
 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 844-617-1890. 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: \$0/individual or \$0/family Tier 2 Network providers: \$4,000/individual or \$8,000/family Out-of-network provider: \$5,000/individual 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: \$0/individual or \$0/family Tier 2 Network providers: \$5,000/individual or \$10,000/family Out-of-network provider: \$20,000/individual or \$60,000/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 cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See katytrailbenefits.com or call 844-617-1890 for a list of network</p>	<p>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</p>

	providers.	billing).
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

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

 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	Katy Trail: No Charge Health Cooperative of Missouri: No Charge	\$40 copayment	30% coinsurance	Includes associated labs & x-rays. Deductible does not apply to copayment .
	Specialist visit	Katy Trail: No Charge Health Cooperative of Missouri: No Charge	\$40 copayment	30% coinsurance	Deductible does not apply to copayment .
	Preventive care/screening/immunization	No charge		30% 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)	Katy Trail: No Charge Health Cooperative of Missouri: No Charge	20% coinsurance	30% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	Katy Trail: No Charge Health Cooperative of Missouri: No Charge	20% coinsurance	30% coinsurance	May require preauthorization .

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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 katytrailbenefits.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> <p>Retail & Mail Order available up to a 90-day supply.</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>			
	Non-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: \$50 copayment Katy Trail Pharmacy and Katy Trail Prescriber: \$100 copayment</p>			

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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-Katy Trail Pharmacy: 30-day supply Retail: \$80 copayment Non-Katy Trail Pharmacy: \$200 copayment			Retail & Mail Order available up to a 30-day supply. All Specialty Prescriptions must be filled at Katy Trail pharmacies, unless the medication is not available.
	Preferred Specialty drugs	Katy Trail Pharmacy and Katy Trail Prescriber: 30-day supply Retail: No Charge Katy Trail Pharmacy and Katy Trail Prescriber: Not Covered Katy Trail Pharmacy and Non-Katy Trail Prescriber: 30-day supply Retail: 20% coinsurance up to \$500 Katy Trail Pharmacy and Katy Trail Prescriber: Not Covered Non-Katy Trail Pharmacy: 30-day supply Retail: 20% coinsurance up to \$500 Non-Katy Trail Pharmacy: Not Covered			
	Non-Preferred Specialty drugs	Katy Trail Pharmacy and Katy Trail Prescriber: 30-day supply Retail: No Charge Katy Trail Pharmacy and Katy Trail Prescriber: Not Covered			
		Katy Trail Pharmacy and Non-Katy Trail Prescriber: 30-day supply Retail: 30% coinsurance up to \$500 Katy Trail Pharmacy and Katy Trail Prescriber: Not Covered Non-Katy Trail Pharmacy: 30-day supply Retail: 30% coinsurance up to \$500 Non-Katy Trail Pharmacy: Not Covered			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Katy Trail: No Charge Health Cooperative of Missouri: No Charge	20% coinsurance	30% coinsurance	May require preauthorization .
	Physician/surgeon fees	Katy Trail: No Charge Health Cooperative of	20% coinsurance	30% coinsurance	

* 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)	
		Missouri: No Charge			
If you need immediate medical attention	Emergency room care	Katy Trail: Not Applicable	\$200 copayment	\$200 copayment	Deductible does not apply to copayment .
		Health Cooperative of Missouri: \$200 copayment			
	Emergency medical transportation	Katy Trail: Not Applicable	20% coinsurance	20% coinsurance	None.
		Health Cooperative of Missouri: No Charge			
	Urgent care	Katy Trail: No Charge	\$40 copayment	30% coinsurance	Deductible does not apply to copayment .
		Health Cooperative of Missouri: No Charge			
If you have a hospital stay	Facility fee (e.g., hospital room)	Katy Trail: No Charge	20% coinsurance	30% coinsurance	Preauthorization required.
		Health Cooperative of Missouri: No Charge			
	Physician/surgeon fees	Katy Trail: No Charge	20% coinsurance	30% coinsurance	None.
		Health Cooperative of Missouri: No Charge			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Katy Trail: No Charge	\$40 copayment	30% coinsurance	Deductible does not apply to copayment .
		Health Cooperative of Missouri: No Charge			
	Inpatient services	Katy Trail: No Charge	20% coinsurance	30% coinsurance	Preauthorization required.
		Health Cooperative of Missouri: No Charge			
If you are pregnant	Office visits	Katy Trail: No Charge	20% coinsurance	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services
		Health Cooperative of Missouri: No Charge			
	Childbirth/delivery	Katy Trail: No Charge	20%	30%	

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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)	
	professional services	Health Cooperative of Missouri: No Charge	coinsurance	coinsurance	described elsewhere in the SBC.
	Childbirth/delivery facility services	Katy Trail: No Charge Health Cooperative of Missouri: No Charge	20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	Katy Trail: No Charge Health Cooperative of Missouri: No Charge	20% coinsurance	30% coinsurance	Preauthorization required. 60 visit limit per Deductible Year
	Rehabilitation services	Katy Trail: No Charge Health Cooperative of Missouri: No Charge	\$40 copayment	30% coinsurance	Deductible does not apply to copayment . Physical Therapy: 20 visit limit per deductible year Occupational Therapy: 20 combined with Speech Therapy per deductible year Speech Therapy: 20 combined with Occupational Therapy per deductible year
	Habilitation services	Katy Trail: No Charge Health Cooperative of Missouri: No Charge	\$40 copayment	30% coinsurance	Occupational Therapy: 20 combined with Speech Therapy per deductible year Speech Therapy: 20 combined with Occupational Therapy per deductible year
	Skilled nursing care	Katy Trail: No Charge Health Cooperative of Missouri: No Charge	20% coinsurance	30% coinsurance	Preauthorization required. 60 visit limit per Deductible Year
	Durable medical equipment	Katy Trail: No Charge Health Cooperative of Missouri: No Charge	20% coinsurance	30% coinsurance	None.
	Hospice services	Katy Trail: No Charge Health Cooperative of Missouri: No Charge	20% coinsurance	30% coinsurance	Preauthorization required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	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.

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

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
- Hearing Aids
- Bariatric Surgery
- 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.)

- 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 Tier 1 [deductible](#) \$1,000
- [Specialist Coinsurance](#) \$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 test](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$10
Coinsurance	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,370

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

- The [plan's](#) overall Tier 1 [deductible](#) \$1,000
- [Specialist Coinsurance](#) \$80
- Hospital (facility) [Coinsurance](#) 20%
- Other [Coinsurance](#) 20%

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- [Diagnostic test](#) (*blood work*)
- Prescription drugs
- [Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$700
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,620

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

- The [plan's](#) overall Tier 1 [deductible](#) \$1,000
- [Specialist Coinsurance](#) \$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	\$1,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$500
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,200