

DEEP DIVE INTO INSURANCE

October 29, 2016

30 plans available

Emphasis: OPTIONS!

30 plans! 30 prices!

Rules for Discussing Insurance

- **Facts, NOT Opinions**
 - ▣ This plan is an EPO. You do not need a referral to see a specialist, but some procedures require prior approval.
 - ▣ NOT: This plan isn't very good. I heard doctors don't like this plan.
- **No Judgment Statements**
 - ▣ Plans aren't good or bad. Plans are different and our job is to educate you on those differences to determine what works for you.
 - ▣ AVOID: better, worse, good, bad, not as good, won't work
- **CACs cannot recommend or choose a plan!**
 - ▣ "Which company is the best?"
 - ▣ "If I were your sister, which plan would you recommend?"

The Changing Marketplace

- Aetna, United, Humana, Scott&White won't sell plans inside the Marketplace in 2017, but will sell individual plans outside the Marketplace (no subsidies)
- Fewer plans than 2016, but still 29/30 choices
- Premium increases: Subsidies shield consumers from price increase, but need to shop around.
- No Platinum plans
- One Catastrophic plan

Understanding the Insurance Companies

- Network
- Geographic region
- Summary of Benefits
- Hospitals
- Major Providers/Oncology
- Using Provider Directory
- Using Formulary
- Special Deals

SENDERO

- 3 Plans available: 1 Bronze, 1 Silver and 1 Gold
- Least expensive option in each category
- Bronze plan has co-pays for PCP, Specialist, Generic Meds

SENDERO: Network

- **HMO** = Health Maintenance Organization
- **Out of Network:** Not Covered
 - ▣ Exception for "Emergency Care"
- **Specialty:** Need Referral
 - ▣ From In-Network PCP
 - ▣ From Nurse's Line

SENDERO: Out-of-Network


"Emergency Care" Exceptions

- Apparent heart attack
- Loss of consciousness
- Stroke
- Poisoning
- Severe bleeding
- Convulsions
- Fractures
- Severe injuries or trauma
- Shock from sudden illness/injury
- Difficulty in breathing, such as severe asthma attack
- Severe abdominal pain of sudden onset
- Chest pain w/heart attack symptoms

SENDERO: Geographic Range

- **LOCAL**
- **Cities listed in Provider Directory:**
Austin, Bastrop, Bee Cave, Bertram, Buda, Burnet, Cedar Park, Dripping Springs, Elgin, Georgetown, Giddings, Horseshoe Bay, Hutto, Kyle, La Grange, Lago Vista, Lakeway, Leander, Liberty Hill, Lockhart, Luling, Manor, Marble Falls, Pflugerville, Round Rock, San Marcos, Schulenburg, Smithville, Taylor, West Lake Hills, Wimberley
- Central Texas counties: Travis, Williamson, Bastrop, Caldwell, Hays
- All within an hour of Austin

SENDERO: Geographic Range



Coverage Available in 5 Texas Counties:

- Bastrop
- Caldwell
- Hays
- Travis
- Williamson

Using the Summary of Benefits

- Details on how the plan covers what it covers
- Order and format is consistent—required by ACA
- Benefit exclusions
 - ▣ Cosmetic Surgery, Acupuncture, Fertility Treatments, etc
- Gives average costs for certain services with plan
 - ▣ Typically pregnancy and managing type 2 diabetes

Sendero Health Plans: IdealCare Complete Standard Coverage Period: Beginning on 01/01/2017
 Summary of Benefits and Coverage: What This Plan Covers & What It Costs Coverage for: Individual, Family | Plan Type: HMO

▲ This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <http://senderohealth.com/idealcarewing/benefits.html> or by calling 1-844-800-4693.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$6,000 individual/ \$12,000 family	For services that are paid based on coinsurance, you must pay all the costs up to the deductible amount before the plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts (usually, but not always, January 1 st). See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on any expenses?	Yes. \$6,500 individual/ \$13,000 family	The 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?	Penalties and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>non-</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see http://senderohealth.com/id-idealcarewing/benefits.html or call 1-844-800-4693.	If you use an <i>in-network</i> doctor or other health care provider, this plan will pay some or all of the costs for covered services. If you use an <i>out-of-network</i> doctor or hospital, you may use an <i>out-of-network</i> provider for some services. Plans use the terms <i>in-network</i> , <i>preferred</i> , or <i>participating</i> for providers or their <i>network</i> . See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I 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 the plan's permission before you see the specialist .
Are there services this plan doesn't cover?	Yes.	Some of the services the plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

Sendero's Silver Plan with no Cost Sharing Subsidies

This is only a summary. If you want more detail about your coverage and costs, you can get the complete version in the policy or plan document at <http://www.healthshare.com/healthshare/healthshare.html> or by calling 1-844-800-4673.

