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

aetna® **Consumer Basic Limited**

Coverage Period: 01/01/2020 – 12/31/2020
Coverage for: Individual + Family | **Plan Type:** EPO
Katy Independent School District

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 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 deductible?	For each calendar year, in-network: Individual **$2,250**/Family **$4,500**.	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 generic prescription drugs 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?	Yes, **$200** per person for brand prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network: Individual **$5,500**/Family **$11,000**	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain preauthorization 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.
Will you pay less if you use a network provider?	Yes. See www.katybenefits.org or call 1-866-222-5473 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.
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	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	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	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.
	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.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$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	Not covered	
	Non-preferred brand drugs	$80 Retail, $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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	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 fees	25% coinsurance	Not covered	Refer to page 2 for list of 12 designated specialties.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	Not covered	None
	Inpatient services	25% coinsurance	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Refer to page 2 for list of 12 designated specialties.
	Childbirth/delivery professional services	25% coinsurance	Not covered	Refer to page 2 for list of 12 designated specialties.
	Childbirth/delivery facility 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 services	25% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Age and frequency schedules may apply.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	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.)

- 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- 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: 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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.

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.

For more information about limitations and exceptions, see the plan or policy document at www.katybenefits.org.

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, kwiijigo holne' 1-888-982-3862

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 j ust 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	**$2,250**
Specialist	**25%**
Hospital (facility)	**25%**
Other	**25%**

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,300
Copayments	$80
Coinsurance	$3,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,540**

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

The plan's overall deductible	**$2,250**
Specialist	**25%**
Hospital (facility)	**25%**
Other	**25%**

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	**$7,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,400
Copayments	$1,100
Coinsurance	$700
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,260**

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

The plan's overall deductible	**$2,250**
Specialist	**25%**
Hospital (facility)	**25%**
Other	**25%**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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