Seguro médico de cobertura alta del Distrito Escolar Independiente de Edgewood

Periodo de seguro: 01/01/2014 al 31/12/2014

Resumen de coberturas: Qué cubre y cuánto cuesta **Asegurados:** Empleado y familiares | **Tipo de plan:** Cost Plus

Esto es solo un resumen. Si desea más información sobre las coberturas de este seguro y los costes asociados, puede consultar todas las condiciones del plan en la página de Internet www.gpatpa.com llamar al número 210-444-4500.

Preguntas	Respuestas	Por qué es importante
¿Hay gastos iniciales no cubiertos por el seguro?	**250 dólares** por persona o **500 dólares** por familia (niveles I-II PPO y no PPO) Los copagos, recetas médicas y servicios de prevención PPO no se descuentan de los gastos iniciales no cubiertos.	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**.
¿Hay otros gastos iniciales no cubiertos por servicios específicos?	**No.**	1D gastos iniciales no cubiertos por servicios espec²ficos&RVXOWH HOFXDGURGHODSjJLQDYHUORVJDVWRVGHRWURVVHUYLFLRV SRUHOVHJXUR
¿Hay algún límite en los gastos no cubiertos por el seguro?	**Yes. $4,000** person/**$8,000** family Level I & Level II PPO & Non-PPO	This **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?	Rx copayments; premiums; balance-billed charges; deductible; charges in excess of UCR (Usual, Customary & Reasonable); health care this plan doesn't cover and any noncompliance penalties.	Aunque usted debe pagar estos gastos, no se descuentan del límite de los **gastos no cubiertos**.
¿Hay algún límite en los gastos que cubre el plan?	**No.**	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
¿Tiene este plan una lista de hospitales y médicos?	**Sí**. Hay una lista de médicos, laboratorios, instalaciones de rayos X, atención doméstica y otros servicios (nivel II). Encontrará la lista completa en la página www.multiplan.com o llame al 1-888-611-7427.	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 hospital or in-network doctor 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 chart starting on page 2 for how this plan pays different kinds of **providers.**
¿Es necesaria la autorización de mi médico para ver a un especialista?	**No.** No necesita autorización.	Puede ir a un **especialista** sin necesidad de autorización.

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Resumen de coberturas: Qué cubre y cuánto cuesta **Asegurados:** Empleado y familiares | **Tipo de plan:** Cost Plus

¿Hay algún servicio que no cubra el seguro?	**Sí.**	Algunos de estos servicios están en la lista de la página 5. Lea las condiciones del seguro para saber cuáles son estos **servicios no cubiertos**.

- **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 may encourage you to use PHCS **providers** for Level II services by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Level I Provider	Your Cost If You Use a Level II PPO or Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	N/A	$25 copay/visit	$0 deductible & 0% coinsurance apply to female sterilization & contraceptive implants/iuds/diaphragms/injections. Deductible & 10% coinsurance applies to PPO & Non-PPO office surgery & allergy serum. $0 copay applies to Teladoc Telephone Consultations. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Specialist visit	N/A	$25 copay/visit	
	Other practitioner office visit	N/A	10% coinsurance	Chiropractic services limited to 35 visits per calendar year combined with Physical/Occupational/Speech Therapy. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Preventive care/screening/ immunization	0% coinsurance; deductible waived	0% coinsurance; deductible waived	See your plan document for additional benefit information & limitations. Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance; deductible waived	0% coinsurance; deductible waived	Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to Usual, Customary & Reasonable fees.

