result in a penalty of \$250.
	<u>Durable medical equipment</u>	20% coinsurance after deductible	50% coinsurance after deductible	Pre-cert is required for cost is greater than \$1,000 billed per date of service, call 855-236-3376. Failure to pre-certify will result in a penalty of \$250.
	<u>Hospice services</u>	20% coinsurance after deductible	50% coinsurance after deductible	Pre-cert is required, call 855-236-3376. Failure to pre-certify will result in a penalty of \$250. Bereavement counseling covered within 6 months of death.
If your child needs dental or eye care	<u>Children's eye exam</u>	No Charge	50% coinsurance after deductible	Coverage limited as required by PPACA.
	<u>Children's glasses</u>	Not Covered	Not Covered	Not a covered service under this Plan.
	<u>Children's dental check-up</u>	No Charge	50% coinsurance after deductible	Coverage limited to oral health risk assessment as required by PPACA.

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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">• Acupuncture• Bariatric surgery• Cosmetic surgery• Dental care (adult)	<ul style="list-style-type: none">• Infertility treatment• Long-term care• Non-emergency care when traveling outside the U.S.	<ul style="list-style-type: none">• 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.)		
<ul style="list-style-type: none">• Chiropractic Care	<ul style="list-style-type: none">• Hearing aids – one aid per ear each per 36 month period	Private-duty nursing (allowable only when Hospital's Intensive Care Unit is full or Hospital has no Intensive Care Unit)

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: 888-673-7115. 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 888-673-7115.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-673-7115.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 888-673-7115.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 888-673-7115.

————— *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 deductible **\$3,000**
- Specialist coinsurance **20%**
- 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	\$12,738
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$2,040
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,100

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

- The plan's overall deductible **\$3,000**
- Specialist coinsurance **20%**
- 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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$585
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$3,640

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

- The plan's overall deductible **\$3,000**
- Specialist coinsurance **20%**
- 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	\$1,925
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,540
Copayments	\$0
Coinsurance	\$385
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,925