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,

If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.preferredadmin.net or by calling 915-532-3778 or 877-532-3778 if outside the area. Our Customer Service Department is available Monday through Friday from 7 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.

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<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
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</thead>
</table>
| **What is the overall deductible?** | UMC/Texas Tech/EPCH  
$150 per Individual  
$450 Family Maximum  
PPO-  
$1,500 per Individual  
$4,500 Family Maximum  
Out of Network-  
$3,500 per Individual  
$10,500 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 pharmacies. There are no other specific deductibles | 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 $6,850 per Individual/Family $13,700 | 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 providers 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 4. 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.
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<th>Your Cost If You Use an Out-of-network Provider (including Tenet Facilities)</th>
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<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15 co-pay/visit</td>
<td>$30 co-pay/visit</td>
<td>$40 co-pay/visit</td>
<td>Covered at 50% after deductible has been met</td>
<td>__<strong><strong><strong><strong><strong>none</strong></strong></strong></strong></strong></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$15 co-pay/visit</td>
<td>$30 co-pay/visit</td>
<td>$40 co-pay/visit</td>
<td>Covered at 50% after deductible has been met</td>
<td>__<strong><strong><strong><strong><strong>none</strong></strong></strong></strong></strong></td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$15 co-pay/visit</td>
<td>$30 co-pay/visit</td>
<td>$40 co-pay/visit</td>
<td>Covered at 50% after deductible has been met</td>
<td>__<strong><strong><strong><strong><strong>none</strong></strong></strong></strong></strong></td>
</tr>
<tr>
<td></td>
<td>Wellness Preventive Care Screening/immunizations according to the United States Preventive Services Task Force (A &amp; B) Recommendations and Guidelines to include Women’s Preventive Services</td>
<td>No Charge</td>
<td>No Charge</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>__<strong><strong><strong><strong><strong>none</strong></strong></strong></strong></strong></td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Covered at 100% after deductible has been met</td>
<td>Covered at 100% after deductible has been met</td>
<td>Covered at 70% after deductible has been met</td>
<td>Covered at 50% after deductible has been met</td>
<td>__<strong><strong><strong><strong><strong>none</strong></strong></strong></strong></strong></td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Covered at 100% after deductible has been met</td>
<td>Covered at 100% after deductible has been met</td>
<td>Covered at 70% after deductible has been met</td>
<td>Covered at 50% after deductible has been met</td>
<td>__<strong><strong><strong><strong><strong>none</strong></strong></strong></strong></strong></td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>$5 co-pay</td>
<td>N/A</td>
<td>$30 co-pay</td>
<td>Not Covered</td>
<td>Co pay applies after applicable pharmacy deductible is met.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$25 co-pay</td>
<td>N/A</td>
<td>$60 co-pay</td>
<td>Not Covered</td>
<td>Co pay applies after applicable pharmacy deductible is met.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$50 co-pay</td>
<td>N/A</td>
<td>$80 co-pay</td>
<td>Not Covered</td>
<td>Co pay applies after applicable pharmacy deductible is met.</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>$50 co-pay; will be dispensed at 30 day supply</td>
<td>N/A</td>
<td>N/A</td>
<td>Not Covered</td>
<td>Specialty drugs will be dispensed at a 30 day supply and must be filled at UMC Pharmacies or by mail order.</td>
</tr>
<tr>
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<td>Limitations &amp; Exceptions</td>
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</tbody>
</table>
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center)  
Note: All Colorectal Cancer Screenings for adults beginning at age 50 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. |
<p>| Physician/surgeon fees | 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 |  |
| If you need immediate medical attention | Emergency Room (ER) Facility services | $50 co-pay and covered at 100% | N/A | $50 co-pay and covered at 100% (please see Limitations &amp; Exceptions) | $50 co-pay and covered at 100% of the Usual and Customary |  |
| Ambulance Transportation | N/A | N/A | Covered at 70% of the Usual and Customary | Covered at 50% after deductible has been met | Additional charges will be incurred when receiving services from a Non-Contracted Provider. |
| Urgent care | N/A | N/A | $40.00 co-pay | Covered at 50% after deductible has been met |  |
| If you have a hospital stay | Facility fee (e.g., hospital inpatient room) | $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. |</p>
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</tr>
</thead>
<tbody>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>N/A</td>
<td>$35 co-pay</td>
<td>$40 co-pay</td>
<td>Covered at 50% after deductible has been met</td>
<td>Maximum of 30 visits per Fiscal Year (outpatient and inpatient visits combined). Pre-authorization requirement for treatment</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>N/A</td>
<td>N/A</td>
<td>$1,000 co-pay and covered at 70% after deductible has been met</td>
<td>$2,500 co-pay and covered at 50% after deductible has been met</td>
<td>Maximum of 30 visits per Fiscal Year (outpatient and inpatient visits combined). Pre-authorization required</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health partial hospitalization/Psychiatric Day Treatment</td>
<td>N/A</td>
<td>N/A</td>
<td>Covered at 70% after deductible has been met</td>
<td>Covered at 50% after deductible has been met</td>
<td>Maximum of 30 visits per Fiscal Year (outpatient and inpatient visits combined). Pre-authorization required</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care covered as (Global Maternity)</td>
<td>Covered as Global Maternity</td>
<td>Covered as Global Maternity</td>
<td>Covered as Global Maternity</td>
<td>Covered at 50% after deductible has been met</td>
<td>Applicable office co-pay applies to initial consultation. Subsequent prenatal/ postnatal visits are covered as Global Maternity.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>$250 co-pay and covered at 100% after deductible has been met</td>
<td>N/A</td>
<td>$1,000 co-pay and covered at 70% after deductible has been met</td>
<td>$2,500 co-pay and covered at 50% after deductible has been met</td>
<td>Pre-authorization required.</td>
</tr>
<tr>
<td>If your child needs Preventative Care</td>
<td>Immunization and routine Preventive Care visits</td>
<td>Covered at 100%</td>
<td>Covered at 100%</td>
<td>Covered at 100%</td>
<td>Not Covered</td>
<td>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.</td>
</tr>
<tr>
<td>Common Medical Event</td>
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<td>Limitations &amp; Exceptions</td>
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<tr>
<td></td>
<td>Home health care</td>
<td>N/A</td>
<td>N/A</td>
<td>Covered at 70% after deductible has been met</td>
<td>Covered at 50% after deductible has been met</td>
<td>Maximum of 120 visits per Fiscal Year (includes Skilled Nursing). Pre-authorization required.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>N/A</td>
<td>N/A</td>
<td>Covered at 70% after deductible has been met</td>
<td>Covered at 50% after deductible has been met</td>
<td>Pre-authorization required for over $500.00 and for rentals over two months.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Covered at 100% after deductible has been met</td>
<td>Covered at 100% after deductible has been met</td>
<td>Covered at 70% after deductible has been met</td>
<td>Covered at 50% after deductible has been met</td>
<td>Pre-authorization required for treatment.</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapy</td>
<td>Covered at 100% after deductible has been met</td>
<td>Covered at 100% after deductible has been met</td>
<td>Covered at 70% after deductible has been met</td>
<td>Covered at 50% after deductible has been met</td>
<td>Pre-authorization required for treatment.</td>
</tr>
<tr>
<td></td>
<td>Physical Therapy</td>
<td>Covered at 100% after deductible has been met</td>
<td>Covered at 100% after deductible has been met</td>
<td>Covered at 70% after deductible has been met</td>
<td>Covered at 50% after deductible has been met</td>
<td>Pre-authorization required for treatment.</td>
</tr>
<tr>
<td></td>
<td>Speech Therapy</td>
<td>Covered at 100% after deductible has been met</td>
<td>Covered at 100% after deductible has been met</td>
<td>Covered at 70% after deductible has been met</td>
<td>Covered at 50% after deductible has been met</td>
<td>Pre-authorization required for treatment.</td>
</tr>
<tr>
<td></td>
<td>Spinal Adjustment/Chiropractic Adjustment</td>
<td>N/A</td>
<td>$30 co-pay and covered at 100% after deductible has been met</td>
<td>$40 co-pay and covered at 70% after deductible has been met</td>
<td>Covered at 50% after deductible has been met</td>
<td>Maximum of 10 visits per Fiscal Year. Pre-authorization required for treatment.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>N/A</td>
<td>N/A</td>
<td>Covered at 70% after deductible has been met</td>
<td>Covered at 50% after deductible has been met</td>
<td>Maximum of 60 visits/days per Fiscal Year. Pre-authorization required.</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>Covered at 100% after deductible has been met</td>
<td>Covered at 100% after deductible has been met</td>
<td>Covered at 70% after deductible has been met</td>
<td>Covered at 50% after deductible has been met</td>
<td>Maximum of 180 visits per Fiscal Year. Pre-authorization required.</td>
</tr>
</tbody>
</table>
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 7:00 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/ebri.

