Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
University Medical Center of El Paso Retiree Benefit Plan

Coverage Period: 10/1/2025- 9/30/2026
Coverage for: Family | **Plan Type:** PPO

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, please visit our website at www.preferredadmin.net or contact Preferred Administrators at 915-532-3778 or 877-532-3778 if outside the area. Our Customer Service Department is available Monday through Friday from 8 am to 5 pm, Mountain Time.

For the most updated in-network provider listing, please visit our website at www.preferredadmin.net. You can download our provider directory, which is found under the member page at www.preferredadmin.net or you can search a provider in our provider directory search.

For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary on page 2.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	UMC/Texas Tech/EPCH $300 per Individual $900 Family Maximum PPO- $1,500 per Individual $4,500 Family Maximum Out of Network- $5,000 per Individual $15,000 Family Maximum	You must pay all the costs up to the deductible amount before Preferred Administrators begins to pay for covered services you use. Check your plan document at www.preferredadmin.net to see how much is your deductible for this Fiscal Year. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes, Preventive care and primary care services are covered before you meet your deductible	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive service without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.preferredadmin.net
Are there other deductibles for specific services?	Yes. There is a $50.00 deductible for prescription drug coverage at in-house UMC Pharmacies and a $100 deductible for prescription drug coverage at Retail	You must pay all the cost for these services up to the specific deductible amount stated on your plan document before Preferred Administrators begins to pay for these services.

What is the out-of-pocket limit for this plan?	Medical combined with Pharmacy $10,150 per Individual/Family $20,300	The out-of-pocket limits are the most you could pay during a coverage period starting October 1st and ending September 30th. The out-of-pocket includes any applicable deductibles, coinsurance and co-pays for services rendered with in-network medical and pharmacy providers. The out of pocket does not include any non-compliance penalties, and amounts in excess of allowable amounts or any non-covered expenses to include any balance billing. The out-of-pocket limit is combined with medical and pharmacy.
What is not included in the out–of–pocket limit?	Amounts excess of allowable amounts, balance-billed charges or any non-covered expenses.	Even though you pay these services, they do not count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No, there is no annual limit.	No Annual Limit.
Will you pay less if you use a network provider?	Yes, see www.preferredadmin.net for a list of participating providers or call **877-532-3778.**	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 (a balance bill). Be aware, your network provider might use an out-of-network provider for some services. For example, lab work, emergency professional provider's services at an in-network facility. Check provider participation, prior to receiving services.
Do I need a referral to see a specialist?	No, you do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan. Your specialist provider might have a Policy to require a referral from your Primary Care Physician.
Are there services this plan does not cover?	Yes. See your policy or plan document for more detailed information about excluded services.	Some examples of services that Preferred Administrators does not cover are listed on page 7. See your policy or plan document for more detailed information about excluded services.

- **Copayments** are fixed dollar amounts (for example, $15) 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 30% would be $300. 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 charges $2,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $1,500 difference. (This is called **balance billing**.)
- This plan may encourage you to use our Preferred Providers (UMC, EPCH, Texas Tech, PPO) by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a UMC/EPCH Provider	Your Cost if You Use a Texas Tech Provider	Your Cost if You Use a PPO Provider/Wrap	Your Cost If You Use an Out-of-Network/Out of Area Provider (including Tenet Facilities)	Limitations & Exceptions
If you visit a health care provider's office or clinic/Telehealth	Primary care visit to treat an injury or illness	$15 co-pay/visit	$30 co-pay/visit	$40 co-pay/visit	Covered at 50% after deductible has been met	none
	Specialist visit	$15 co-pay/visit	$30 co-pay/visit	$40 co-pay/visit	Covered at 50% after deductible has been met	none
	Other practitioner office visit	$15 co-pay/visit	$30 co-pay/visit	$40 co-pay/visit	Covered at 50% after deductible has been met	none
	Telehealth	$15 co-pay	$30 co-pay	$40 co-pay	Not Covered	none
	Wellness Preventive Care Screening/immunizations according to the United States Preventive Services Task Force (A & B) Recommendations and Guidelines to include Women's Preventive Services	Covered at 100%	Covered at 100%	Covered at 100%	Not Covered	none
	Diabetes Counseling and Education	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 50% after deductible has been met	none
If you have a test	Diagnostic test (x-ray, blood work)	Covered at 100% after deductible has been met	Covered at 100% after deductible has been met	Covered at 70% after deductible has been met	Covered at 50% after deductible has been met	none
	Imaging (CT/PET scans, MRIs)	Covered at 100% after deductible has been met	Covered at 100% after deductible has been met	Covered at 70% after deductible has been met	Covered at 50% after deductible has been met	none
	Generic drugs	$10 co-pay	N/A	$40 co-pay	Not Covered	Co pay applies after applicable pharmacy deductible is met.
	Preferred brand drugs	$30 co-pay	N/A	$65 co-pay	Not Covered	Co pay applies after applicable pharmacy deductible is met.
	Non-preferred brand drugs	$60 co-pay	N/A	$90 co-pay	Not Covered	Co pay applies after applicable pharmacy deductible is met.