Common Medical Event	Services You May Need	Your Cost If You Use a Level I Provider	Your Cost If You Use a Level II PPO or Non-PPO Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	10% coinsurance	10% coinsurance	$250 copay/procedure applies to MRIs, CTs & PET Scans billed by One Call Care Management. Copay waived if deductible is satisfied. Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.envisionrx.com	Generic drugs	Copays: Retail $0/Mail Order $0		Covers a 30 day supply for Retail/90 day supply for Mail Order. Drugs requiring prior authorization include but are not limited to specialty drugs, growth hormones, Fycompa & Xolair. Excluded drugs include but are not limited to fertility drugs, cosmetic drugs, impotence/sexual dysfunction drugs and drugs labeled "Caution-limited by Federal Law to Investigational use" or experimental drugs.
	Preferred brand drugs	Copays: Retail $30/Mail Order $90		
	Non-preferred brand drugs	Copays: Retail $50/Mail Order $150		
	Specialty drugs	Retail copays apply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	N/A	UR notification required or $250 non-compliance penalty applies. Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Physician/surgeon fees	N/A	10% coinsurance	
If you need immediate medical attention	Emergency room services	$100 copay/visit		UR notification required if admitted or $250 non-compliance penalty applies. Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Urgent care	N/A	$40 copay/visit	Non-PPO charges are subject to Usual, Customary & Reasonable fees.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	N/A	UR notification required or $250 non-compliance penalty applies. Level I charges based on Allowable Claims Limits. Non-PPO charges are

Common Medical Event	Services You May Need	Your Cost If You Use a Level I Provider	Your Cost If You Use a Level II PPO or Non-PPO Provider	Limitations & Exceptions
	Physician/surgeon fee	N/A	10% coinsurance	subject to Usual, Customary & Reasonable fees.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	10% coinsurance	See '**If you visit a health care provider's office or clinic**' for the office visit benefit. UR notification required if admitted or $250 non-compliance penalty applies. Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Mental/Behavioral health inpatient services	10% coinsurance	10% coinsurance	
	Substance use disorder outpatient services	10% coinsurance	10% coinsurance	
	Substance use disorder inpatient services	10% coinsurance	10% coinsurance	
If you are pregnant	Prenatal and postnatal care	N/A	10% coinsurance	Office visit copayment applies to the initial visit only. Contact UR for coordination of prenatal care. UR notification required or $250 non-compliance penalty applies. Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Delivery and all inpatient services	10% coinsurance	10% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use a Level I Provider	Your Cost If You Use a Level II PPO or Non-PPO Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	Services limited per calendar year to 35 combined visits for Physical/ Occupational/Speech Therapy/Chiropractic, 60 days for Home Health, 35 days for Rehabilitation Facilities & 35 days for Skilled Nursing Facilities. Hospice limited to $20,000 per lifetime. Treatment of developmental delays may not be covered. See your policy or plan document for additional information about **excluded services.** Contact UR for coordination of care for Outpatient/Homebound Hospice & Home Health. UR notification required if admitted or $250 non-compliance penalty applies. Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Rehabilitation services	10% coinsurance	10% coinsurance	
	Habilitation services	10% coinsurance	10% coinsurance	
	Skilled nursing care	10% coinsurance	10% coinsurance	
	Durable medical equipment	10% coinsurance	10% coinsurance	
	Hospice service	10% coinsurance	10% coinsurance	
If your child needs dental or eye care	Eye exam	0% coinsurance; deductible waived	0% coinsurance; deductible waived	Benefit applies to age 19 only. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Glasses	Not Covered		Not Covered
	Dental check-up	Not Coveed		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
- Bariatric Surgery
- Care outside the U.S. when travel is specifically for medical care
- Charges not medically necessary
- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Long Term Care
- Private Duty Nursing
- 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.)

- Chiropractic Care
- Hearing Aids
- Medical Services incurred while traveling outside the U.S. **only if** a medical emergency, subject to medical necessity and approved AMA procedure
- Routine eye care (to age 19)

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 210-444-4500. 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: 800-827-7223 or the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 800-827-7223

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 will also 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** $6,240
- **Patient pays** $1,300

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 preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$30
Coinsurance	$620
Limits or exclusions	$150
Total	**$1,300**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,770
- **Patient pays** $630

Sample care costs:

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

Patient pays:

Deductibles	$250
Copays	$200
Coinsurance	$0
Limits or exclusions	$80
Total	**$630**

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.