
 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 844-610-7872. 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 844-617-1890 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|--|
| <p>What is the overall deductible?</p> | <p>Tier 1 Network providers: N/A Tier 2 Network providers: \$5,000/individual, \$5,000/individual under family or \$10,000/family Out-of-network provider: \$5,000/individual, \$5,000/individual under family or \$10,000/family</p> | <p>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. The deductible is Embedded. 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. Deductible year runs 01/01 – 12/31</p> |
| <p>Are there services covered before you meet your deductible?</p> | <p>Yes. Preventive care services are covered before you meet your deductible.</p> | <p>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 care 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/.</p> |
| <p>Are there other deductibles for specific services?</p> | <p>No.</p> | <p>You don't have to meet deductibles for specific services.</p> |
| <p>What is the out-of-pocket limit for this plan?</p> | <p>Tier 1 Network providers: N/A Tier 2 Network providers: \$6,500/individual, \$6,500/individual under family or \$13,000/family Out-of-network provider: \$13,000/individual, \$13,000/individual under family or \$26,000/family</p> | <p>The out-of-pocket limit is the most you could pay in a year for covered services. The out-of-pocket limit is Embedded. 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.</p> |
| <p>What is not included in the out-of-pocket limit?</p> | <p>Premiums, balance billing charges, and health care this plan doesn't</p> | <p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p> |

| | | |
|--|---|--|
| | cover. | |
| Will you pay less if you use a network provider? | Yes. See KatyTrailBenefits.com or call 844-617-1890 for a list of network providers . | This plan uses a provider network . You will pay less if you use a provider in the plan's network . 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). |
| 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 |
|---|--|--|---------------------------------|---|---|
| | | Tier 1 Network Provider (You will pay the least) | Tier 2 Network Provider | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | No charge | \$40 copayment | 40% coinsurance | Deductible does not apply to copayment . |
| | Specialist visit | No charge | \$80 copayment | 40% coinsurance | Deductible does not apply to copayment . |
| | Preventive care/screening/immunization | No charge | No charge | 40% coinsurance | You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | No charge | 40% coinsurance | Labs in a clinic or independent lab setting are covered at no charge |
| | Imaging (CT/PET scans, MRIs) | Not Available | \$400 copayment | 40% coinsurance | May require preauthorization . Deductible does not apply to copayment . |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|-----------------------|---|-------------------------|---|---|
| | | Tier 1 Network Provider (You will pay the least) | Tier 2 Network Provider | Out-of-Network Provider (You will pay the most) | |
| <p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at KatyTrailsBenefits.com</p> | Generic drugs | <p>Katy Trail Pharmacy and Katy Trail Prescriber: 30-day supply Retail: No Charge Katy Trail Pharmacy and Katy Trail Prescriber: No Charge</p> <p>Katy Trail Pharmacy and Non-Katy Trail Prescriber: 30-day supply Retail: \$5 copayment Katy Trail Pharmacy and Katy Trail Prescriber: \$10 copayment</p> <p>Non-Katy Trail Pharmacy: 30-day supply Retail: \$20 copayment Non-Katy Trail Pharmacy: \$50 copayment</p> | | | <p>Cost sharing does not apply for preventive Prescriptions. Deductible does not apply to copayment</p> |
| | Preferred brand drugs | <p>Katy Trail Pharmacy and Katy Trail Prescriber: 30-day supply Retail: No Charge Katy Trail Pharmacy and Katy Trail Prescriber: No Charge</p> <p>Katy Trail Pharmacy and Non-Katy Trail Prescriber: 30-day supply Retail: \$20 copayment Katy Trail Pharmacy and Katy Trail Prescriber: \$40 copayment</p> <p>Non-Katy Trail Pharmacy: 30-day supply Retail: \$45 copayment Non-Katy Trail Pharmacy: \$113 copayment</p> | | | |

* For more information about limitations and exceptions, see the plan or policy document at KatyTrailBenefits.com.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|----------------------|--|---|-------------------------|---|--|
| | | Tier 1 Network Provider (You will pay the least) | Tier 2 Network Provider | Out-of-Network Provider (You will pay the most) | |
| | Non-preferred brand drugs | <p>Katy Trail Pharmacy and Katy Trail Prescriber: 30-day supply Retail: No Charge</p> <p>Katy Trail Pharmacy and Katy Trail Prescriber: No Charge</p> <p>Katy Trail Pharmacy and Non-Katy Trail Prescriber: 30-day supply Retail: \$50 copayment</p> <p>Katy Trail Pharmacy and Katy Trail Prescriber: \$100 copayment</p> <p>Non-Katy Trail Pharmacy: 30-day supply Retail: \$80 copayment</p> <p>Non-Katy Trail Pharmacy: \$200 copayment</p> | | | |
| | Preferred Specialty drugs Non-Preferred Specialty drugs | <p>Katy Trail Pharmacy and Katy Trail Prescriber: 30-day supply Retail: No Charge</p> <p>Katy Trail Pharmacy and Katy Trail Prescriber: Not Covered</p> <p>Katy Trail Pharmacy and Non-Katy Trail Prescriber: 30-day supply Retail: 20% coinsurance up to \$500</p> <p>Katy Trail Pharmacy and Katy Trail Prescriber: Not Covered</p> <p>Non-Katy Trail Pharmacy: 30-day supply Retail: 20% coinsurance up to \$500</p> <p>Non-Katy Trail Pharmacy: Not Covered</p> <p>Katy Trail Pharmacy and Katy Trail Prescriber: 30-day supply Retail: No Charge</p> <p>Katy Trail Pharmacy and Katy Trail Prescriber: Not Covered</p> <p>Katy Trail Pharmacy and Non-Katy Trail Prescriber: 30-day supply Retail: 30% coinsurance up to \$500</p> <p>Katy Trail Pharmacy and Katy Trail Prescriber: Not Covered</p> <p>Non-Katy Trail Pharmacy: 30-day supply Retail: 30% coinsurance up to \$500</p> <p>Non-Katy Trail Pharmacy: Not Covered</p> | | | |