Common Medical Event	Services You May Need	Your Cost If You Use a UMC/EPCH Provider	Your Cost if You Use a Texas Tech Provider	Your Cost if You Use a PPO Provider/Wrap	Your Cost If You Use an Out-of-Network/Out of Area Provider (including Tenet Facilities)	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.preferredadmin.net.	Specialty drugs	$150 co-pay; will be dispensed at 30- day supply	N/A	N/A	Not Covered	Specialty medications can be purchased at University Medical Center (UMC) Pharmacy and through Lumicera Health Services. These medications will include a 30-day supply with a $150.00 copay and a $50.00 deductible per plan year.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Note: All Colorectal Cancer Screenings for adults beginning at age 45 years and over will be covered at 100% with any of our participating providers.	$100 co-pay and covered at 100% after deductible has been met	Service only applicable for Facility	$300 co-pay and covered at 70% after deductible has been met	$1,000 co-pay and covered at 50% after deductible has been met	Pre-authorization required.
	Physician/surgeon fees	Covered at 100% after deductible has been met	Covered at 100% after deductible has been met	Covered at 70% after deductible	Covered at 50% after deductible has been met	Preferred Administrators Network physicians, who provide services at UMC or EPCH, will have professional services paid at the contracted rate. Member's responsibilities will be UMC/EPCH/Texas Tech benefit coverage level.
If you need immediate medical attention	Emergency Room (ER) Facility services	$200 co-pay and covered at 100%	N/A	$200 co-pay and covered at 100% (please see Limitations & Exceptions)	$200 co-pay and covered at 100% (please see Limitations & Exceptions)	If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services

Common Medical Event	Services You May Need	Your Cost If You Use a UMC/EPCH Provider	Your Cost if You Use a Texas Tech Provider	Your Cost if You Use a PPO Provider/Wrap	Your Cost If You Use an Out-of-Network/Out of Area Provider (including Tenet Facilities)	Limitations & Exceptions
	Ambulance Transportation	N/A	N/A	Covered at 70%	Covered at 70% of the Maximum of Allowable Charge	Additional charges will be incurred when receiving services from a ground ambulance Non-Contracted Provider.
	Urgent care	$50 copay and covered at 100%	N/A	$50.00 copay and then 70% After deductible has been met	Covered at 50% after deductible has been met	Applicable office co-pay applies to consultation only. Other services example (Labs, X-ray's Injections, etc.) are subject to deductible and co insurance.
If you have a hospital stay	Facility fee (e.g., hospital inpatient room) Long Term	$250 co-pay and covered at 100% after deductible has been met	N/A	$1,000 co-pay and covered at 70% after deductible has been met	$2,500 co-pay and covered at 50% after deductible has been met	Pre-authorization required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 co-pay	$30 co-pay	$40 co-pay	Covered at 50% after deductible has been met	No authorization required.
	Mental/Behavioral health/Residential inpatient services	N/A	N/A	$1,000 co-pay and covered at 70% after deductible has been met	$2,500 co-pay and covered at 50% after deductible has been met	Pre-authorization required.
	Mental/Behavioral health partial hospitalization/Psychiatric Day Treatment	N/A	N/A	Covered at 70% after deductible has been met	Covered at 50% after deductible has been met	Pre-authorization required.
If you are pregnant	Prenatal and postnatal care covered as (Global Maternity)	Covered as Global Maternity	Covered as Global Maternity	Covered as Global Maternity	Covered at 50% after deductible has been met	Applicable office co-pay applies to initial consultation. Subsequent prenatal/ postnatal visits are covered as Global Maternity.

