Benefits at a Glance

October 1 – September 30 Plan Year

City of MATHIS
Small Town. Big Lake. Great People.

2021

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Medical EPO Plan Feature

*The table below highlights **in-network** features and associated monthly premiums:*

PLAN FEATURES	In-Network	Out-Network
Calendar Year Deductible	$3,000 Individual $6,000 Family	Not Covered
Coinsurance	20%	
Out-of-Pocket Maximum	$6,500 Individual $13,000 Family	
Primary Physician Office Visit	$0 copay/ office visit	Not Covered
Specialist Physician Office Visit	$100 copay/ office visit	
Preventative Care	You pay nothing	
Hospital and Other Services		
Inpatient / Outpatient	DED then 20%	Not Covered
Urgent Care	$50 copay/ visit	
Emergency Room Charges	$250 copay/ visit + DED	
Prescription Drugs		
Tier 1	$5 copay	Not Covered
Tier 2	$50 copay	
Tier 3	$100 copay	
Tier 4	$250 copay	
Specialty	35% coinsurance	
Semi-Monthly Employee Cost		
Employee Only	$25.00	
Employee & Spouse	$341.95	
Employee & Child(ren)	$262.71	
Employee & Family	$606.07	

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.welcometouhc.com or by calling 1-800-782-3740. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $3,000 Individual / $6,000 Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, Prescription drugs - $250 Individual/ $500 Family Does not apply to Tier 1 and 2 drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network: $6,500 Individual / $13,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing 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.
Will you pay less if you use a network provider?	Yes. See www.welcometouhc.com or call 1-800-782-3740 for a list of network providers.	This plan uses a provider Network. You will pay less if you use a provider in the plan's Network. You will pay the most if you use an out-of-Network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your Network provider might use an out-of-Network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	Not Covered	Virtual visits (Telehealth) - No Charge by a Designated Virtual Network Provider.
	Specialist visit	$100 copay per visit, deductible does not apply	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welcometouhc.com.	Tier 1 - Your Lowest-Cost Option	Retail: $5 copay Mail-Order: $12.50 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order*: 90 day supply or *Preferred 90 Day Retail Network pharmacy. If you use an out-of-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Copay is per prescription order up to the day supply limit listed above. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Certain preventive medications and Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail: $50 copay Mail-Order: $125 copay	Not Covered	
	Tier 3 - Your Midrange-Cost Option	Retail: $100 copay Mail-Order: $250 copay	Not Covered	
	Tier 4 - Additional High-Cost Options	Retail: $250 copay Mail-Order: $625 copay	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	None
	Physician/surgeon fees	20% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	$250 Emergency per occurrence copay applies prior to the overall deductible.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$50 copay per visit, deductible does not apply	Not Covered	If you receive services in addition to urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	Not Covered	Network partial hospitalization /intensive outpatient treatment: 20% coinsurance
	Inpatient services	20% coinsurance	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, deductibles, or coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	20% coinsurance	Not Covered	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	Limited to 60 visits per calendar year.
	Rehabilitation services	20% coinsurance	Not Covered	Limits per calendar year: Physical, Speech, Occupational, Pulmonary: 20 visits each; Cardiac: 36 visits.
	Habilitation services	20% coinsurance	Not Covered	Limits per calendar year: Physical, Speech, Occupational: 20 visits each.
	Skilled nursing care	20% coinsurance	Not Covered	Skilled nursing is limited to 60 days per calendar year (combined with Inpatient Rehabilitation) .
	Durable medical equipment	20% coinsurance	Not Covered	Covers 1 per type of Durable medical equipment (including repair/replace) every 3 years.
	Hospice services	20% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Eye exam.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Dental check-up.

Vision Plan Features

United Health Care offers you and your family a vision program that covers the cost of eye exams, eyeglasses and contact lenses. To receive the highest level of benefits, you must use a vision care provider in the United Health Care Vision network. United Health Care covers online provider Warby Parker both single vision and progressive starting at $95. If you use an out-of-network provider, you will pay full fees to the provider, and you will be reimbursed for services rendered up to a maximum allowance.

Members have access to a personalized electronic version of an ID card. Please log onto www.myuhc.com or call Customer Service at **1-866-414-1959** for assistance.

Major features of the Vision Plan Include:

- **Eye Exams** – The plan covers a yearly eye exam at 100% after a $10 co-payment

- **Eyeglasses** – You pay a $25 co-payment for materials, including frames and lenses. This benefit includes some anti-reflective coatings, some progressive lenses, polycarbonate lenses, and UV coating and tinting.

- **Contact Lens Benefits** (in lieu of eyeglasses) – If you choose to have contact lenses, you receive a $130 allowance towards contact lenses and 15% off balance over $130.

Vision Coverage Level	Semi-Monthly Employee Cost
Employee Only	$3.87
Employee + Spouse	$7.35
Employee + Child(ren)	$8.62
Employee + Family	$12.13

UnitedHealthcare

Dental Plan Features

The Dental Plan helps you and your family with the cost of many dental services. Preventive care, such as routine checkups and cleanings, is covered at 100% with no deductible. You must first meet an annual deductible for basic and major services, and then the Plan pays a percentage of the cost for your dental care. It is always a good idea to ask for a pre-determination of costs for services over $300.

To receive the highest level of benefits, you should use a dental provider in the Humana PPO Plan. You also have the option of using an out of network provider. To locate a network dentist refer to the online provider directory at www.humana.com or call Customer Service at **1-877-877-1051** for assistance.

DENTAL COVERAGE SERVICES	HUMANA PPO
Annual Deductible (waived for Preventative)	$50 Individual $150 Family
Calendar Year Maximum	$1,500
Preventative Services	100%
Basic Services	80%
Major Services	50%
Endodontics/ Periodontics	80%
Child Orthodontia Services	Discount up to 20%
Semi-Monthly Employee Cost	
Employee Only	$12.62
Employee + Spouse	$25.23
Employee + Child(ren)	$32.17
Employee + Family	$44.78

Life and AD&D Plan Rates

Basic Life and AD&D		
Employee Age	**Employee Cost**	
All Ages - $15,000 in Coverage	Employer Paid; No Cost to Employee	
Voluntary Employee / Spouse Life and AD&D Semi-Monthly Employee Cost per $1,000 to max of $100,000		
Age	**Employee**	**Spouse**
< 30	$0.050	$0.045
30-34	$0.055	$0.050
35-39	$0.065	$0.065
40-44	$0.090	$0.090
45-49	$0.135	$0.125
50-54	$0.205	$0.195
55-59	$0.315	$0.300
60-64	$0.435	$0.415
65-69	$0.705	$0.670
70-74	$1.365	$1.300
75-79	$2.620	$2.490
80+	$4.880	$4.635
Dependent Coverage Amount	**Semi-Monthly Employee Cost**	
$10,000	$1.00	

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