

Keating Auto Group E.B.P.T.: Platinum Plan B

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. 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 ?	\$350 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 <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there services covered before you meet your deductible ?	Yes	You don't have to meet <u>deductibles</u> 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 <u>deductibles</u> 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 ?	\$5,000 Individual \$10,000 Family	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> .
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 <u>specialist</u> you choose without permission from this plan.

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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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 Copay	—————none—————
	Specialist visit	\$45 Copay	—————none—————
	Preventive care/screening/immunization	No Charge	—————none—————
If you have a test	Diagnostic test (x-ray, blood work)	\$35 Copay	—————none—————
	Imaging (CT/PET scans, MRIs)	20% 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 (maximum copay of \$300 per prescription)	—————none—————
	Non-preferred brand drugs	30% Copay (maximum copay of \$300 per prescription)	—————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	20% coinsurance after \$500 Copay	—————none—————
	Emergency medical transportation	20% coinsurance after deductible	—————none—————
	Urgent care	\$60 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—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	
	Inpatient services	Not Covered	

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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	20% coinsurance after deductible	Limited to 100 Visits Per Plan Year
	Rehabilitation services	20% coinsurance after deductible	—————none—————
	Habilitation services	Not Covered	
	Skilled nursing care	20% coinsurance after deductible	Limited to 30 Days Per Plan Year
	Durable medical equipment	20% coinsurance after deductible	—————none—————
	Hospice services	20% 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

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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 excluded services .)		
<ul style="list-style-type: none">• Acupuncture• Bariatric Surgery• Cosmetic Surgery• Mental Health Services	<ul style="list-style-type: none">• Habilitation services• Hearing Aids• Infertility Treatment• Long Term Care	<ul style="list-style-type: none">• 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.)		
<ul style="list-style-type: none">• Dental Care (If Elected)	<ul style="list-style-type: none">• Routine Eye Care (If Elected)	<ul style="list-style-type: none">• 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 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* —————

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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](#) \$350
- [Specialist](#) copayment \$45
- Hospital (facility) coinsurance 0%
- 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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$350
Copayments	\$330
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$680

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

- The [plan's](#) overall [deductible](#) \$350
- [Specialist](#) copayment \$45
- Hospital (facility) coinsurance 0%
- 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	\$350
Copayments	\$1,180
Coinsurance	\$281
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$1,811

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

- The [plan's](#) overall [deductible](#) \$350
- [Specialist](#) copayment \$45
- Hospital (facility) coinsurance 0%
- 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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$350
Copayments	\$565
Coinsurance	\$256
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,171