**Important Note** There may be other coverage options for you and your family. Other options, to continue coverage are available 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 provide 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 7:00 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. 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.

**Spanish Access Services**

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

- Amount allowed to providers: $9,897
- Plan pays to provider: $5,690
- Patient pays: $4,207

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 Example Cost | $9,897

In this example, the Patient would pay:

| Deductibles | $1,500 |
| In-Patient Co-payment | $1,000 |
| Coinsurance 30% | $1,707 |

The total Patient would pay is $4,207

Having a baby at UMC Hospital

- Amount owed to providers: $5,900
- Plan pays: $5,500
- Patient pays: $400.00

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 Example Cost | $5,900

In this example, the Patient would pay:

| Deductibles | $150 |
| In-Patient Co-payment | $250 |
| Coinsurance | $0 |

The total Patient would pay is $400.00
Managing Joe’s type 2 diabetes (PPO)
(a year of routine in-network care of a well-controlled condition)

- Amount owed to providers: $6,940
- Plan pays: $3,780
- Patient pays: $3,160

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 Example Cost $6,940

In this example, Joe would pay:
- Deductibles $1,500
- Co-payments $40
- Coinsurance 30% $1,620
- The total Joe would pay is $3,160

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

- Amount owed to providers: $3,665
- Plan pays: $3,500
- Patient pays: $165

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 Example Cost $3,665

In this example, Joe would pay:
- Deductibles $150
- Co-payments $15
- Coinsurance $0
- The total Joe would pay is $165
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.