




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/departments/hr/plan-documents/](http://www.conroeisd.net/departments/hr/plan-documents/) or call 1-866-314-0335. 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](http://www.healthcare.gov/sbc-glossary) or call 1-866-314-0335 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	For <a href="#">network providers</a> : \$3,500/Individual or \$7,000/Family For <a href="#">out-of-network providers</a> : \$6,900/Individual or \$13,800/Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> services 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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$500/admission to an <a href="#">out-of-network</a> facility. 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.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">network providers</a> : \$7,000/Individual or \$14,000/Family For <a href="#">out-of-network providers</a> : This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-866-314-0335 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 <a href="#">plan's 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 <a href="#">provider's</a> 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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay less)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Virtual Visit with a designated virtual <a href="#">network provider</a> – 30% <a href="#">coinsurance</a> .
	<a href="#">Specialist</a> visit	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required.
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="https://www.optumrx.com/oe_premium/landing">https://www.optumrx.com/oe_premium/landing</a>	Tier 1 drugs	30% <a href="#">coinsurance</a>	Not covered	Covers up to a 31-day supply (retail) or up to a 90-day supply (mail order and preferred retail <a href="#">network pharmacy</a> ). <a href="#">Preauthorization</a> , 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 <a href="#">formulary</a> : Optum Premium.
	Tier 2 drugs	30% <a href="#">coinsurance</a>	Not covered	
	Tier 3 drugs	30% <a href="#">coinsurance</a>	Not covered	
	<a href="#">Specialty drugs</a>	30% <a href="#">coinsurance</a>	Not covered	Limited to 30-day supply. Must obtain from OptumRx® specialty pharmacy. Applicable <a href="#">formulary</a> : Optum Premium.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.conroeisd.net/departments/hr/plan-documents/](http://www.conroeisd.net/departments/hr/plan-documents/).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay less)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	You are responsible for obtaining <a href="#">preauthorization</a> if you use <a href="#">out-of-network providers</a> .
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</a> plus \$150 <a href="#">copay</a>	30% <a href="#">coinsurance</a> plus \$150 <a href="#">copay</a>	None
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> ; after overall <a href="#">deductible</a> and \$500 admission <a href="#">deductible</a>	You are responsible for obtaining <a href="#">preauthorization</a> if you use <a href="#">out-of-network providers</a> .
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Mental Health Virtual Visit with a designated virtual <a href="#">network provider</a> – 30% <a href="#">coinsurance</a> .
	Inpatient services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> ; after overall <a href="#">deductible</a> and \$500 admission <a href="#">deductible</a>	You are responsible for obtaining <a href="#">preauthorization</a> if you use <a href="#">out-of-network providers</a> .
If you are pregnant	Office visits	No charge	50% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copay</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> ; after overall <a href="#">deductible</a> and \$500 admission <a href="#">deductible</a>	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.conroeisd.net/departments/hr/plan-documents/](http://www.conroeisd.net/departments/hr/plan-documents/).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay less)	Out-of-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limited to 120 visits/year.
	<a href="#">Rehabilitation services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limited to 60 visits/year for physical, occupational, and speech therapy, and <a href="#">habilitation services</a> combined.
	<a href="#">Habilitation services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limited to 60 visits/year for physical, occupational, and speech therapy, and <a href="#">habilitation services</a> combined. You are responsible for obtaining <a href="#">preauthorization</a> if you use <a href="#">out-of-network providers</a> .
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	Inpatient: 50% <a href="#">coinsurance</a> ; after overall <a href="#">deductible</a> and \$500 admission <a href="#">deductible</a> Outpatient: 50% <a href="#">coinsurance</a>	Limited to 60 days/year.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	You are responsible for obtaining <a href="#">preauthorization</a> if you use <a href="#">out-of-network providers</a> for DME over \$1,000.
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	Inpatient: 50% <a href="#">coinsurance</a> ; after overall <a href="#">deductible</a> and \$500 admission <a href="#">deductible</a> Outpatient: 50% <a href="#">coinsurance</a>	You are responsible for obtaining <a href="#">preauthorization</a> if you use <a href="#">out-of-network providers</a> .
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	None
	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult &amp; Child)</li> <li>• Glasses</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 eye care (Adult &amp; Child)</li> <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 <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture – in lieu of anesthesia</li> <li>• Bariatric surgery – limited to \$10,000 lifetime maximum</li> <li>• Chiropractic care – limited to 20 visits/year</li> </ul>	<ul style="list-style-type: none"> <li>• Habilitation services – limited to 60 visits/year (combined with physical, occupational, and speech therapy)</li> <li>• Infertility treatment – limited to the diagnosis and treatment of the underlying medical condition</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing – limited to 70 eight-hour shifts/year</li> </ul>

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.conroeisd.net/departments/hr/plan-documents/](http://www.conroeisd.net/departments/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](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 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 1-866-314-0335 or [www.myuhc.com](http://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 1-866-314-0335.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-314-0335.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-314-0335.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-314-0335.

*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 [plan's](#) overall [deductible](#) **\$3,500**
- [Specialist coinsurance](#) **30%**
- Hospital (facility) [coinsurance](#) **30%**
- Other [coinsurance](#) **30%**

**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>\$12,731</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,180
Copayments	\$0
Coinsurance	\$3,720
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,960</b>

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

- The [plan's](#) overall [deductible](#) **\$3,500**
- [Specialist copayment](#) **30%**
- Hospital (facility) [coinsurance](#) **30%**
- Other [coinsurance](#) **30%**

**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>\$7,389</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$0
Coinsurance	\$2,160
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$5,720</b>

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

- The [plan's](#) overall [deductible](#) **\$3,500**
- [Specialist copayment](#) **30%**
- Hospital (facility) [coinsurance](#) **30%**
- Other [coinsurance](#) **30%**

**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>\$1,925</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,350
Copayments	\$0
Coinsurance	\$580
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,930</b>