Common Medical Event	Services You May Need	Your Cost If You Use a UMC/EPCH Provider	Your Cost if You Use a Texas Tech Provider	Your Cost if You Use a PPO Provider/Wrap	Your Cost If You Use an Out-of-Network/Out of Area Provider (including Tenet Facilities)	Limitations & Exceptions
	Delivery and all inpatient services	$250 co-pay and covered at 100% after deductible has been met	N/A	$1,000 co-pay and covered at 70% after deductible has been met	$2,500 co-pay and covered at 50% after deductible has been met	Require Notification from your provider. Preferred Administrators Network physicians, who provide services at UMC or EPCH, will have professional services paid at the contracted rate. Member's responsibilities will be UMC/EPCH/Texas Tech benefit coverage level.
If your child needs Preventative Care	Immunization and routine Preventive Care visits	Covered at 100%	Covered at 100%	Covered at 100%	Not Covered	All immunizations and routine preventive visits approved by the American of Pediatrics Periodicity Table and required by the Centers for Disease Control and Prevention are covered. Note: Covered through medical and pharmacy
If you need help recovering or have other special health needs	Home health care	N/A	N/A	Covered at 70% after deductible has been met	Covered at 50% after deductible has been met	Maximum of 60 visits/days per Fiscal Year. Pre-authorization required.
	Durable medical equipment	N/A	N/A	Covered at 70% after deductible has been met	Covered at 50% after deductible has been met	Pre-authorization required for over $500.00 and for rentals over two months.
	Rehabilitation services	Covered at 100% after deductible has been met	Covered at 100% after deductible has been met	Covered at 70% after deductible has been met	Covered at 50% after deductible has been met	Pre-authorization required for treatment. (excluding initial evaluation)
	Occupational Therapy	Covered at 100% after deductible has been met	Covered at 100% after deductible has been met	Covered at 70% after deductible has been met	Covered at 50% after deductible has been met	Pre-authorization required (excluding initial evaluation)
	Physical Therapy	Covered at 100% after deductible has been met	Covered at 100% after deductible has been met	Covered at 70% after deductible has been met	Covered at 50% after deductible has been met	Pre-authorization required (excluding initial evaluation)
	Speech Therapy	Covered at 100% after deductible has been met	Covered at 100% after deductible has been met	Covered at 70% after deductible has been met	Covered at 50% after deductible has been met	Pre-authorization required (excluding initial evaluation)

Common Medical Event	Services You May Need	Your Cost If You Use a UMC/EPCH Provider	Your Cost if You Use a Texas Tech Provider	Your Cost if You Use a PPO Provider/Wrap	Your Cost If You Use an Out-of-Network/Out of Area Provider (including Tenet Facilities)	Limitations & Exceptions
	Spinal Adjustment/Chiropractic Adjustment	N/A	$30 co-pay and covered at 100% after deductible has been met	$40 co-pay and covered at 70% after deductible has been met	Covered at 50% after deductible has been met	Pre-authorization required (excluding initial evaluation)
If you need help recovering or have other special health needs	Skilled nursing care	N/A	N/A	Covered at 70% after deductible has been met	Covered at 50% after deductible has been met	Maximum of 60 visits/days per Fiscal Year. Pre-authorization required.
	Hospice service	N/A	N/A	Covered at 70% after deductible has been met	Covered at 50% after deductible has been met	Maximum of 180 visits per Fiscal Year. Pre-authorization required.

Excluded Services & Other Covered Services:

Examples of Services NOT Covered (This is not a complete list). Check your plan document for other excluded services.)

- Cosmetic Procedures
- Infertility Treatment
- Treatments in connection with Dietary Control or Weight Reduction
- Bariatric Surgery
- Routine Dental Care to include Anesthesia not Medically Necessary
- Routine Eye Care
- Routine Vision
- Non-Emergency Care when traveling outside the U.S.
- Acupuncture or Hypnosis
- Treatment of Sexual Dysfunctions
- Reversal or Attempted Reversal of Sterilization
- Investigational or Experimental Drugs including compounded medications for non-FDA approved use

Other Covered Services (This is not a complete list. Check your Plan Document at www.preferredadmin.net for other covered services and your costs for these services.)

- Allergy Testing
- Chemotherapy/Radiation Therapy
- Diagnostic X-Ray and Laboratory Services
- Durable Medical Equipment
- Cataract Surgery
- Preventive Services
- Hospice Care
- Occupational Therapy/Physical Therapy
- Speech Therapy
- Behavioral Health (Mental and Substance Abuse)
- Diagnostic X-Ray and Laboratory Services
- Pregnancy Expenses

Your Rights to Continue Coverage:

If you lose coverage under the plan, you have the right to continue with COBRA (Consolidated Omnibus Budget Reconciliation Act). COBRA continuation coverage can become available to you and to your family members who are covered under the Plan when you would otherwise end because of a life event known as "qualifying event." 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 Preferred Administrators at 915-532-3778 Monday – Friday 8:00 a.m. – 5:00 p.m. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-32-72 or www.dol.gov/ebsa.

