

## 2011 Summary of Benefits - Plan E

This table outlines **what you pay** for covered services. Refer to the Summary Benefit Description for a detailed list of the plan's benefits, limitations and exclusions.

	In-Network	Out-of-Network
<b>1. Annual Medical Deductible</b>		
	\$1,000 per person \$3,000 per family	\$1,500 per person \$4,500 per family
<b>2. Annual Out-of-Pocket Maximum – Medical</b>		
<i>Includes medical deductible</i>	\$2,500 per person \$5,000 per family	\$5,000 per person \$10,000 per family
<b>3. Annual Out-of-Pocket Maximum – Pharmacy</b>		
	\$1,000 per person \$2,000 per family	Not covered, except emergencies <i>(For emergency services, the in-network benefit level applies)</i>
<b>4. Preventive Care</b>		
a. Routine periodic preventive exams	a. 0%	a. Not covered
b. Well-baby/child exams ( <i>up to age 6</i> )	b. 0%	b. 0%
c. Childhood immunizations ( <i>up to age 18</i> )	c. 0%	c. 0%
d. Adult immunizations	d. 0%	d. Not covered
e. Cancer screenings	e. 0%	e. Not covered
<b>5. Physician and Related Services (except preventive care)</b>		
a. Office visits	a. 20% after deductible	a. 40% after deductible
b. Physician visits (inpatient)	b. 20% after deductible	b. 40% after deductible
<b>6. Urgent Care Services</b>		
Includes physician services and facility charges.	20% after deductible	20% after deductible
<b>7. Emergency Services</b>		
Includes physician services and facility charges. <i>If admitted, plan must be notified within 48 hours</i>	20% after deductible	20% after deductible
<b>8. Outpatient Hospital, Ambulatory Care or Surgical Facility Services</b>		
Includes physician services and facility charges. <i>Prior authorization is required for some surgeries and procedures.</i>	20% after deductible	40% after deductible
<b>9. Outpatient Diagnostic Tests</b>		
Includes X-rays, lab tests, MRI, CT and PET scans. <i>Prior authorization is required for PET scans.</i>	20% after deductible	40% after deductible
<b>10. Maternity Care</b>		
Includes delivery and inpatient services <i>Notification is required for inpatient services.</i>	20% after deductible	40% after deductible
<b>11. Inpatient Hospital Services</b>		
<i>Prior authorization required.</i>	20% after deductible	40% after deductible
<b>12. Ambulance</b>		
	20% after deductible	20% after deductible

	In-Network	Out-of-Network
<b>13. Rehabilitation Services</b>		
Outpatient physical, occupational, speech therapy and treatment visits <i>Prior authorization required after 20 visits.</i>	20% after deductible	40% after deductible
<b>14. Chiropractic Services</b>		
<i>Maximum benefit of 15 visits per year.</i>	20% after deductible (HSM network applies)	40% after deductible
<b>15. Behavioral Health</b>		
a. Inpatient – <i>Prior authorization is required.</i>	20% after deductible	40% after deductible
b. Outpatient	20% after deductible	40% after deductible
<b>16. Chemical Dependency</b>		
a. Inpatient – <i>Prior authorization is required.</i>	20% after deductible	40% after deductible
b. Outpatient	20% after deductible	40% after deductible
<b>17. Continued Care (as Hospital Alternative) – Prior authorization is required</b>		
a. Home health care	20% after deductible	40% after deductible
b. Skilled nursing facility <i>Combined 60-day maximum applies for in-network and out-of-network services.</i>	20% after deductible	40% after deductible
c. Hospice care	20% after deductible	40% after deductible
<b>18. Durable Medical Equipment (DME)</b>		
DME, prosthetics orthotics and disposable supplies <i>Prior authorization is required for items over \$750 or rentals longer than four months.</i>	20% after deductible	40% after deductible
<b>19. Prescription Drugs</b>		
Includes oral prescription drugs, injectables including insulin, Mayo Clinic mail order drugs and diabetic supplies. <i>You must obtain your prescription at an SXC pharmacy or there will be no coverage except in an emergency.</i> <b>Formulary</b> Up to 100-day supply from a retail pharmacy or from the Mayo Clinic mail order service. <b>Non-Formulary</b> Up to 100-day supply from a retail pharmacy or from the Mayo Clinic mail order service.	30% coinsurance (\$5 minimum) <i>Applies to <u>pharmacy</u> out-of-pocket maximum.</i>  50% coinsurance (\$5 minimum) <i>Applies to <u>pharmacy</u> out-of-pocket maximum.</i>	Not covered, except emergencies <i>For emergency services, the in-network benefit level applies.</i>
<b>21. Lifetime Maximum Medical Benefit</b>		
	Unlimited	

The City of Austin Employee Medical Benefit Plan is administered by MMSI, a subsidiary of Mayo Foundation, operating under contract to The City of Austin. If there are any inconsistencies between this document and the Summary Benefit Description (SBD), the SBD is the document that will be relied upon for plan administration and is the document that governs the benefits available. For more information, contact MMSI Customer Service toll-free at 1-866-226-1163.

The term 'In-Network' refers to the MMSI provider network. All out-of-network services are subject to usual and customary limitations. When prior authorization is required for out-of-network services and not obtained, a \$250 penalty applies.

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