aetna

# Consumer Basic Limited

**Coverage Period: 01/01/2017 – 12/31/2017**
**Coverage for:** Individual + Family **Plan Type:** EPO
**KATY INDEPENDENT SCHOOL DISTRICT**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at *Benefits Outlook* at www.katybenefits.org or by calling 1-866-222-5473.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | For each Calendar Year, Individual **$2,250** / Family **$4,500**. Does not apply to preventive care in-network. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | Yes. **$200** per person, for brand prescription drug coverage. There are no other specific **deductibles**. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out-of-pocket limit on my expenses?** | Yes. In-network: Individual **$5,500** / Family **$11,000.** | The **out-of-pocket limit** 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, penalties for failure to obtain pre-authorization for services and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of in-network **providers**, see www.katybenefits.org or call 1-866-222-5473. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**. |

**Questions:** Call 1-866-222-5473 or visit us at www.katybenefits.org.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.HealthReformPlanSBC.com or call 1-888-982-3862 to request a copy.

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan has in-network benefits only. It features a very limited network of designated specialists and only allows use of Memorial Hermann hospitals for in and outpatient hospital care. A designated provider is an in-network provider who meets additional criteria and is identified with an icon in the provider directory.
- Designated specialties are: cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetrics and gynecology, orthopedics, otolaryngology, neurology, neurosurgery, plastic surgery, urology and vascular surgery.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-Of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 25% coinsurance | Not covered | Includes Internist, General Physician, Family Practitioner or Pediatrician |
| | Specialist visit | 25% coinsurance | Not covered | See list of 12 designated specialties above. |
| | Other practitioner office visit | 25% coinsurance | Not covered | Coverage is limited to 20 visits per calendar year for Chiropractic care. |
| | Preventive care /screening /immunization | No charge | Not covered | Age and frequency schedules may apply. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 25% coinsurance | Not covered | ———— None ———— |
| | Imaging (CT/PET scans, MRIs) | 25% coinsurance | Not covered | Precertification required. |

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|---|---|---|---|---|
| **If you need drugs to treat your illness or condition.**<br><br>More information about **prescription drug coverage** is available at www.express-scripts.com | Generic drugs | $20 Retail,<br>$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,<br>$100 Mail Order | Not covered | |
| | Non-preferred brand drugs | $80 Retail,<br>$200 Mail Order | Not covered | |
| | Specialty drugs | Covered at Retail copay levels shown above. Most specialty medications are only available via Mail Order through Express Scripts specialty pharmacy, Accredo. | Not covered | Prescriptions are limited to a 30-day supply. There is limited retail access for a small subset of specialty medications. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 25% coinsurance | Not covered | ——— None ——— |
| | Physician/surgeon fees | 25% coinsurance | Not covered | ——— None ——— |
| **If you need immediate medical attention** | Emergency room services | 35% coinsurance after $250 copay per visit | 35% coinsurance after $250 copay per visit | No coverage for non-emergency use. Copay waived if admitted to the hospital. |
| | Emergency medical transportation | 35% coinsurance | 35% coinsurance | No coverage for non-emergency transport. |
| | Urgent care | 25% coinsurance | Not covered | No coverage for non-urgent use. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 25% coinsurance | Not covered | Memorial Hermann Hospitals only. |
| | Physician/surgeon fee | 25% coinsurance | Not covered | Refer to page 2 for list of 12 designated specialties. |
| **If you have mental health, behavioral** | Mental/Behavioral health outpatient services | 25% coinsurance | Not covered | ——— None ——— |
| | Mental/Behavioral health inpatient services | 25% coinsurance | Not covered | ——— None ——— |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-Of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **health, or substance abuse needs** | Substance use disorder outpatient services | 25% coinsurance | Not covered | ——— None ——— |
| | Substance use disorder inpatient services | 25% coinsurance | Not covered | ——— None ——— |
| **If you are pregnant** | Prenatal and postnatal care | No charge | Not covered | Refer to page 2 for list of 12 designated specialties. |
| | Delivery and all inpatient services | 25% coinsurance | Not covered | Memorial Hermann Hospitals only. |
| **If you need help recovering or have other special health needs** | Home health care | 25% coinsurance | Not covered | Coverage is limited to 100 visits per calendar year. |
| | Rehabilitation services | 25% coinsurance | Not covered | Coverage is limited to 60 visits per calendar year for Physical, Occupational, Speech Therapy and Autism Spectrum combined. |
| | Habilitation services | 25% coinsurance | Not covered | ——— None ——— |
| | Skilled nursing care | 25% coinsurance | Not covered | Coverage is limited to 60 days per calendar year. |
| | Durable medical equipment | 25% coinsurance | Not covered | Diabetic supplies not covered, except for monitors & pumps and support equipment. |
| | Hospice service | 25% coinsurance | Not covered | ——— None ——— |
| **If your child needs dental or eye care** | Eye exam | No charge | Not covered | Age and frequency schedules may apply. |
| | Glasses | Not covered | Not covered | Not covered. |
| | Dental check-up | Not covered | Not covered | Not covered. |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other **excluded services**.)

- Acupuncture
- Cosmetic surgery
- Dental Care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care – Coverage is limited to 20 visits per calendar year
- Infertility treatment – Coverage is limited to the diagnosis and treatment of underlying medical condition
- Prescription drugs
- Private-duty nursing – Coverage is limited to 70 – 8 hour shifts per calendar year
- Routine eye care (Adult and child) – Age and frequency schedules may apply

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-888-982-3862. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or 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.

## Your Grievance and Appeals Rights:

- If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice or assistance, you can contact us by calling the toll free number on your Medical ID Card. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 Coverage Provide Minimum Essential Coverage?

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 Coverage Provide Minimum Value Standard?

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**.

## Language Access Services:

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-982-3862.

如果需要中文的帮助，请拨打这个号码 1-888-982-3862.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-982-3862.

Para obtener asistencia en Español, llame al 1-888-982-3862.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

# About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $3,870
- **Patient pays:** $3,670

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventative | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $2,250 |
| Copays | $20 |
| Coinsurance | $1,250 |
| Limits or exclusions | $150 |
| **Total** | **$3,670** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,230
- **Patient pays:** $3,170

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventative | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $2,250 |
| Copays | $800 |
| Coinsurance | $40 |
| Limits or exclusions | $80 |
| **Total** | **$3,170** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✔ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✔ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.