## Schedule of Coverage



The following information summarizes the benefits available under the Managed Health Care Benefits section of your coverage. To get the most out of your coverage, it is important that you carefully read your Benefit Booklet so you are aware of plan requirements, provisions and limitations and exclusions.

## Plan RMH3

### BlueChoice PPO<sup>SM</sup> Network

Overall	Paymen	t Provisions		In-Netw	ork Benefits	C	Dut-of-N	etwork Benefits
_			 					

Copayment Amounts, Deductibles and Out-of-Pocket Maximums are subject to change or increase as permitted by applicable law

### Deductibles

Calendar Year Deductible Applies to all Eligible Expenses	\$5,000 Individual / \$10,000 Family	\$10,000 Individual / \$20,000 Family
ut-of-Pocket Maximum	\$5,000 Individual / \$10,000 Family	\$20,000 Individual / \$40,000 Family
patient Hospital Expenses	In-Network Benefits	Out-of-Network Benefits
Inpatient Hospital Expenses		
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Penalty for failure to preauthorize services	None	\$250
ledical/Surgical Expenses	In-Network Benefits	Out-of-Network Benefits
Physician office visit/consultation, including lab and x- ray	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Lab & x- ray in other outpatient facilities, excluding Certain Diagnostic Procedures	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Inpatient visits and Certain Diagnostic Procedures	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Home Infusion Therapy	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Physician surgical services performed in any setting	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
xtended Care Expenses	In-Network Benefits	Out-of-Network Benefits
	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Skilled Nursing Facility	25 days per C	Calendar Year *
Home Health Care	60 visits per 0	Calendar Year *
Hospice Care	Unli	mited
pecial Provisions Expenses	In-Network Benefits	Out-of-Network Benefits

#### **Behavioral Health Services**

\* Benefits used In-Network and Out- of-Network will apply toward satisfying any day, visit, Calendar Year Maximum amounts indicated A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association



<b>T</b> ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		
Treatment of Chemical Dependency		
Certain Services will require Preauthorization		
Inpatient Services		
Inpatient treatment must be provided in a Chemical	100% of Allowable Amount after	70% of Allowable Amount after
Dependency Treatment Center / Hospital (facility)	Calendar Year Deductible	Calendar Year Deductible
Penalty for failure to preauthorize inpatient services	None	\$250
(facility)	None	φ200
Behavioral Health Practitioner services	100% of Allowable Amount after	70% of Allowable Amount after
	Calendar Year Deductible	Calendar Year Deductible
Outpatient Services		
Behavioral Health Practitioner expenses (office setting)	100% of Allowable Amount after	70% of Allowable Amount after
	Calendar Year Deductible	Calendar Year Deductible
Other outpatient services	100% of Allowable Amount after	70% of Allowable Amount after
	Calendar Year Deductible	Calendar Year Deductible
Serious Mental Illness		
Certain Services will require Preauthorization.		
Inpatient Services		
Hospital services (facility)	100% of Allowable Amount after	70% of Allowable Amount after
nospital services (lacility)	Calendar Year Deductible	Calendar Year Deductible
Penalty for failure to preauthorize inpatient services	None	\$250
(facility)		7
Behavioral Health Practitioner services	100% of Allowable Amount after	70% of Allowable Amount after
	Calendar Year Deductible	Calendar Year Deductible
Outpatient Convises		
Outpatient Services Behavioral Health Practitioner expenses (office setting)	100% of Allowable Amount after	70% of Allowable Amount after
Denavioral freatur Fractitioner expenses (onice setting)	Calendar Year Deductible	Calendar Year Deductible
Other outpatient services	100% of Allowable Amount after	70% of Allowable Amount after
	Calendar Year Deductible	Calendar Year Deductible
Mental Health Care		
Certain Services will require Preauthorization		
Inpatient Services		
Hospital services (facility)	100% of Allowable Amount after	70% of Allowable Amount after
	Calendar Year Deductible	Calendar Year Deductible
Penalty for failure to preauthorize inpatient services	Alex -	<b>*</b> 250
(facility)	None	\$250
Behavioral Health Practitioner services	100% of Allowable Amount after	70% of Allowable Amount after
Denavioral medium maculioner services	Calendar Year Deductible	Calendar Year Deductible
Outpatient Services		
Behavioral Health Practitioner expenses (office setting)	100% of Allowable Amount after	70% of Allowable Amount after
	Calendar Year Deductible	Calendar Year Deductible
Other outpatient services	100% of Allowable Amount after	70% of Allowable Amount after
•	Calendar Year Deductible	Calendar Year Deductible

### Emergency Room/Treatment Room

\* Benefits used In-Network and Out- of-Network will apply toward satisfying any day, visit, Calendar Year Maximum amounts indicated A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

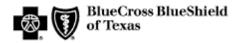
Schedule of Coverage
----------------------



