UnitedHealthcare® OPTUMRx® CONROE INDEPENDENT SCHOOL DISTRICT

Charter Kelsey-Seybold Plan

Coverage for: Individual+Family | **Plan Type:** GIL

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, please visit www.conroeisd.net/department/hr/plan-documents/ or call 1-877-805-1970. 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.healthcare.gov/sbc-glossary or call 1-877-805-1970 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network, per plan year: $1,200/Individual or $3,000/Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. 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.
Are there services covered before you meet your deductible?	Yes. Preventive care, primary care provider, diagnostic test, and urgent 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?	Yes. $200 per person for prescription drug coverage. Does not apply to Tier 1 drugs. 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?	Network, per plan year: $6,250/Individual or $12,500/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?	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. See www.kelsey-seybold.com or call 713-442-0000 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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
		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	$35 copay/visit; deductible does not apply	Not covered	Virtual Visit with a designated virtual network provider – no charge/visit
	Specialist visit	$50 copay/visit; deductible does not apply	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	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)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	$100 copay/visit; deductible does not apply	Not covered	Preauthorization required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.optumrx.com/oe_premium/landing	Tier 1 drugs	Copay/prescription: $15 (retail) and $30 (mail order); deductible does not apply	Not covered	Covers up to a 31-day supply (retail) or up to a 90-day supply (mail order and preferred retail network pharmacy). Preauthorization, step-therapy, exclusions, and quantity limits may apply. Your cost will be higher if you choose a brand-name drug when a generic equivalent is available. Certain preventive drugs (including specified contraceptives) are covered at no charge. Applicable formulary: Optum Premium.
	Tier 2 drugs	Copay/prescription: $60 (retail) and $120 (mail order); after prescription drug deductible	Not covered	
	Tier 3 drugs	Copay/prescription: $120 (retail) and $240 (mail order); after prescription drug deductible	Not covered	
	Specialty drugs	Copay/prescription: $250 (retail) after prescription drug deductible; not available through mail order	Not covered	Limited to 30-day supply. Must obtain from OptumRx® specialty pharmacy. Applicable formulary: Optum Premium.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	None
	Physician/surgeon fees	10% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	20% coinsurance plus $250 copay	20% coinsurance plus $250 copay	None
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	$75 copay/visit; deductible does not apply	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	None
	Physician/surgeon fees	10% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay/visit; deductible does not apply	Not covered	Mental Health Virtual Visit with a designated virtual network provider - $50 copay/visit; deductible does not apply. Partial hospitalization/intensive outpatient treatment - 10% coinsurance
	Inpatient services	10% coinsurance	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copay, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	Not covered	
	Childbirth/delivery facility services	10% coinsurance	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at www.conroeisd.net/department/hr/plan-documents/.

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 help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	Limited to 120 visits/plan year.
	Rehabilitation services	$50 copay/visit; deductible does not apply	Not covered	Limited to 60 visits/plan year for physical, occupational, and speech therapy, and habilitation services combined.
	Habilitation services	$50 copay/visit; deductible does not apply	Not covered	Limited to 60 visits/plan year for physical, occupational, and speech therapy, and habilitation services combined.
	Skilled nursing care	10% coinsurance	Not covered	Limited to 60 days/plan year.
	Durable medical equipment	50% coinsurance	Not covered	None
	Hospice services	10% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	$50 copay/visit; deductible does not apply	Not covered	Limited to one routine exam every 24 months.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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
- Dental care (Adult & Child)
- Glasses
- 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.)

- Acupuncture – in lieu of anesthesia
- Bariatric surgery – limited to $10,000 lifetime maximum
- Chiropractic care – limited to 20 visits/plan year
- Habilitation services – limited to 60 visits/plan year (combined with physical, occupational, and speech therapy)
- Infertility treatment – limited to the diagnosis and treatment of the underlying medical condition
- Private-duty nursing – limited to 70 eight-hour shifts/plan year
- Routine eye care (Adult) – limited to one routine exam/24 months

* For more information about limitations and exceptions, see the plan or policy document at www.conroeisd.net/department/hr/plan-documents/.

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 these agencies is: 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 on how 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: UnitedHealthcare Member Services at 1-877-805-1970 or www.myuhc.com. Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance at 1-800-578-4677 (phone) or http://www.tdi.texas.gov/index.html (website) or 333 Guadalupe, Austin, TX 78701 (mail).

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 1-877-805-1970.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-805-1970.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-805-1970.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-805-1970.

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	$1,200
Specialist copayment	$50
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,200
Copayments	$130
Coinsurance	$1,140
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,530**

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

The plan's overall deductible	$1,200
Specialist copayment	$50
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,060
Copayments	$1,630
Coinsurance	$860
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,610**

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

The plan's overall deductible	$1,200
Specialist copayment	$50
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,180
Copayments	$350
Coinsurance	$210
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,740**

*This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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