

# UnitedHealthcare Choice Plan - City of Austin

Coverage Period: 01/01/2013 - 12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for Individual + Dependents | 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 [www.austintexas.gov/benefits/enrollment](http://www.austintexas.gov/benefits/enrollment) or by calling 512-974-3284.

Important Questions	Answers	Why this Matters:
What is the overall <b>deductible</b> ?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other <b>deductibles</b> for specific services?	Yes. \$50 prescription deductible for Tier 2 and 3 drugs per individual.	Must be met before prescription <b>copays</b> apply.
Is there an <b>out-of-pocket</b> limit on my expenses?	Yes, for in-network providers. \$3,500 / person, \$7,000 / family.	The <b>out-of-pocket</b> limit for medical is the most you could pay each 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 <b>out-of-pocket</b> limit?	Premiums and prescription <b>copays</b> .	Even though you pay these expenses, they don't count toward the <b>out-of-pocket</b> 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>specific</i> covered services.
Does this plan use a <b>network</b> of <b>providers</b> ?	Yes. For a list of <b>preferred providers</b> , see <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-800-430-7316.	There is no coverage for out-of-network services.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see an in-network <b>specialist</b> without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your plan document for additional information about excluded services.

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- **Co-payments** are fixed dollar amounts (for example, \$25) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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**.
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-net-work Provider	
If you visit a health care <b>provider's</b> office or clinic.	Primary care visit to treat an injury or illness.	\$25 / visit.	Not covered.	Annual physicals and well-woman exams are limited to one each plan year.
	Specialist visit.	\$45 / visit.		
	Other practitioner office visit.	\$45 / visit.		
	Preventive care/screening/immunization.	No charge.		
If you have a test.	Diagnostic test (x-ray, blood work).	No charge.		
	Imaging (CT/PET scans, MRIs).	\$100 copay / test.		

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
<b>If you need drugs to treat your illness or condition.</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.austintexas.gov/benefits/enrollment">www.austintexas.gov/benefits/enrollment</a> .	Generic drugs. (Tier 1)	\$10 copay / 30 day prescription (retail and mail order).	Not covered.	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs. (Tier 2)	\$35 copay / prescription (retail and mail order).	Not covered.	Must be purchased from an in-network provider.
	Non-preferred brand drugs. (Tier 3)	\$55 copay/ prescription (retail and mail order).	Not covered.	
	Speciality drugs.	\$55 copay / speciality pharmacist.	Not covered.	You will be directed to a speciality pharmacy determined by the medical plan.
<b>If you have outpatient surgery.</b>	Facility fee (e.g, ambulatory surgery center).	\$600 / admission.	Not covered.	None.
	Physician / Surgeon fees.	\$25 / visit. \$45 / visit.		
<b>If you need Immediate Medical attention.</b>	Emergency room services.	\$175 / visit.	\$175 / visit.	None.
	Emergency medical transportation.	\$100 / transport.	\$100 / transport.	
	Urgent care.	\$45 / visit.	Not covered.	
<b>If you have a hospital stay.</b>	Facility fee (e.g, hospital room).	\$1,000 / admission.	Not covered.	Semi-private room.
	Physician / surgeon fee.	No copay.	Not covered.	None.

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		In-network Provider	Out-of-network Provider	
<b>If you have mental health, behavioral health, or substance abuse needs.</b>	Mental/Behavioral health outpatient services.	\$25 / visit.	Not covered.	None.
	Mental/Behavioral health inpatient services.	\$1,000 / admission.		
	Substance use disorder outpatient services.	\$25 / visit.		
	Substance use disorder inpatient services.	\$1,000 / admission.		
<b>If you are pregnant.</b>	Prenatal and postnatal care.	\$25 / first visit.	Not covered.	Copay only on first visit.
	Delivery and all inpatient services.	\$1,000 / admission.		No separate copay for newborn if the child is discharged with the mother.
<b>If you need help recovering or have other special health needs.</b>	Home health care.	\$30 / visit.	Not covered.	None.
	Rehabilitation services.	\$45 / visit.		None.
	Habilitation services.	\$45 / visit.		None.
	Skilled nursing care.	\$25 copay / day.		Limited to 30 days per covered person, per calendar year.
	Durable medical equipment.	No charge.		Pre-notification required.
	Hospice service.	No charge.		\$20,000 per covered person, per calendar year.
<b>If your child needs dental or eye care.</b>	Eye exam.	\$45 / visit, Choice Network \$25 / visit, Routine Vision Network	Not covered.	Limited to one routine eye exam per calendar year.
	Glasses.	Not covered.		None.
	Dental check-up.	Not covered.		None.

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## Excluded Services & Other Covered Services:

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

- Acupuncture
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Bariatric Surgery
- Infertility treatment
- Weight loss programs
- Cosmetic surgery
- Long-term care

**Other Covered Services (This isn't a complete list. Check your plan document for other covered services and your costs for these services.)**

- Chiropractic - Limited to 20 visits per year.
- Private-duty nursing when approved by plan administrator.
- Hearing Aids - Plan pays \$1,000 every three years, no copay.
- Routine eye care (Adult) - Limited to one per calendar year.

## 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 limitation on you rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-512-974-3284. 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](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). The City also allows continuing coverage for domestic partners, surviving spouses, and surviving family members of employees killed in the line of duty.

## 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 UnitedHealthcare at 1-800-430-7316 or [www.myuhc.com](http://www.myuhc.com).

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## Language Access Services:

Para obtener asistencia en Espanol, llame al 512-974-3284.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

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## 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 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 \$6,515
- Patient pays \$1,025

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient Pays:

Deductibles	\$ 0
Co-pays	\$1,025
Co-insurance	\$0
Limits or exclusions	None
<b>Total</b>	<b>\$1,025</b>

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

- Amount owed to providers: \$4,100
- Plan pays \$3,570
- Patient pays \$530

#### Sample care costs:

Prescriptions	\$1,500
Medical Equipment & Supplies	\$1,300
Office Visits and Procedures	\$730
Education	\$290
Laboratory tests	\$140
Vaccines, other preventive	\$140
<b>Total</b>	<b>\$4,100</b>

#### Patient Pays:

Deductibles	\$50
Co-pays	\$480
Co-insurance	\$0
Limits or exclusions	None
<b>Total</b>	<b>\$530</b>

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## 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**, submitted expense would have been denied.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.

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