Summary of Plan Benefits

The City of Fort Worth Basic and Consumer Choice plans provide services in the office of a Primary Care Physician (PCP) and Specialist. For purposes of the City's Health Plan, a PCP will be a physician who has contracted with UnitedHealth Care (UHC) as a Primary Care Provider. This will include providers who have contracted as a Family Practitioner, General Practitioner, Internal medicine, Pediatric or OB/GYN provider and are listed in the UHC Insurance provider directory as a PCP or an OB/GYN provider. All other providers will be considered Specialists. A member is not required to elect a specific PCP and a referral from the PCP is not required to see a Specialist. Below are some general services and your payment amount or percentage.

Plan Features	Basic Plan		Consumer Choice Plan	
	In-Network	UHC Premium Designated Provider	In-Network	UHC Premium Designated Provider
Medical Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Annual Deductible				
• Individual	$950		$1,500	
• Family	$1,900		$3,000	
Plan Coinsurance Percent the member pays after deductible is met	35%	15%	35%	15%
Facility Coinsurance	20%	20%	20%	20%
Total Out of Pocket Max–includes deductibles, copays, coinsurance, prescription deductible, prescription copays				
• Individual	$5,000		$6,250	
• Family	$10,000		$10,125	
Physician Office Visit				
• **PCP**	$45 copay	$25 copay	35% after deductible	15% after deductible
• **PCP at USMD Clinic**	$10 copay	Not applicable	15% after deductible	Not Applicable
• **Specialist**	$55 copay	$35 copay	35% after deductible	15% after deductible
Allergy Testing & Treatment Office Visit (Serum/Injections)	$55 copay	$35 copay	35% after deductible	15% after deductible
Routine Physicals/Immunization				
• Children *	$0	$0	$0 deductible waived	$0 deductible waived
• Adult 18 and older * 1 exam per calendar year	$0	$0	$0 deductible waived	$0 deductible waived
• At USMD primary care provider	$0	$0	$0 deductible waived	$0 deductible waived
Routine GYN Exam *				
1 routine GYN exam per year with 1 Pap smear & related lab fees	$0	$0	$0 deductible waived	$0 deductible waived
USMD GYN	$0	$0	$0 deductible waived	$0 deductible waived
Routine Mammogram Annual mammogram for females ages 40 & over if at a free-standing lab	$0	$0	$0 deductible waived	$0 deductible waived
Routine Prostate Specific Antigen (PSA) Test & Digital Rectal Exam Annual DRE & PSA for males age 40 & over	$0	$0	$0 deductible waived	$0 deductible waived
Colonoscopy				
• Initial screening • 1 screening every 10 calendar years for individual age 50 & over or with family history	$0 deductible waived	$0 deductible waived	$0 deductible waived	$0 deductible waived
• Subsequent Colonoscopy(ies) (Physician charge)	35% after deductible	15% after deductible	35% after deductible	15% after deductible
Refractive Eye Exam (1 exam every 24 months**)**	$0	$0	$0 deductible waived	$0 deductible waived
Short-Term Rehabilitation Physical, speech or occupational therapy for acute conditions. 60 visits per calendar year.	$35	Not applicable	15% after deductible	Not Applicable
Musculoskeletal Rehabilitation				
Airrosti Clinic	$15 copay	Not applicable	15% after deductible	Not Applicable
Spinal Manipulation—24 visits per calendar year limited to one visit and treatment per day. Limited to actual spinal manipulation only.	$55 copay	Not applicable	35% after deductible	Not Applicable
Diagnostic X-ray & Lab				
• Free-standing facility & services rendered in a physician's office when office visit is not billed	$0	Not applicable	20% after deductible	Not Applicable
• Outpatient hospital	20% after deductible	Not applicable	20% after deductible	Not Applicable
Complex Imaging (MRI, PET & CAT scans) (Facility)	20% after deductible	Not applicable	20% after deductible	Not Applicable
Emergency Room	$350 copay waived if admitted		20% after deductible	
Non-emergency use of emergency room	50% after deductible		50% after deductible	
Ambulance Services-Emergency Only	20% after deductible	Not applicable	20% after deductible	Not Applicable
Urgent Care Center	$60 copay	Not applicable	20% after deductible	Not Applicable