Important Questions	Answers	Why This Matters
What is the overall deductible?	\$6,000 individual/ \$12,000 family	For services that are paid based on co-insurance, you must pay all the costs up to the deductible amount before the plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts each benefit, but not above January 1. See the chart starting on page 2 for more costs for services the plan covers.
Are there other deductibles for specific services?	No.	A You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services the plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. \$6,000 individual/ \$12,000 family	The 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. The limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Prescriptions and health care that does not cover	B Although you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	C The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of an in-network provider , see http://www.healthshare.com/healthshare/healthshare.html or call 1-844-800-4673.	D If you use an in-network doctor or other health care provider, the plan will pay more on all of the costs for covered services. Be aware, you as network doctor or hospital may not be an in-network provider for some services. Please see the notes on network providers participating for guidelines on these network. See the chart starting on page 2 for how the plan pays different levels of providers.
Do I need a referral to see a specialist?	Yes.	D This plan will pay more on all of the costs to use a specialist for covered services but only if you have the plan's permission before you see the specialist.
Are there services this plan doesn't cover?	Yes.	Some of the services the plan doesn't cover are listed on page 3. See your policy or plan document for additional information about excluded services.

Sendero Summary of Benefits PAGE 1

A) Is there a separate **Deductible**?
 B) What is excluded from the **Out of Pocket Max**?
 C) ACA eliminated Lifetime Maximums, but certain visits have limits
 D) Uses a **network of providers and requires referrals**.

The amount for the plan plus the 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 \$1,000 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$100 difference. (This is called **balance billing**.)

The plan cost coverage you use as an in-network provider for charges you have deductibles, copayments and co-insurance amounts.

Common Medical Event	Services You May Hear	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
A	Primary care visit to treat an injury or illness	\$10 copay per visit	Not covered	Copayment (Copay) per visit
	Specialist visit	\$40 copay per visit	Not covered	Copay per visit
	Other practitioner office visit	\$40 copay per visit for Habilitation and Rehabilitation. \$10 copay per visit all others	Not covered	Chiropractors, Physical Therapists (PT), Occupational Therapists (OT) and Speech Therapists (ST). Copay per visit. Pre-authorization may apply. Acupuncture: Not Covered.
B	Diagnostic test (x-ray, blood work)	\$0 copay per test \$20 copay per test \$20 copay per test	Not covered	None. Copayment per occurrence.
	Imaging (CT, PET scan, MRI)	\$0 copay per test \$20 copay per test	Not covered	None. Copayment per occurrence.
C	Genetic testing	\$0 copay per occurrence	Not covered	Covers up to a 30 day supply. Genetic testing drugs are covered with an inject. Out of network facility drugs are excluded. Copay and co-insurance not.
	Professional health drugs	\$0 copay per occurrence	Not covered	None. Copayment per occurrence.
D	Non-professional health drugs	\$0 copay per occurrence	Not covered	None. Copayment per occurrence.

Sendero Summary of Benefits PAGE 2

Copayment to see a A) PCP, a B) Specialist, and D) Medications

Co-insurance for C) Tests—Applies after deductible is met

Common Medical Event	Services You May Hear	You Use an In-Network Provider	You Use an Out-of-Network Provider	Limitations & Exceptions
A	Specialty drugs	20% co-insurance per occurrence	Not covered	occurrences
	Prescription (e.g. antidepressant, insulin, cancer)	20% co-insurance per occurrence	Not covered	None. Copayment per occurrence.
B	Emergency room services	\$100 copay per visit \$100 copay per hospital stay \$100 copay per emergency department stay	Not covered	Copay per visit. Emergency room services also allow after deductible. Copay per hospital stay. Copay per emergency department stay.
	Emergency medical transportation	\$100 copay per trip	Not covered	Copay per trip.
C	Urgent care	\$40 copay per visit	Not covered	Copay per visit.
	Facility fee (e.g. hospital stay)	\$0 copay per stay	Not covered	None.
D	Skilled nursing care	\$0 copay per day	Not covered	None.
	Home health care	\$0 copay per visit	Not covered	Copay per visit.
E	Substance use disorder treatment services	\$0 copay per visit	Not covered	Copay per visit.
	Substance use disorder treatment services	\$0 copay per visit	Not covered	Copay per visit.
F	Preventive and prenatal care	\$0 copay per visit	Not covered	Copay per visit and delivery. No charge for prenatal care visits with the same provider participating in program. Depending on.

Sendero Summary of Benefits PAGE 3

A) **Specialty Drugs**—deductible + co-insurance
 B) **OUTPATIENT Surgery**—deductible + co-insurance
 C) **Medical Emergencies** and D) **Hospital stays**
 E) Copayments for **Mental and Behavioral Health and Pregnancy**

