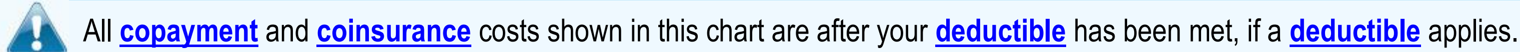
Keating Auto Group E.B.P.T.: Gold Plan A

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage Period: 4/1/2026-3/31/2027**

Coverage for: Individual & Family **Plan Type:** Open Access

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.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.90degreebenefits.com or call 1-844-355-7878 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$475** Monthly Deductible. Doesn't apply to preventive care, prescription drugs, physician office visits, urgent care clinics and convenience care clinics. Copays do not apply to the 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 1st). 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?	**Yes**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs of services this plan covers.
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 of services this plan covers.
What is the out-of-pocket limit for this plan?	**$6,850 Individual** **$13,700 Family**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed 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 services from any provider.
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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$45 Copay	———————none———————
	Specialist visit	$60 Copay	———————none———————
	Preventive care/screening/ immunization	No Charge	———————none———————
If you have a test	Diagnostic test (x-ray, blood work)	$40 Copay	———————none———————
	Imaging (CT/PET scans, MRIs)	25% coinsurance after deductible	———————none———————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.90degreebenefits.com	Generic drugs	$15 Copay	———————none———————
	Preferred brand drugs	30% Copay	———————none———————
	Non-preferred brand drugs	30% Copay	———————none———————
	Specialty drugs	Not Covered	———————none———————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	———————none———————
	Physician/surgeon fees	0% coinsurance after deductible	———————none———————
If you need immediate medical attention	Emergency room care	25% coinsurance after $500 Copay	———————none———————
	Emergency medical transportation	25% coinsurance after deductible	———————none———————
	Urgent care	$70 Copay	———————none———————
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after deductible	———————none———————
	Physician/surgeon fees	0% coinsurance after deductible	———————none———————

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	
	Inpatient services	Not Covered	
If you are pregnant	Office visits	Covered as any other illness	——————none——————
	Childbirth/delivery professional services	Covered as any other illness	——————none——————
	Childbirth/delivery facility services	Covered as any other illness	——————none——————
If you need help recovering or have other special health needs	Home health care	25% coinsurance after deductible	Limited to 100 Visits Per Plan Year
	Rehabilitation services	25% coinsurance after deductible	——————none——————
	Habilitation services	Not Covered	
	Skilled nursing care	25% coinsurance after deductible	Limited to 30 Days Per Plan Year
	Durable medical equipment	25% coinsurance after deductible	——————none——————
	Hospice services	25% coinsurance after deductible	——————none——————
If your child needs dental or eye care	Children's eye exam	50% Copay	Limited to one Exam Per Plan Year / $150 Maximum Benefit Per Plan Year including examination, refraction and contact lens fitting
	Children's glasses	No Charge	$150 Maximum Benefit Per Plan Year including frames/ lenses and contacts.
	Children's dental check-up	No Charge	Limited to Two Exams Per Plan Year

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 • Habilitation services	• Hearing Aids • Infertility Treatment • Long Term Care • Mental Health Services	• Non-emergency care when traveling outside the U.S. • Private Duty Nursing • 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.)		
• Dental Care (If Elected)	• Routine Eye Care (If Elected)	• Chiropractic Care

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-EBSA (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 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: 90 Degree Benefits – Houston 22322 Grand Corner Dr., Ste. 200, Katy, TX 77494; or by phone at 1-844-355-7878.
Additionally, a consumer assistance program can help you file your appeal. Contact: Texas consumer Health Assistance Program Texas Department of Insurance, Mail Code 111-1A, 333 Guadalupe, P.O. Box 149091, Austin, TX 78714; or by phone at (855)839-2427 or www.texashealthoptions.com; chap@tdi.state.tx.us
Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (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.

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** **$475**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **25%**

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$475
Copayments	$260
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$735**

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

- **The plan's overall deductible** **$475**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **25%**

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	$475
Copayments	$1,215
Coinsurance	$320
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,010**

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

- **The plan's overall deductible** **$475**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **25%**

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	$475
Copayments	$500
Coinsurance	$288
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,263**

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