

UnitedHealthcare Choice Plan - City of Austin

Coverage Period: 01/01/2016 - 12/31/2016

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

Coverage for Employees & 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 austintexas.gov/benefits or by calling 512-974-3284.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes. \$50 prescription deductible for Tier 2 and 3 drugs per individual.	You must pay for all of the costs for these services up to the \$50 deductible before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. \$4,000/employee, \$8,000/family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) 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 out-of-pocket limit ?	Premiums, balance-billed charges, 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>specific</i> covered services.
Does this plan use a network of providers ?	Go to myuhc.com or call 1-800-430-7316 for a list of participating providers.	There is no coverage for out-of-network services.
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 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 policy or plan document for additional information about excluded services .

Questions: Call 512-974-3284 or visit us at austintexas.gov/benefits

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- **Copayments** are fixed dollar amounts (for example, \$25) 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 charge \$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 requires you to use **in-network providers** except for emergencies.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care provider's 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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		In-network Provider	Out-of-network Provider	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at austintexas.gov/benefits .	Generic drugs. (Tier 1)	\$10 copay / 31 day prescription (retail and mail order).	Not covered.	Covers up to a 31-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs. (Tier 2)	\$35 copay or 20 % of the cost with a \$70 maximum copay.	Not covered.	Must be purchased from an in-network provider.
	Non-preferred brand drugs. (Tier 3)	\$55 copay or 20 % of the cost with a \$110 maximum copay.	Not covered.	
	Specialty drugs.	\$55 copay or 20 % of the cost with a \$110 maximum copay.	Not covered.	You will be directed to a specialty pharmacy determined by the medical plan.
If you have outpatient surgery.	Facility fee (e.g., ambulatory surgery center).	\$1,000 / admission.	Not covered.	None.
	Physician / Surgeon fees.	\$ 0 / visit. \$ 0 / visit.		
If you need Immediate Medical attention.	Emergency room services.	\$200 / visit.	\$200 / visit.	None.
	Emergency medical transportation.	\$100 / transport.	\$100 / transport.	
	Urgent care.	\$45 / visit.	Not covered.	
If you have a hospital stay.	Facility fee (e.g., hospital room).	\$1,500 / 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	
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services.	\$25 / visit.	Not covered.	None.
	Mental/Behavioral health inpatient services.	\$1,500 / admission.		
	Substance use disorder outpatient services.	\$25 / visit.		
	Substance use disorder inpatient services.	\$1,500 / admission.		
If you are pregnant.	Prenatal and postnatal care.	\$25 / first visit.	Not covered.	None.
	Delivery and all inpatient services.	\$1,500 / admission.		No separate copay is applied for newborn if the child is discharged with the mother.
If you need help recovering or have other special health needs.	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 for any item over \$1,000.
	Hospice service.	No charge.		Limited to 50 visits per person, per calendar year..
If your child needs dental or eye care.	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 policy or plan document for other excluded services.)

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

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

- Bariatric Surgery - Weight loss program with a surgical option offer by UnitedHealthcare.
- Chiropractic - Limited to 20 visits per year.
- Private-duty nursing when approved by plan administrator.
- Hearing Aids - Plan pays for one pair every 48 months.
- Routine eye care - Limited to one exam per calendar year.
- Applied Behavior Analysis - Limited to 680 hours per individual diagnosed with autism per calendar year.

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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 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, 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 UnitedHealthcare at 1-800-430-7316 or www.myuhc.com.

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?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, 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: \$7,467
- Plan pays \$5,797
- Patient pays \$1,670

Sample care costs:

Hospital charges (mother)	\$2,714
Routine obstetric care	\$2,084
Hospital charges (baby)	\$852
Anesthesia	\$906
Laboratory tests	\$527
Prescriptions	\$173
Radiology	\$176
Vaccines, other preventive	\$35
Total	\$7,467

Patient Pays:

Deductibles	\$ 0
Co-pays	\$1,520
Co-insurance	\$0
Limits or exclusions	\$ 150
Total	\$1,670

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

- Amount owed to providers: \$5,126
- Plan pays \$4,205
- Patient pays \$921

Sample care costs:

Prescriptions	\$2,666
Medical Equipment & Supplies	\$1,171
Office Visits and Procedures	\$725
Education	\$287
Laboratory tests	\$137
Vaccines, other preventive	\$140
Total	\$5,126

Patient Pays:

Deductibles	\$0
Co-pays	\$845
Co-insurance	\$0
Limits or exclusions	\$ 76
Total	\$901

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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**, **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.

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