Common Medical Event	Services You May Hear	You Use an In-Network Provider	You Use an Out-of-Network Provider	Limitations & Exceptions
A	Delivery and all obstetric services	\$700 copay per delivery after deductible	Not covered	For type of services, visitation and visit frequency. Maternity care does not include term and services described elsewhere on the SBC (i.e. ultrasound).
	Home health care	\$0 copay per visit	Not covered	Limited to 30 visits per year. Copayment per occurrence.
B	Rehabilitation services	\$40 copay per visit	Not covered	Habilitation, Rehabilitation and/or Chiropractors, Physical Therapist (PT), Occupational Therapist (OT) and Speech Therapist (ST). Copay per visit. Pre-authorization may apply.
	Skilled nursing care	\$0 copay per day	Not covered	Limited to 30 days per year. Copay per admission.
C	Skilled nursing care	\$0 copay per day	Not covered	None. Copayment per occurrence.
	Skilled nursing care	\$0 copay per day	Not covered	None. Copayment per occurrence.
D	Eye exams	\$40 copay per visit	Not covered	Limited to one (1) visit per year. Copay per admission.
	Glaucoma	\$0 copay per visit	Not covered	Limited to contact lenses or 1 year of glaucoma (lenses and frames) per calendar year for members 65-74 years of age. Limited to the end of the plan year in which age 75 is reached.
E	Child check-up	\$0 copay per visit	Not covered	Available through a network office.

Sendero Summary Of Benefits PAGE 4

A) **Pregnancy (continued)**
 B) **Rehabilitation Services**—Visit Limits—HH=60, SNC=25 (NO limits with Rehab visits)
 C) **Medical Equipment**
 D) **Pediatric Extras**—Vision Benefits for kids—note limits!

Services You Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Amputation
- Behavioral therapy
- Comanor support
- Direct Care (MHI)
- Long term care
- Non-emergency care when traveling outside the U.S.
- Personal device leasing
- Personal property

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 as mandated with habilitation/rehabilitation (PT, OT, ST, and Chiropractic Services)
- Flu shot (see limited to 1 per year every 3 years)
- Substance treatment or limited to diagnostic services only. Treatment to assist the individual maintain and improve skills in their habilitation and medical administration are excluded from coverage.
- Return eye care (MHI) is limited to 1 eye exam per calendar year.
- Return foot care is limited to four (4) visits in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic ulcers or wounds/ulcerations.

Your Rights to Continue Coverage: Federal and State laws may provide protections that allow you to keep the health insurance coverage as long as you meet certain conditions. These are exceptions, however, such as if:

- You cannot afford it.
- The annual charges of the coverage are too high.
- You move outside of the coverage area.

For more information on your rights to continue coverage, contact the insurer at 1-844-800-4673. You may also contact your state insurance department at 1-800-375-6677.

Your Grievance and Appeal 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 more information on your rights, the terms, or conditions, you may contact the insurer at 1-844-800-4673. You may also contact your state insurance department at 1-800-375-6677.

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's policy does provide minimum essential coverage.

Sendero Summary Of Benefits PAGE 5

A) **Excluded Services**
 B) **Excluded Services (HAVE limits)**
 C) **Consumer Coverage Rights** and D) **Appeals** Contact Information
 E) **Meets Minimum Essential Coverage**—What does that mean?

Sendero Health Plans: IdealCare Complete Standard Coverage Period: Beginning on 01/01/17
Summary of Benefits and Coverage: What This Plan Covers & What It Costs Coverage for Individual, Family | Plan Type: HMO

Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 80% (actuarial value). If health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services: Spanish (Español): Pass phrases available in Spanish. Email at 1-844-800-4673.

—This is an example of how this plan might cover costs for a sample medical situation, on the next page—

Sendero Summary Of Benefits PAGE 6

Meets Minimum Value Standard—What does that mean?
 Assistance in Spanish—Contact Information

Sendero's Provider Directory

The screenshot shows a search interface for Sendero's Provider Directory. It includes several dropdown menus: 'Provider Type', 'City', 'Specialty', 'Languages Spoken', and 'Radius'. Red arrows point to the 'Specialty' dropdown (labeled 'WHO WHAT'), the 'City' dropdown (labeled 'WHERE'), and the 'Languages Spoken' dropdown (labeled 'EXTRAS').

Special Deals/Offers with Sendero!

□ \$10 HEB gift card if you get Flu shot!

AMBETTER

- 13 Plans: 2 Bronze, 10 Silver, 1 Gold
- 5 plans include
- Offers EPOs—the only non HMO option available through MP

AMBETTER: Network

- EPO = Exclusive Provider Organization
- Out of Network: Not Covered
 - Exceptions for Life Threatening Emergency
- Specialty: Do **NOT** Need Referral
 - Still needs to be in network
 - May require Prior Approval (specialist provider will request)