		~
Accidental Injury & Emergency Care(including Accidental Injury & Emergency Care for Behavioral Health Services)		
Facility charges (excluding Certain Diagnostic Procedures)	100% of Allowable Amount at	ter Calendar Year Deductible
Physician charges	100% of Allowable Amount at	ter Calendar Year Deductible
Non-Emergency Care (including Non-Emergency Care for Behavioral Health Services)		
Facility charges (excluding Certain Diagnostic Procedures)	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Physician charges	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Irgent Care Services		
Urgent Care center visit, including lab & x-ray services and Certain Diagnostic Procedures	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
mbulance Services	100% of Allowable Amount at	ter Calendar Year Deductible
Preventive Care Services		
	100% of Allowable Amount	70% of Allowable Amount
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing function with hearing aids	Covered as any other sickness	Covered as any other sickness
Hearing Aids	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Hearing Aids maximum	Limited to one hearing aid pe	r ear each 36- Month period*
Cardiovascular Tests		
One of the following early detection tests for cardiovascular disease will be covered for a Participant who meets the age requirements and is a diabetic or has been determined to have a risk of developing coronary heart disease:	Maximum benefit of	1 test every 5 years*
<ul> <li>Computed tomography (CT) scanning measuring coronary artery calcification.</li> </ul>	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
<ul> <li>Ultrasonography measuring carotoid intima-media thickness and plaque.</li> </ul>	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Physical Medicine Services		
Dhusia Madisia - Osmissa (includes hutis not limited to	100% of Allowable Amount after	70% of Allowable Amount after
Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy)	Calendar Year Deductible	Calendar Year Deductible

<sup>\*</sup> Benefits used In-Network and Out- of-Network will apply toward satisfying any day, visit, Calendar Year Maximum amounts indicated A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

## Schedule of Coverage



The following chart summarizes the pharmacy benefits available under your coverage. To get the most out of your coverage, it is important that you carefully read the **PHARMACY BENEFITS** section of your Benefit Booklet so you are aware of plan requirements, provisions, limitations and exclusions.

Pharmacy Benefits	Participating Pharmacy	Non-Participating Pharmacy (member files claims)
Retail Pharmacy		

One Copayment Amount per 30- day supply, no more than a 90- day supply	100% of Allowable Amount after Calendar Year Deductible		
Mail-Order Program	Mail Order Program	Other Pharmacy	
One Copayment Amount per 30-day supply, up to a 90-day supply	100% of Allowable Amount after Calendar Year Deductible	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	
<i>Specialty Drugs</i> Available In-Network through Specialty Pharmacy Program	Specialty Pharmacy Provider	Other Pharmacy	
One Copayment Amount per 30- day supply - limited to a 30- day supply	100% of Allowable Amount after Calendar Year Deductible		
Vaccinations obtained through Pharmacies**	Select Participating Pharmacies	Non-Participating Pharmacy (member files claims)	
	Flu vaccine - \$0 Copayment Amount	100% of Allowable Amount minus Copayment Amount after Calendar Year Deductible	

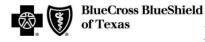
Diabetes Supplies are available under the Pharmacy Benefits portion of your Plan. All provisions of this portion of the Plan will apply including any Deductibles, Copayment Amounts, Coinsurance Amounts, and any pricing differences.

\*\* Each Participating Pharmacy that has contracted with BCBSTX to provide this service may have age, scheduling, or other requirements that will apply, so you are encouraged to contact them in advance. Childhood immunizations subject to state regulations are not available under this pharmacy benefit. Refer to your BCBSTX medical coverage for benefits available for childhood immunizations.

Preferred Drug List 1 applies.

Pharmacy Network A applies.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association



Summary of Benefits and Coverage: What this Plan Covers & What it Costs

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <u>www.bcbstx.com/member/policy-forms/</u> or by calling 1-800-521-2227.

Important Questions	Answers	Why this Matters:	
What is the overall <u>deductible</u> ?	For Network <b>\$5,000</b> Individual/ <b>\$10,000</b> Family. For Out-of-Network <b>\$10,000</b> Individual/ <b>\$20,000</b> Family. Preventive care does not apply to the Network deductible.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .	
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.	
Is there an <u>out-of-pocket</u> <u>limit</u> on my expenses?	Yes. For Network <b>\$5,000</b> Individual/ <b>\$10,000</b> Family. For Out-of-Network <b>\$20,000</b> Individual/ <b>\$40,000</b> Family.	The <b><u>out-of-pocket</u></b> limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.	
What is not included in the <u>out-of-pocket limit</u> ?	Pre-authorization penalties, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></b> .	
Does this plan use a <u>network</u> of <u>providers</u> ?	Yes. See <u>www.bcbstx.com</u> or call <b>1-800-810-2583</b> for a list of Network Providers.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some of the costs of covered services. Be aware, your in-network doctor or hospital may use a out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how the plan pays different kinds of <b>providers</b> .	
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <b>specialist</b> you choose without permission from this plan.	
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .	

