City of Kingsville Employee Benefit Plan Trust.: Plan A

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 10/1/2021-9/30/2022
Coverage for: Individual & Family **Plan Type: PPO**

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.enformed.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.enformed.com or call 1-800-436-8787 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$350 Family Monthly Deductible**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay
Are there services covered before you meet your deductible?	**Yes. Preventive Care and primary care services are covered before you meet your deductible.**	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 services 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/.
Are there other deductibles for specific services?	**No.**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$6,600 Individual** **$13,200 Family**	The out-of-pocket limit is the most you could pay in a year for covered services. 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.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing 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?	Yes. www.christusspohnhealthnetwork.org or call 800-419-3461 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). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 Co-pay, then covered at 100% up to a maximum of $200 per visit, then deductible and coinsurance apply	None
	Specialist visit	$25 Co-pay, then covered at 100% up to a maximum of $200 per visit, then deductible and coinsurance apply	None
	Preventive care/screening/ immunization	No Charge	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$15 Co-pay, then covered at 100% up to a maximum of $150 per visit, then deductible and coinsurance apply	None
	Imaging (CT/PET scans, MRIs)	$15 Co-pay, then covered at 100% up to a maximum of $150 per visit, then deductible and coinsurance apply	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.enformed.com	Generic drugs	$15 Copay	None
	Preferred brand drugs	35% Copay	$10,000 maximum benefit
	Non-preferred brand drugs	35% Copay	$10,000 maximum benefit
	Specialty drugs	35% Copay	$10,000 maximum benefit
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	$250 Co-pay, then covered at 100%	None
	Emergency medical transportation	0% coinsurance after deductible	None

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Urgent care	0% coinsurance after deductible	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	Benefits will be the same as those under each covered category	None
	Inpatient services	Benefits will be the same as those under each covered category	None
If you are pregnant	Office visits	Benefits will be the same as those under each covered category	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Benefits will be the same as those under each covered category	
	Childbirth/delivery facility services	Benefits will be the same as those under each covered category	
If you need help recovering or have other special health needs	Home health care	0% coinsurance after deductible	None
	Rehabilitation services	0% coinsurance after deductible	None
	Habilitation services	Not Covered	None
	Skilled nursing care	0% coinsurance after deductible	None
	Durable medical equipment	0% coinsurance after deductible	None
	Hospice services	0% coinsurance after deductible	None
If your child needs dental or eye care	Children's eye exam	50% coinsurance	Max $50 per Calendar Year
	Children's glasses	Not Covered	
	Children's dental check-up	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental Care
- 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.)

- Chiropractic Care
- Routine Eye 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: Entrust, Inc., P.O. Box 441588, Houston, TX 77244-1588; or by phone at 1-800-436-8787.
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**

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this plan meet the Minimum Value Standards? **Yes**

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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	$350
Specialist *[Copay]*	$25
Hospital *[cost sharing]*	0%
Other *[cost sharing]*	0%

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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$350
Copayments	$90
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$500**

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 *[Copay]*	$25
Hospital *[cost sharing]*	0%
Other *[cost sharing]*	0%

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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$350
Copayments	$1,149
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,554**

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

The plan's overall deductible	$350
Specialist *[Copay]*	$25
Hospital *[cost sharing*	0%
Other *[cost sharing*	0%

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$350
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$390**

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