AMBETTER: Out-of-Network

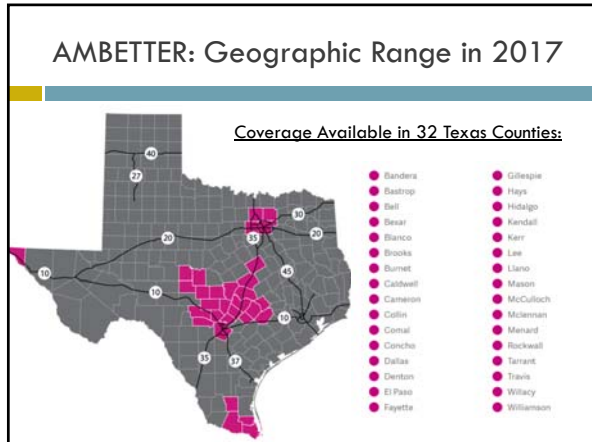
“Life Threatening Emergency” Exceptions

- Broken bones
- Bleeding that won't stop
- Labor pains or other bleeding (if pregnant)
- Severe chest pains or heart attack symptoms
- Overdosed on drugs
- Ingested poison
- Bad burns
- Shock symptoms (sweat, thirst, dizziness, pale skin)
- Convulsions or seizures
- Trouble breathing
- Sudden inability-see, move, speak
- Gun or knife wounds

AMBETTER: Geographic Range in 2016

Coverage Available in 20 Texas Counties:

Bandera	Hidalgo
Bastrop	Kendall
Bell	Lee
Bexar	McLennan
Blanco	Travis
Brooks	Willacy
Burnet	Williamson
Caldwell	
Cameron	
Comal	
El Paso	
Fayette	
Hays	



Summary of Benefits and Coverage: What This Plan Covers & What It Costs

Coverage for: Individual/Family | Plan Type: EPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms at the policy or plan document at <http://ambetterexpensiveilverplan.com> or by calling 877-687-5196, Relay Texas /TTY: 800-738-2999

Important Questions	Answers	Key Takeaways
What is the overall deductible?	\$7,000 individual / \$14,000 family. Do not apply to preventive care, vision, dental, but not others. January 1st. See the chart on page 2 for how much you pay for covered services after you meet the deductible.	You must pay all the costs up to the deductible amount before the plan begins to pay for the deductible. Do not apply to preventive care, vision, dental, but not others. January 1st. See the chart on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart on page 2 for when costs the services that plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, for network providers \$7,000 individual/ \$14,000 family. No, for out-of-network providers.	The 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 the health care expenses.
What is not included in the out-of-pocket limit?	Prevents, balance billed charges, and out-of-network services that plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart on page 2 describes any limits on what the plan will pay for in-network services, such as office visits.
Does this plan use a network of providers?	Yes. See Find a Provider , at call 1-877-687-5196 for a list of participating providers.	If you use an out-of-network doctor or other health care provider, the plan will pay more or all of the cost of covered services. Be aware, you as a network doctor or hospital care as an out-of-network provider for the same services. Please use the terms as network, participating , or participating providers.
Do I need a referral to see a specialist?	No, you don't need a referral to see a specialist.	You can see the specialist you choose without permission from the plan.
Are there services that are not covered?	Yes.	Some of the services this plan does not cover are listed on page 4. See your policy or plan document for more details.

Ambetter Summary of Benefits PAGE 1

No referral required to see a specialist!

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or ER	Specialist visit	\$80 Copay/visit	Not covered	Plan approval required.
	Emergency services	No charge after deductible	Not covered	Plan approval required.
If you have a test	Diagnostic test (e.g., blood work)	No charge after deductible	Not covered	Plan approval required.
	Imaging (CT, PET scans, MRIs)	No charge after deductible	Not covered	Plan approval required.
If you need drugs to treat your illness or condition	Generic drugs	Brand: \$11 Copay / prescription, Mail Order: \$41 Copay / prescription	Not covered	Plan approval required.
	Particled brand drugs	Brand: \$10 Copay / prescription, Mail Order: \$130 Copay / prescription	Not covered	Plan approval required.
If you need drugs to treat your illness or condition	Non-particled brand drugs	\$130 Copay / prescription	Not covered	Plan approval required. Subject to deductible.
	Specialty drugs	No charge after deductible	Not covered	Plan approval required. Subject to deductible.

Ambetter Summary of Benefits PAGE 2

Two ways to get Prior Approval
 Consumer calls insurance company
 "I need prior authorization to go to this dermatologist!"
 Or the Provider calls

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	Not covered	Plan approval required.
	Physician/surgeon fees	No charge after deductible	Not covered	Plan approval required.
If you need immediate medical attention	Emergency acute services	No charge after deductible	Not covered	Plan approval required.
	Emergency medical transportation	No charge after deductible	Not covered	Plan approval required.
If you have a hospital stay	Co-pay rate	\$100 Copay	Not covered	Plan approval required.
	Facility fee (e.g., hospital room)	No charge after deductible	Not covered	Plan approval required.
If you have an extended health, behavioral health, or substance abuse or substance abuse services	Physician/surgeon fee	No charge after deductible	Not covered	Plan approval required.
	Mental, Behavioral health outpatient services	\$30 Copay	Not covered	Plan approval required.
If you are pregnant	Mental, Behavioral health outpatient services	No charge after deductible	Not covered	Plan approval required.
	Substance use disorder outpatient services	\$30 Copay	Not covered	Plan approval required.
If you are pregnant	Substance use disorder outpatient services	No charge after deductible	Not covered	Plan approval required.
	Prenatal and postnatal care	\$30 Copay	Not covered	Plan approval required.
If you are pregnant	Delivery and all associated services	No charge after deductible	Not covered	Plan approval required.
	Delivery and all associated services	No charge after deductible	Not covered	Plan approval required.