* For more information about limitations and exceptions, see the plan or policy document at KatyTrailBenefits.com.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|---|--|
| | | Tier 1 Network Provider (You will pay the least) | Tier 2 Network Provider | Out-of-Network Provider (You will pay the most) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Not Available | 20% coinsurance | 40% coinsurance | May require preauthorization . |
| | Physician/surgeon fees | Not Available | 20% coinsurance | 40% coinsurance | |
| If you need immediate medical attention | Emergency room care | Not Available | \$100 copayment , then 20% coinsurance | | Deductible does not apply to copayment . |
| | Emergency medical transportation | 10% coinsurance | 20% coinsurance | | None. |
| | Urgent care | Not Available | \$40 copayment | \$80 copayment | Deductible does not apply to copayment . |
| If you have a hospital stay | Facility fee (e.g., hospital room) | Not Available | 20% coinsurance | 40% coinsurance | Preauthorization required. |
| | Physician/surgeon fees | Not Available | 20% coinsurance | 40% coinsurance | None. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No charge | \$80 copayment | 40% coinsurance | Deductible does not apply to copayment . |
| | Inpatient services | Not Available | 20% coinsurance | 40% coinsurance | Preauthorization required. |
| If you are pregnant | Office visits | Not Available | 20% coinsurance | 40% coinsurance | Cost sharing does not apply for preventive services. |
| | Childbirth/delivery professional services | Not Available | 20% coinsurance | 40% coinsurance | Depending on the type of services, a copayment or coinsurance may apply. |

* For more information about limitations and exceptions, see the plan or policy document at KatyTrailBenefits.com.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|--|---------------------------------|---|--|
| | | Tier 1 Network Provider (You will pay the least) | Tier 2 Network Provider | Out-of-Network Provider (You will pay the most) | |
| | Childbirth/delivery facility services | Not Available | 20% coinsurance | 40% coinsurance | Maternity care may include tests and services described elsewhere in the SBC. |
| If you need help recovering or have other special health needs | Home health care | Not Available | 20% coinsurance | 40% coinsurance | Preauthorization required. 60 visit limit per year. |
| | Rehabilitation services | Not Available | \$80 copayment | 40% coinsurance | Occupational Therapy: 20 visit limit combined with speech therapy per Deductible year Speech Therapy: 20 visit limit combined with occupational therapy per Deductible year Physical Therapy: 20 visit limit per Deductible year Deductible does not apply to copayment . |
| | Habilitation services | Not Available | \$80 copayment | 40% coinsurance | |
| | Skilled nursing care | Not Available | 20% coinsurance | 40% coinsurance | Preauthorization required. 60 days per year maximum. |
| | Durable medical equipment | Not Available | 20% coinsurance | 40% coinsurance | None. |
| | Hospice services | Not Available | 20% coinsurance | 40% coinsurance | Preauthorization required. |
| If your child needs dental or eye care | Children's eye exam | Not Available | 20% coinsurance | 40% coinsurance | Limit of 1 routine exam per year. |
| | Children's glasses | Not Covered | Not Covered | Not Covered | None. |
| | Children's dental check-up | Not Covered | Not Covered | 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](#).)

- Cosmetic surgery
- Weight loss programs
- Dental Care (Adult)
- Bariatric Surgery
- Acupuncture
- Long-term care
- Non-emergency care when traveling outside the U.S.

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

- Private Duty Nursing (inpatient only)
- Infertility Treatment (correction of physiological abnormalities)
- Emergency care when traveling outside the U.S.
- 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: : 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

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? 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 844-617-1890

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-617-1890

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 844-617-1890

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 844-617-1890

————— *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](#) \$5,000
- [Specialist Copayment](#) \$80
- 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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$5,000 |
| Copayments | \$0 |
| Coinsurance | \$1,500 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$6,560 |

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist Copayment](#) \$80
- 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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$900 |
| Copayments | \$800 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,720 |

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist Copayment](#) \$80
- 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 | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,700 |
| Copayments | \$700 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,400 |