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

Coverage Period: 09/01/2017 - 08/31/2018

CONROE INDEPENDENT SCHOOL DISTRICT: Aetna Select℠ - Aetna Memorial Hermann ACO

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

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.HealthReformPlanSBC.com** or call 1-866-381-8933. 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 **https://www.healthcare.gov/sbc-glossary/** or call 1-866-381-8933 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each Plan Year, In-Network Tier 1: EE Only $1,000 / EE+ Family $2,000. In-Network Tier 2: EE Only $2,000 / EE+ Family $4,000.	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. Emergency care; plus in-network office visits & preventive care 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 for prescription drugs. Does not apply to preferred generic 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?	For each Plan Year, In-Network Tier 1: EE Only $5,000 / EE+ Family $10,000. In-Network Tier 2: EE Only $7,150 / EE+ Family $14,300.	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 & 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.aetna.com/docfind or call 1-866-381-8933 for a list of in-network providers.	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 you need a referral to see a specialist?	Yes, for in-network specialists.	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.

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
		In-Network Tier 1 Provider (You will pay the least)	In-Network Tier 2 Provider (You will pay more)	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	$30 copay/visit	$50 copay/visit	Not covered	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	$45 copay/visit	$80 copay/visit	Not covered	———————— None ————————
	Preventive care / screening / immunization	No charge	No charge	Not covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	Not covered	———————— None ————————
	Imaging (CT/PET scans, MRIs)	$100 copay/visit	$100 copay/visit	Not covered	Pre-certification required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/value Value Formulary	Preferred generic drugs	Copay/prescription: $15 (retail), $30 (mail order)	Copay/prescription: $15 (retail), $30 (mail order)	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Includes contraceptive drugs and devices obtainable from a pharmacy, and oral fertility drugs. No charge for formulary generic FDA-approved women's contraceptives in-network. Precertification required. Step therapy required. Your cost will be higher for choosing Brand over Preferred
	Preferred brand drugs	After drug deductible, copay/prescription: $60 (retail), $120 (mail order)	After drug deductible, copay/prescription: $60 (retail), $120 (mail order)	Not covered	
	Non-preferred brand and non-preferred generic drugs	After drug deductible, copay/prescription: $120 (retail), $240 (mail order)	After drug deductible, copay/prescription: $120 (retail), $240 (mail order)	Not covered	
	Specialty drugs	After drug deductible: $250 copay/ prescription	After drug deductible: $250 copay/ prescription	Not covered	Aetna Specialty CareRx℠ - First Prescription must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. After 1st fill, subsequent fills must be through Aetna Specialty Pharmacy®.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	35% coinsurance	Not covered	———————— None ————————

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		In-Network Tier 1 Provider (You will pay the least)	In-Network Tier 2 Provider (You will pay more)	Out–of–Network Provider (You will pay the most)	
	Physician/surgeon fees	10% coinsurance	35% coinsurance	Not covered	———— None ————
If you need immediate medical attention	Emergency room care	$350 copay/visit (waived if admitted)	$350 copay/visit (waived if admitted)	$350 copay/visit (waived if admitted)	No coverage for non-emergency use.
	Emergency medical transportation	10% coinsurance	10% coinsurance	10% coinsurance	———— None ————
	Urgent care	$75 copay/visit	$75 copay/visit	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	35% coinsurance	Not covered	———— None ————
	Physician/surgeon fees	10% coinsurance	35% coinsurance	Not covered	———— None ————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$45 copay/visit	$80 copay/visit	Not covered	———— None ————
	Inpatient services	10% coinsurance	35% coinsurance	Not covered	———— None ————
If you are pregnant	Office visits	No charge	No charge	Not covered	———— None ————
	Childbirth/delivery professional services	10% coinsurance	35% coinsurance	Not covered	Includes outpatient postnatal care.
	Childbirth/delivery facility services	10% coinsurance	35% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	35% coinsurance	Not covered	Coverage is limited to 120 visits/plan year.
	Rehabilitation services	$45 copay/visit	$45 copay/visit	Not covered	Coverage is limited to 60 visits/plan year for Physical, Occupational, and Speech Therapy combined.
	Habilitation services	Not covered	Not covered	Not covered	Not covered.
	Skilled nursing care	10% coinsurance	35% coinsurance	Not covered	Coverage is limited to 100 days/plan year.
	Durable medical equipment	50% coinsurance	50% coinsurance	Not covered	———— None ————
	Hospice services	10% coinsurance	35% coinsurance	Not covered	———— None ————