Ambetter Summary of Benefits PAGE 3

Services with Copayments
Prior Authorization required for all non emergency services!

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge after deductible	Not covered	Plan approval required. 90 Visits per Year.
	Rehabilitation services	No charge after deductible	Not covered	Plan approval required. 30 visits per benefit per year. 30 visits per benefit per year. 30 visits per benefit per year. 30 visits per benefit per year.
If you need help recovering or have other special health needs	Habilitation services	No charge after deductible	Not covered	Plan approval required. 30 visits per benefit per year.
	Skilled nursing care	No charge after deductible	Not covered	Plan approval required. 27 days per Year.
If you need help recovering or have other special health needs	Portable medical equipment	No charge after deductible	Not covered	Plan approval required.
	Hospice services	No charge after deductible	Not covered	Plan approval required.
If you need help recovering or have other special health needs	Eye exams	\$0 Copay/visit	Not covered	1 Visit per Year.
	Contact lenses	\$0 Copay/visit	Not covered	1 lens per Year.
If you need help recovering or have other special health needs	Dental checkup	No charge	Not covered	---None---
	Dental checkup	No charge	Not covered	---None---

Ambetter Summary Of Benefits PAGE 4

Note Visit Limits--HH=60, REHAB=35, SNC=25 (Limits on Rehab visits)
 Prior Approval Required for Above Services
NOTE excluded list (vs. Sendero...)

The Ambetter Formulary

Prescription Drug List

- Control F to search for the Medication.
- Note the Medication Name.
- Note the Tier and any Special Codes.

Tier 1 refers to Generic Drugs
Tier 2 refers to Preferred Brand drugs,
Tier 3 refers to Non Preferred Brand drugs
Tier 4 refers to Specialty

Medications that are not listed are typically NOT covered

Check whether a generic version is listed and whether the consumer can or take or does take that generic.

The plan's Summary of Benefits gives the accompanying co-payment or coinsurance.

Ambetter: Hospitals

SETON

- **Seton Includes:**
 - Brackenridge
 - Cedar Park Regional Medical Center
 - Dell Children's Hospital

ST. DAVID'S

- **St. David's Includes:**
 - Heart Hospital of Austin
 - St. David's Children's Hospital

Ambetter: Providers

BIGGEST IN NETWORK PROVIDERS:

- Austin Diagnostic Clinics
- CommUnityCare Clinics
 - Walk In Clinics in North and South Austin

ONCOLOGY:

- Texas Oncology
- Seton Shivers Cancer Center
- Seton Oncology

AMBETTER: Hospitals outside Austin

- Baptist Health System, San Antonio
- Medical City Dallas Hospital, Dallas

Ambetter's Provider Directory

Ambetter's Provider Directory

Ambetter's Provider Directory

Special Deals/Offers with Ambetter

Rewards Program
my healthpays

Earn up to \$365 annually on your My Health Pays card for:

ACTIVITY	TIMEFRAME TO EARN	REWARD	IF YOU
Complete your Welcome Survey	First 90 days of your Ambetter membership	\$50	Work Online
Complete your annual Wellness Exam with your PCP	Anytime, but within your appointment window	\$50	Visit a PCP
Join our First & Provider tool for health & safety	September 1 - December 31	\$25	Use Web Resources
Get your flu shot	September 1 - December 31	\$25	Use Web Resources
Sign	At least 6 times a month	Up to \$10 a month	Find a gym near you

Use your rewards to help pay for:

- Doctor Copays*
- Deductibles
- Coinsurance
- Your monthly premium payments

*My Health Pays rewards cannot be used for pharmacy copays.

Describe the Differences

- With your neighbor, describe the differences between Sendero and Ambetter's type of plans and coverage area.
- Be aware of judgmental language versus facts.

Blue Cross Blue Shield

- 14 Plans: 1 Catastrophic, 5 Bronze, 5 Silver, 3 Gold
- "Non-Participating" Coverage for Plus and Multi-State plans
- Most expensive option in all categories
- Limited coverage in every county in Texas

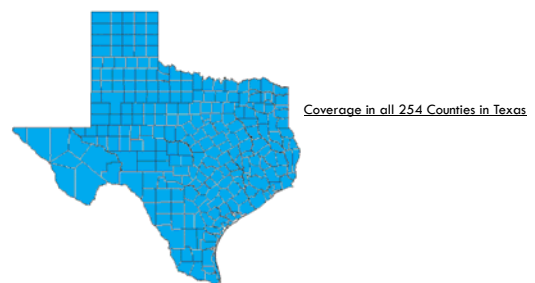
BCBS Advantage: Network

- **HMO** = Health Maintenance Organization
- **Out of Network:** Not Covered
 - ▢ Exceptions for Life Threatening Emergency
- **Specialty:** Need **WRITEN** Referral
 - ▢ From In-Network PCP
 - ▢ Exceptions for emergencies and OBGYN

