



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, visit *Benefits Outlook* at [www.katybenefits.org](http://www.katybenefits.org) or call 1-866-222-5473. 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 <http://www.HealthReformPlanSBC.com> or call 1-800-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For each calendar year, In-network: Tier I Individual <b>\$1,750</b> /Family <b>\$3,500</b> In-network: Tier II Individual <b>\$2,250</b> /Family <b>\$4,000</b> .	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and generic <a href="#">prescription drugs</a> are covered before you meet your <a href="#">deductible</a>	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes, <b>\$200</b> per person for brand <a href="#">prescription drug coverage</a> . There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	In-network: Tier I Individual <b>\$4,500</b> /Family <b>\$9,000</b> In-network: Tier II Individual <b>\$6,000</b> /Family <b>\$10,500</b>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billed</a> charges, penalties for failure to obtain <a href="#">preauthorization</a> for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.katybenefits.org">www.katybenefits.org</a> or call 1-866-222-5473 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.



Designated [specialties](#) are: cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetrics and gynecology, orthopedics, otolaryngology, neurology, neurosurgery, plastic surgery, urology and vascular surgery.

All primary care physicians are Tier 1; non-designated [specialists](#) are Tier 1.

Tier 1 hospitals are Christus, Memorial Hermann, St. Joseph's, CHI St. Luke's, Tenet, and Texas Children's.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider – Tier I (You will pay the least)	Network Provider – Tier II	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	Not covered	Refer to page 2 for list of 12 designated <a href="#">specialties</a> .
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	Not covered	Age and frequency schedules may apply.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	Not covered	Precertification required. See "tiered" comment above for hospital list. Exclusions do not apply to outpatient place of service.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	\$20 Retail, \$40 Mail Order	\$20 Retail, \$40 Mail Order	Not covered	Covers up to a 30-day supply (retail prescription); 84-90 day supply maintenance medications available via an Express Scripts Smart90 retail pharmacy or through Express Scripts' Home Delivery service.
	Preferred brand drugs	\$40 Retail, \$100 Mail Order	\$40 Retail, \$100 Mail Order	Not covered	
	Non-preferred brand drugs	\$80 Retail, \$200 Mail Order	\$80 Retail, \$200 Mail Order	Not covered	
	<a href="#">Specialty drugs</a>	Covered at Retail copay levels shown above. Most specialty medications are	Covered at Retail copay levels shown above. Most specialty medications are	Not covered	Prescriptions are limited to a 30-day supply. There is limited retail access for a small subset of specialty medications.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider – Tier I (You will pay the least)	Network Provider – Tier II	Out-of-Network Provider (You will pay the most)	
		only available via Mail Order through Express Scripts specialty pharmacy, Accredo.	only available via Mail Order through Express Scripts specialty pharmacy, Accredo.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	Not covered	Refer to page 2 for list of 12 designated <a href="#">specialties</a> .
If you need immediate medical attention	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</a> after \$250 <a href="#">copay</a> per visit	30% <a href="#">coinsurance</a> after \$250 <a href="#">copay</a> per visit	30% <a href="#">coinsurance</a> after \$250 <a href="#">copay</a> per visit	No coverage for non-emergency use. Copay waived if admitted.
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	No coverage for non-emergency transport.
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a> after \$500 <a href="#">copay</a> per stay	Not covered	Hospital “tiering” applies.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	Not covered	Refer to page 2 for list of 12 designated <a href="#">specialties</a> .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	None
	Inpatient services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	None
If you are pregnant	Office visits	No charge	No charge	Not covered	Refer to page 2 for list of 12 designated <a href="#">specialties</a> .
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	Not covered	Refer to page 2 for list of 12 designated <a href="#">specialties</a> .
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a> after \$500 <a href="#">copay</a> per stay	Not covered	Hospital “tiering” applies.
If you need help	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	Coverage is limited to 100 visits per calendar year.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider – Tier I (You will pay the least)	Network Provider – Tier II	Out-of-Network Provider (You will pay the most)	
recovering or have other special health needs	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	Not covered	Coverage is limited to 60 visits per calendar year for Physical, Occupational, Speech Therapy and Autism Spectrum combined.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	Not covered	None
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	Coverage is limited to 60 days per calendar year.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	Diabetic supplies not covered, except for monitors & pumps and related supplies.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	None
If your child needs dental or eye care	Children’s eye exam	No charge	No charge	Not covered	Age and frequency schedules may apply.
	Children’s glasses	Not covered	Not covered	Not covered	Not covered.
	Children’s dental check-up	Not covered	Not covered	Not covered	Not covered.

**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"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental Care (Adult &amp; Child)</li> <li>• Glasses (Child)</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
|---|--|---|

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

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| <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Chiropractic care – 20 visits per calendar year</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment – Coverage is limited to the diagnosis and treatment of underlying medical condition</li> <li>• Prescription drugs</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing – Coverage is limited to 70 – 8 hour shifts per calendar year</li> <li>• Routine eye care (Adult &amp; Child) – Age and frequency schedules may apply</li> </ul> |
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**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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](http://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](http://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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

Additionally, a consumer assistance program can help you file an appeal. Contact information is at <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>

**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 1-888-982-3862

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-982-3862

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-982-3862

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijigo holne' 1-888-982-3862

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*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,750
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	20%
■ Hospital (facility) [ <i>cost sharing</i> ]	20%
■ Other [ <i>cost sharing</i> ]	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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,800
Copayments	\$80
Coinsurance	\$2,600
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,540</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,750
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	20%
■ Hospital (facility) [ <i>cost sharing</i> ]	20%
■ Other [ <i>cost sharing</i> ]	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*)

<b>Total Example Cost</b>	<b>\$7,600</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$1,100
Coinsurance	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$3,760</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,750
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	20%
■ Hospital (facility) [ <i>cost sharing</i> ]	20%
■ Other [ <i>cost sharing</i> ]	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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,600
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>