Plan Features	Basic Plan		Consumer Choice Plan	
Convenient Care Clinic (eg Minute Clinic at CVS)	$30 copay	Not applicable	20% after deductible	Not Applicable
Hospital Services				
• Inpatient	20% after deductible	Not applicable	20% after deductible	Not Applicable
• Outpatient	20% after deductible	Not applicable	20% after deductible	Not Applicable
SurgeryPlus	$0 after deductible	Not applicable	0% after deductible	Not Applicable
Physician Non-Office Visit (Hospital)	35% after deductible	15% after deductible	35% after deductible	15% after deductible
Maternity				
• Office Visit	$45 copay (copay for initial visit only)	$25 copay (copay for initial visit only)	35% after deductible	15% after deductible
• Delivery Expenses	35% after deductible	15% after deductible	35% after deductible	15% after deductible
Durable Medical Equipment	20% after deductible	Not applicable	20% after deductible	Not Applicable
Skilled Nursing/Convalescent Facility 60 days per calendar year	20% after deductible	Not applicable	20% after deductible	Not Applicable
Home Health Care 60 visits per calendar year	20% after deductible	Not applicable	20% after deductible	Not Applicable
Hospice Care 360 days lifetime maximum				
• Inpatient	15% after deductible	Not applicable	15% after deductible	Not Applicable
• Outpatient-includes bereavement counseling & respite care	15% after deductible	Not applicable	15% after deductible	Not Applicable
Mental Health & Chemical Dependency Services				
• Inpatient	20% after deductible	Not applicable	20% after deductible	Not Applicable
• Outpatient Visit (Physician)	$35 copay	Not applicable	15% after deductible	Not Applicable
Diabetes Program				
USMD				
Office Visit at USMD Provider	$10	Not applicable	15% after deductible	Not Applicable
Equipment through a DME Provider (eg insulin pump)	0%	Not applicable	20% after deductible	Not Applicable
Envision				
Prescription medications				
Generic	$0 deductible waived	Not applicable	$0 deductible waived**	Not Applicable
Preferred	$15 deductible waived	Not applicable	50% deductible waived	Not Applicable
Non-Preferred	$50 after deductible	Not applicable	20% after deductible	Not Applicable
PRESCRIPTION DRUGS - Envision				
Annual Rx deductible	$50			
	In-Network	Out-of-Network	In-Network	Out-of-Network
• Retail—up to 30 day supply				
- Generic	100% after Rx deductible & $10 copay	Not applicable	20% after deductible***	Not Applicable
- Preferred (formulary)	100% after Rx deductible & $30 copay	Not applicable	20% after deductible****	Not Applicable
- Non-Preferred (non-formulary)	100% after Rx deductible & $50 copay	Not applicable	20% after deductible	Not Applicable
- Specialty	20% after deductible*****	Not applicable	20% after deductible	Not Applicable
• RX90 Maintenance Medications - Walgreens/Envision Mail Order				
- Generic	100% after Rx deductible & $25 copay	Not applicable	20% after deductible	Not applicable
- Preferred (formulary)	100% after Rx deductible & $75 copay	Not applicable	20% after deductible	Not applicable
- Non-Preferred (non-formulary)	100% after Rx deductible & $125 copay	Not applicable	20% after deductible	Not applicable
• Wal-Mart/Sam's Club—up to 30 day supply				
- Generic	100% after Rx deductible & $5 copay	Not applicable	20% after deductible	Not applicable
- Preferred (formulary)	100% after Rx deductible & $25 copay	Not applicable	20% after deductible	Not applicable
- Non-Preferred (non-formulary)	100% after Rx deductible & $45 copay	Not applicable	20% after deductible	Not applicable
• Wal-Mart/Sam's Club - 90 day supply				
- Generic	100% after Rx deductible & $15 copay	Not applicable	20% after deductible	Not applicable
- Preferred (formulary)	100% after Rx deductible & $75 copay	Not applicable	20% after deductible	Not applicable
- Non-Preferred (non-formulary)	100% after Rx deductible & $135 copay	Not applicable	20% after deductible	Not applicable

Note:

* Assumes service is provided by a primary care physician (PCP) per National guidelines

** On specific medications only

***Certain generic preventive maintenance medications are covered at 100% deductible waived

****Certain preferred preventive maintenance medications are covered at 50% deductible waived

*****To a maximum of $200/script

Only one copay will apply per office visit.

A **PCP** can be a general practitioner, family practitioner, internal medicine, pediatrician, an OB/GYN.

THE SUMMARY PLAN DESCRIPTION PROVIDES A MORE DETAILED DESCRIPTION OF EACH PLAN