BCBS Advantage Plus and Multi-State: Network

- **HMO**
 - ▢ Health Maintenance Organization
- **Out of Network: Covered**
 - ▢ A higher much higher deductible (\$15,000) and limitless out of pocket max applies
- **Specialty:** Need a Referral
 - ▢ From In-Network PCP
 - ▢ Exceptions for emergencies and OBGYN

BCBS: Geographic Range



BCBS: Geographic Range

- Blue Card Program
 - Limited access to Urgent Care outside of Texas at in-network prices
- BCBS may assist with locating Provider who will accept the in network rate (outside of Texas)

Questions	Answers	Why this Matters
How much will I pay overall?	\$3,000 Individual/\$9,000 Family. Does not apply to preventive care, office visits that charge a copay or non-specialty prescription drugs. Copays and non-specialty prescription drug costs don't count toward the overall deductible.	You must pay all the costs up to the deductible amount before this plan begins to pay for services you use. Check your policy or plan document to see when the deductible is (usually, but not always, January 1st). See the chart starting on page 2 for how much for covered services after you meet the deductible.
Are there other costs for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit?	Yes. \$7,150 Individual/\$14,300 Family. Premiums and health care this plan does not cover.	The out-of-pocket limit is the most you could pay during a coverage period (usually for your share of the cost of covered services). This limit helps you plan for health care. Even though you pay these expenses, they don't count toward the out-of-pocket limit.
How do I find a participating provider?	Yes. For a list of Participating providers please call 1-888-697-0683 or see www.bcbs.com.	If you use an in-network doctor or other health care provider, this plan will pay most the costs of covered services. Be aware, your in-network doctor or hospital may not be a part of network providers for some services. Please use the same in-network provider for different kinds of services.
What if I need a referral to see a specialist?	Yes. All specialist visits require a written PCP referral unless it's for an OB/GYN or for emergency services this plan covers.	This plan will pay some or all of the costs to see a specialist for covered services but you must have the plan's permission before you see the specialist.
What services does this plan cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

BCBS Summary of Benefits PAGE 1

Referrals required

The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges an amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay, you may have to pay the \$500 difference. (This is called balance billing.)

The plan may encourage you to use Participating providers by charging you lower deductibles, copayments, and coinsurance.

Common Medical Event / Services You May Need	Services You May Need	What Cost If You Use a Participating Provider	What Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$40 copay/visit	Not Covered	—none—
	Specialist visit	\$60 copay/visit	Not Covered	—none—
	Other practitioner office visit	\$40 copay/Primary Care office visits/ \$60 copay/Specialist office visits or 30% coinsurance for other services	Not Covered	Aspirin/anti-Clonidine/anti-epileptic/anti-nausea/beta-blocker/blood-thinner/cholesterol-lowering/heart/insulin/IV/OTC/2017, 1X, UT, Z-Pack
If you have a test	Preventive care/screening/immunization	No Charge	Not Covered	—none—
	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	—none—
If you have a test	Imaging (CT / PET scans, MRIs)	Hospital – 50% coinsurance Non-Hospital – 30% coinsurance	Not Covered	—none—

BCBS Summary of Benefits PAGE 2

Where test happens affects the cost

Common Medical Event / Services You May Need	Services You May Need	What Cost If You Use a Participating Provider	What Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition	Preferred generic drugs	\$0 copay/visit	Not Covered	—none—
	Non-preferred generic drugs	\$0 copay/visit	Not Covered	—none—
	Specialty drugs	\$0 copay/visit	Not Covered	—none—
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital – \$300 coinsurance Non-Hospital – \$100 coinsurance	Not Covered	Copay is charged in addition to the overall deductible. Facility fee/charge is not covered except in limited circumstances.
	Physician/consult fees	50% coinsurance	Not Covered	—none—
If you need immediate medical attention	Emergency room services	\$100 copay/visit plus 50% coinsurance	Not Covered	Copay is charged in addition to the overall deductible and is waived if admitted.
	Emergency medical transportation	\$0 copay/visit	Not Covered	—none—
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 copay/visit plus 50% coinsurance	Not Covered	Copay is charged in addition to the overall deductible.
	Physician/consult fees	50% coinsurance	Not Covered	—none—

BCBS Summary of Benefits PAGE 3

- A) Why the multiple co-pays in one Medication Tier?
- B) Services that cost a co-pay + deductible + co-insurance