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		In-Network Tier 1 Provider (You will pay the least)	In-Network Tier 2 Provider (You will pay more)	Out–of–Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$45 copay/visit	$45 copay/visit	Not covered	Coverage is limited to 1 routine eye exam/24 months.
	Children's glasses	Not covered	Not covered	Not covered	———————— None ————————
	Children's dental check-up	Not covered	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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Habilitation services
- 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 - Coverage is limited to $10,000 maximum per lifetime.
- 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.
- Private-duty nursing - Coverage is limited to 70 eight-hour shifts per plan year.
- Routine eye care (Adult) - Coverage is limited to one routine eye exam per 24 months.

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:

- For more information on your rights to continue coverage, contact the plan at 1-866-381-8933.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-866-381-8933.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your 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 Minimum Value Standard? **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.**

----------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**	$1,000
Specialist copayment	$45
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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles*	$1,000
Copayments	$100
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,160**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The **plan's** overall **deductible**	$1,000
Specialist copayment	$45
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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$200
Copayments	$1,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,120**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The **plan's** overall **deductible**	$1,000
Specialist copayment	$45
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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$600
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

*Note: 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.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-381-8933.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com.

California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

TTY: 711

Language Assistance:

For language assistance in your language call 1-866-381-8933 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-866-381-8933.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-866-381-8933 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-866-381-8933
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-866-381-8933 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-866-381-8933 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-866-381-8933 ku busa
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-866-381-8933 nga walay bayad.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-866-381-8933 sin gåstu.
Chinese -	欲取得繁體中文語言協助，請撥打 1-866-381-8933，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi ł paya hinla 1-866-381-8933.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-866-381-8933 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-866-381-8933.
French -	Pour une assistance linguistique en français appeler le 1-866-381-8933 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-866-381-8933 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-866-381-8933 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-866-381-8933 χωρίς χρέωση.

Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-866-381-8933. Kāki ʻole ʻia kēia kōkua nei.
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-381-8933.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-866-381-8933 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-381-8933 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-381-8933.
Japanese -	日本語で援助をご希望の方は、1-866-381-8933　まで無料でお電話ください。
Karen -	v>w>frRp>Rw>fuwdRusd.ft*D>f usd.f ud; 1-866-381-8933 v>wtd.f'D;w>fv>mfbl.fv>mfphRb.f
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-381-8933번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ́ m̀ ké gbo-kpá-kpá dyé pídyi ɖé Ɓǎsɔ́ɔ̀-wùɖùǔn wɛ̃ɛ, ɖá 1-866-381-8933
Kurdish -	بۆ یارمەتی بە زمانی کوردی تەلەفۆن بکە بە ژمارە 1-866-381-8933 بۆ وەرگێڕانی بە زمانی فارسی بە ژمارە
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-381-8933 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-381-8933 ni sohte isais.
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-381-8933
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-866-381-8933 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-866-381-8933 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-381-8933 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-866-381-8933 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-866-381-8933 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-381-8933.

Portuguese -	Para obter assistência linguística em português ligue para o 1-866-381-8933 gratuitamente.
Romanian -	Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-866-381-8933
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-381-8933.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-866-381-8933 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-866-381-8933.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-866-381-8933.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-866-381-8933. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-866-381-8933 bila malipo.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-381-8933 nang walang bayad.
Tongan -	Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-866-381-8933 ‘o ‘ikai hā tōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-866-381-8933 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-866-381-8933.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-381-8933.
Urdu -	1-866-381-8933
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-866-381-8933.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-866-381-8933 פריי פון אפצאל.
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-866-381-8933 lái san owó kankan rárá.