****Important Note**** There may be other coverage options for you and your family. Other options, to continue coverage are avail be to you, including buying individual insurance coverage through **the Health Insurance Marketplace (at 1-800-318-2596 or www.healthcare.gov).** In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan document also provides complete information to submit a claim appeal or a grievance for any reason to your plan. If you have a complaint or are dissatisfied with a denial of coverage for claims, you may be able to **Appeal** or file a **Grievance**. For questions about your rights, this notice, or assistance, you can contact Preferred Administrators at 915-532-3778 Monday- Friday 8:00 a.m. – 5:00 p.m. Preferred Administrators has designated Customer Service Representatives to assist Members with the complaints and appeals process. All Complaints can be submitted in writing or verbal. Covered Participants may contact Preferred Administrators Customer Service Department to request assistance on how to submit a written complaint; the complaint form and supporting documentation must be mailed or faxed. All Complaints and Appeals should be mailed to Preferred Administrators Complaints & Appeals Unit 1145 Westmoreland, El Paso, TX 79925 915-532-3778 or Faxed to 915-298-7872.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services

Spanish (Español): Para obtener asistencia en Español, llame a Preferred Administrators al 915-532-3778.

Coverage Examples

The following are three examples of how this plan might cover costs for a sample medical situation.

About these Coverage Examples:

This is not a cost estimator.

Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

EXAMPLE 1

Having a baby at PPO Hospital

- **The plan's overall deductible:** **$1500**
- **Specialist copayment:** **$40**
- **Hospital (facility) coinsurance:** **30%**
- **Other coinsurance:** **30%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit *(anesthesia)*

Total Allowable Example Cost	**$9,000**

In this example, the Patient would pay:

Deductibles	$1,500
PPO Specialist Co-Payment	$40
In-Patient Co-payment	$1,000
Coinsurance 30%	$1,950
The total Patient would pay is	**$4,490**

Having a baby at UMC Hospital

- **The plan's overall deductible:** **$300**
- **Specialist copayment:** **$30**
- **Hospital (facility) coinsurance:** **0%**
- **Other coinsurance:** **0%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit *(anesthesia)*

Total Allowable Example Cost	**$7,000**

In this example, the Patient would pay:

Deductibles	$300
Texas Tech Specialist Co-Payment	$30
In-Patient Co-payment	$250
Coinsurance	$0
The total Patient would pay is	**$580**

About these Coverage Examples:

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EXAMPLE 2

Managing Joe's type 2 diabetes (PPO)
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible:** **$1500**
- **Specialist copayment:** **$40**
- **Hospital (facility) coinsurance:** **30%**
- **Other coinsurance:** **30%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Allowable Example Cost	**$6,000**

In this example, Joe would pay:

Deductibles	$1,500
PPO Office Co-payment	$40
Coinsurance 30%	$1,338
The total Joe would pay is	**$2,878**

Managing Joe's type 2 diabetes (UMC)
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible:** **$300**
- **Specialist copayment:** **$**
- **Hospital (facility) coinsurance:** **0%**
- **Other coinsurance:** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Allowable Example Cost	**$5,000**

In this example, Joe would pay:

Deductibles	$300
UMC Office Co-payment	$15
Coinsurance	$0
The total Joe would pay is	**$315**

About these Coverage Examples:

This is not a cost estimator.

Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

EXAMPLE 3

Mia's Simple Fracture (PPO)
(in-network facility emergency room visit and follow up care)

- **The plan's overall deductible: $1500**
- **Specialist copayment: $40**
- **Hospital (ER Facility) coinsurance: 0%**
- **Other coinsurance: (PPO Follow Up) 30%**

This EXAMPLE event includes services like:
Facility Emergency Room Care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation Services *(physical therapy)*

Total Allowable Example Cost	**$15,000**

In this example, Joe would pay:

Deductible applies toward DME, X-Rays, Therapy	$1,500
PPO ER Co-payment	$200
PPO Office Co-payment	$40
Coinsurance 30%	$4,023
The total Joe would pay is	**$5,763**

Mia's Simple Fracture (UMC)
(in-network facility emergency room visit and follow up care)

- **The plan's overall deductible: $300**
- ER **copayment: $200**
- **Hospital (ER Facility) coinsurance: 0%**
- **Other coinsurance: (UMC Follow Up) 0%**

This EXAMPLE event includes services like:
Facility Emergency Room Care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation Services *(physical therapy)*

Total Allowable Example Cost	**$14,000**

In this example, Joe would pay:

Deductibles applies toward DME, X-Rays, Therapy	$300
UMC ER Co-payment	$200
UMC Office Co-payment	$15
Coinsurance	$0
The total Joe would pay is	**$515**

NOTE: Deductible/Coinsurance does not apply when obtaining emergency services. If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services.

Questions and Answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs do not include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and are not 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**, costs would have been higher.

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 is not 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 cannot 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 will 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 will 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.