Common Medical Event / Services You May Need	Services You May Need	What Cost If You Use a Participating Provider	What Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	\$40 copay for office visits or 30% coinsurance for other outpatient services	Not Covered	—none—
	Mental/behavioral health inpatient services	\$500 copay/admission plus 30% coinsurance	Not Covered	Inpatient copay is charged in addition to the overall deductible.
	Substance use disorder outpatient services	\$40 copay for office visits or 30% coinsurance for other outpatient services	Not Covered	—none—
If you are pregnant	Prenatal and postnatal care	\$40 copay/Primary Care office visits/ \$60 copay/Specialist office visits or 30% coinsurance for other services	Not Covered	Copay applies to first prenatal visit (per pregnancy).
	Delivery and all inpatient services	\$500 copay/admission plus 30% coinsurance	Not Covered	Copay is charged in addition to the overall deductible.
If you need help managing or have other special health needs	Home health care	30% coinsurance	Not Covered	all visit maximum per benefit period
	Rehabilitation services	30% coinsurance	Not Covered	35 visit maximum per benefit period combined with Chronic care.
	Habituation services	30% coinsurance	Not Covered	—none—
	Skilled nursing care	30% coinsurance	Not Covered	25 day maximum per benefit period.
If you need help managing or have other special health needs	urable medical equipment	30% coinsurance	Not Covered	—none—
	Hospice services	30% coinsurance	Not Covered	—none—

BCBS Summary of Benefits PAGE 4

Behavior Services—co-pay is after deductible
Note Visit Limits:--HH=60, REHAB=35, SNC=25 (Same as Ambetter)

Blue Cross BlueShield of Texas

If you or someone you are helping, have questions, you have the right to get help and information in your language of choice. To talk to an interpreter, call 888-637-0683.

Language	Phone Number
Arabic	888-637-0683
Chinese	888-637-0683
French	888-637-0683
German	888-637-0683
Spanish	888-637-0683
Tamil	888-637-0683
Tagalog	888-637-0683
Vietnamese	888-637-0683

BCBS Summary of Benefits PAGE 9-10

BCBS Language Line!

Blue Solution 102
Least expensive Silver Multi-State Plan

Important Questions	Answers	Why this Matters
What is the annual deductible?	Network: \$1,700 Individual/ \$3,400 Family. Out of Network: \$15,000 Individual/\$45,000 Family. Deductibles apply to non-specialty prescription drugs, or to the following services from participating providers: preventive care, first two Primary care office visits, urgent care or mental health/substance use disorder office visits. Copay and non-specialty prescription drug costs don't count toward the annual deductible.	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 3 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. Network: \$6,500 Individual/ \$13,000 Family. Out of Network: Unlimited Individual/Unlimited Family.	The 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?	Previsions, balance-billed charges and health care the plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Does this plan use a network of providers?	Yes. For a list of Network providers please call 1.800.497.0683 or use www.bcbstx.com	If you use an in-network doctor or other health care provider, this plan will pay more 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. Please see the terms in-network, qualified , or participating for providers in this network. See the chart starting on page 3 for how this plan pays different kinds of providers.

Blue Advantage Plus and Multi-State Plans PAGE 1

Out of Network Coverage!
\$15,000 Deductible
Out of Pocket Max=Unlimited

Blue Solution 102
Least expensive Silver Multi-State Plan

• Copayments are your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the health plan's allowed amount for an overnight hospital stay is \$1,000, your copayment payment of 20% would be \$200. This may change if you haven't met your deductible.

• 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 health 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 interest 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**.)

• The plan may encourage you to use Network providers by charging you lower deductibles, copayments, and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Restrictions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	See your Network office visits are no charge, deductible and coinsurance apply for subsequent visits.
	Specialist visit	20% coinsurance	50% coinsurance	Specialist is not covered. Diagnostic care visit limit is 35 per benefit period including chiropractic visits for Rehabilitation and Rehabilitation services.
	Other practitioner office visit	20% coinsurance	50% coinsurance	same
If you have a test	Preventive care/testing/screening/examination	No Charge	50% coinsurance	same
	Diagnostic test (e.g. blood work)	Hospital - 40% coinsurance Non-Hospital - 20% coinsurance	50% coinsurance	same
If you have a test	Imaging (CT / PET scans, MRI)	Hospital - 40% coinsurance Non-Hospital - 20% coinsurance	50% coinsurance	same

Blue Advantage Plus and Multi-State Plans PAGE 3

Out of Network Coverage!
50% co-insurance (after \$15,000 deductible) for all of 2017, for all out of network services

Using the BCBS Formulary

Health Insurance Marketplace 2 Plan Drug List
January 2017

- Control F to search for the Medication.
- Type the Medication Name.
- Note the Tier and any Restrictions.

Tier 1 refers to Preferred Generic drugs
Tier 2 refers to Non-preferred Generic drugs
Tier 3 refers to Preferred Brand drugs
Tier 4 refers to Non-Preferred Brand drugs
Tier 5 refers to Specialty drugs

The plan's Summary of Benefits gives the accompanying co-payment or coinsurance.

BCBS: Hospitals

SETON

- Seton Includes:
 - Brackenridge
 - Cedar Park Regional Medical Center
 - Dell Children's Hospital

ST. DAVID'S

- St. David's Includes:
 - Heart Hospital of Austin
 - St. David's Children's Hospital

BCBS: Providers

BIGGEST IN NETWORK PROVIDERS:

- Austin Diagnostic Clinic
- Community Care Clinics
- Walk In Clinics in North and South Austin

ONCOLOGY:

- Texas Oncology
- Austin Cancer Centers
- Seton Shivers Cancer Center
- Seton Oncology

BCBS: Hospitals outside Austin

- Baylor Scott & White All Saints Medical Center, Fort Worth
- Methodist Dallas Medical Center, Dallas
- Methodist Specialty and Transplant Hospital, San Antonio

Describe the Differences

- With your neighbor, provide an overview of the three insurance companies available in our area, the type of plans they offer, and the differences in the coverage area.
- Be aware of judgmental language versus facts.

Using BCBS's Provider Directory

Using BCBS's Provider Directory

Exercise: Looking Up Providers

What plans are the following providers in network with:

- Lisa Ellis
- Nelly Perez
- Andrea Lack

Links to Providers Directories available on ICT Resource Page at helpenroll.org.

Exercise: Networks

Referred by Texas Oncology

Mark is 55, self-employed and earns \$27,000/year:

\$369/month in Premium Tax credit

201-250% FPL (04 or 73% Cost Sharing Reduction)

Priorities: Keeping his doctors but also needs to pay attention to drug costs.

Navigating Networks

- **Providers?**
 - PCP at Red River Family Practice (2x a year)
 - Texas Oncology (1x a week)
 - Receiving Infusions at Texas Oncology
 - Private Psychologist (1x a month)
 - Would like to see Specialist with MD Anderson
 - Had surgery earlier in 2016 at St. David's

First: Look at Plans & Networks

1. **PCP at Red River Family Practice**
2016: United was only MP plan accepted
Accepts BCBS HMO Blue but ≠ Blue Advantage HMO
2. **Texas Oncology:**
Accepts Marketplace Ambetter and BCBS.
3. **Private Psychologist:** Only accepts BCBS PPO
4. **MD Anderson**

Reality, at this time...

**Red River Family Practice,
Specific Private Psychologist,
& MD Anderson:**
Not in-network with current Marketplace plans, at this time.

Network Options / Discussion

Could select Individual Plan outside Marketplace, but NO subsidies

Without \$369 in MP assistance and 73% CRS

Ask consumer to prioritize doctors/providers

Needs to go to Texas Oncology every week = Ambetter or BCBS

Options with PCP and Psychologist

Find new PCP and Psychologist

Pay out of pocket to see these doctors in 2017

Options with MD Anderson

Why MD Anderson? Joining an experimental trial?

Note: ACA included helpful reforms for covering routine care during trials.

Unlikely Option for MD Anderson: BCBS Advantage Plus or Multi-State

- Out-of-Network Coverage
 - \$15,000 Deductible
 - NO Out-of-Pocket Maximum
 - 50% co-insurance

Prioritizing Providers

- Ongoing treatments at Texas Oncology?
 - Texas Oncology is in-Network with Ambetter or BCBS
 - Co-pays to see a specialist
- Previous surgery at St. David's
 - St. David's is in-Network with Sendero, Ambetter and BCBS

Consumers who had Aetna, United, Humana or Scott & White

- **Options:**
 - Look at Marketplace (MP) plans
 - Purchase individual plan outside of MP but no subsidies
- **What are their medical needs?**
 - Doctors or Facilities
 - Challenge: Austin Regional Clinic (ARC) is not in-network with any MP plan
 - Hospital Preferences
 - Good News! Sendero, Ambetter & BCBS are all in-network with Seton & St. David's
 - Medications

Premium Assistance Programs

- **CHAP** (Sendero PAP)
- **SIMS Foundation Members** (Sendero PAP)
- **Health Alliance for Austin Musicians (HAAM)**
 - ▣ Sendero PAP
 - ▣ Ambetter PAP
- **PENDING: Sliding Fee Scale** (Sendero PAP)
 - ▣ Long Term FQHC users
 - ▣ Advantage of Insurance

Sendero PAP (funded by Central Health)

- Live in Travis County
- Income \leq 200% FPL
- Qualify for Premium Tax Credits plus 06 or 05 CSR
- Use all Premium Tax Credits
- Select Sendero Silver Plan
- Information entered into Redcap upon enrollment
- Who is eligible?
 - ▣ HAAM & SIMS members
 - ▣ Previous MAP clients selected & identified by Central Health for CHAP

Ambetter PAP for HAAM Members

- Income \leq 200% FPL
 - ▣ Not eligible for Sendero PAP
 - ▣ Do not live in Travis County
- Income 201 – 400% FPL
- Use all Premium Tax Credits
- Select Ambetter Bronze, Silver or Gold

Pays 50% of premium or \$200/month, whichever is less.

Verifying Information

- **Immigration/Citizenship Proof**
 - ▣ Upload the Correct Documents!
 - ▣ OKAY to upload Naturalization Certificate
- **Incarceration**
 - ▣ Looking for proof the person has participated in society in the past 30 days
- **Income**
 - ▣ Template for cover letter on ICT Resource Page
 - ▣ Proof needs to match estimate
 - ▣ Show the Math
 - ▣ Less is More
 - ▣ Zero income? Use template on ICT Resource Page