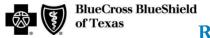
Questions: Call 1-800-521-2227 or visit us at <u>www.bcbstx.com/coverage</u>

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-756-4448 to request a copy. Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
  - <u>Coinsurance</u> is *your* share of the costs of a covered service, calculated as a percent of the <u>allowed amount</u> for the service. For example, if the health plan's <u>allowed amount</u> for an overnight hospital stay is \$1,000, your <u>coinsurance</u> payment of 20% would be \$200. This may change if you haven't met your <u>deductible</u>.
- The amount the plan pays for covered services is based on the <u>allowed amount</u>. If an out-of-network <u>provider</u> charges more than the <u>allowed</u> <u>amount</u>, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the <u>allowed</u> <u>amount</u> is \$1,000, you may have to pay the \$500 difference. (This is called <u>balance billing</u>.)
- The plan may encourage you to use Network **providers** by charging you lower **<u>deductibles</u>**, **<u>copayments</u>**, and <u>**coinsurance**</u> amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care	Primary care visit to treat an injury or illness	No Charge	30% coinsurance	
provider's office or clinic	Specialist visit	No Charge	30% coinsurance	none
	Other practitioner office visit	No Charge	30% coinsurance	
	Preventive care/screening/immunization	No Charge	30% coinsurance	There is No Charge for Out-of-Network immunizations from birth through the day of the 6th birthday.
If you have a toot	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance	
If you have a test	Imaging (CT/PET scans, MRIs)	No Charge	30% coinsurance	none

Questions: Call 1-800-521-2227 or visit us at <u>www.bcbstx.com/coverage</u>



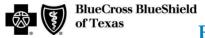
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 06/01/2015 - 05/31/2016

Coverage for: Individual/Family | Plan Type: HSA

Common Medical Event		Your cost if you use a Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition	Generic drugs	No Charge	No Charge	
your miless of condition	Preferred brand drugs	No Charge	No Charge	Benefit payments are based on a 30-day supply for retail and mail order. With
More information about prescription drug <u>coverage</u> is available at <u>www.bcbstx.com/memb</u> <u>er/rx_drugs.html</u>	Non-preferred brand drugs	No Charge	No Charge	appropriate Prescription Order, up to a 90-day supply. Preferred Drug List 1 applies.
	Specialty drugs	No Charge	No Charge	Benefit payments are based on a 30-day
				supply for retail only, no mail order. With appropriate Prescription Order, up to a 90-day supply. Preferred Drug List 1 applies.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	No Charge	30% coinsurance	none
surgery	Physician/surgeon fees No Charge	No Charge	30% coinsurance	
	Emergency room services	No Charge	No Charge	
If you need immediate medical attention	Emergency medical transportation	No Charge	No Charge	none
	Urgent care	No Charge	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	30% coinsurance	Preauthorization is required and there is a \$250 penalty if Out-of-Network is not preauthorized.
	Physician/surgeon fee	No Charge	30% coinsurance	none

Questions: Call 1-800-521-2227 or visit us at <u>www.bcbstx.com/coverage</u>



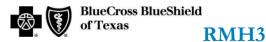
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 06/01/2015 - 05/31/2016

Coverage for: Individual/Family | Plan Type: HSA

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse	Mental/behavioral health outpatient services	No Charge	30% coinsurance	Certain services must be preauthorized; refer to benefit booklet for details.
needs	Mental/behavioral health inpatient services	No Charge	30% coinsurance	All services must be preauthorized; \$250 penalty for failure to preauthorize Out-of-Network
	Substance use disorder outpatient services	No Charge	30% coinsurance	Certain services must be preauthorized; refer to benefit booklet for details.
	Substance use disorder inpatient services	No Charge	30% coinsurance	All services must be preauthorized; \$250 penalty for failure to preauthorize Out-of-Network
If you are pregnant	Prenatal and postnatal care	No Charge	30% coinsurance	none
	Delivery and all inpatient services	No Charge	30% coinsurance	Preauthorization is only required if extension of minimum length of stay is requested.
If you need help recovering or have other special health needs	Home health care	No Charge	30% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required.
	Rehabilitation services	No Charge	30% coinsurance	Limited to combined 35 visits per year,
	Habilitation services	No Charge	30% coinsurance	including Chiropractic.
	Skilled nursing care	No Charge	30% coinsurance	Limited to 25 days per calendar year. Preauthorization is required.
	Durable medical equipment	No Charge	30% coinsurance	none
	Hospice service	No Charge	30% coinsurance	Preauthorization is required.

Questions: Call 1-800-521-2227 or visit us at <u>www.bcbstx.com/coverage</u>



Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 06/01/2015 - 05/31/2016

Coverage for: Individual/Family | Plan Type: HSA

	Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions	
	If your child needs dental or eye care	Eye exam	No Charge	30% coinsurance		
		Glasses	Not Covered	Not Covered	none	
dental of eye care	Dental check-up	Not Covered	Not Covered			

### **Excluded Services & Other Covered Services:**

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)				
<ul><li>Acupuncture</li><li>Bariatric surgery</li><li>Cosmetic surgery</li></ul>	<ul><li>Dental care (Adult)</li><li>Long term care</li><li>Private duty nursing</li></ul>	<ul><li>Termination of pregnancy</li><li>Weight loss programs</li></ul>		
Other Covered Services (This isn't	a complete list. Check your policy or plan document for other c	covered services and your costs for these services.)		
<ul><li>Chiropractic care</li><li>Hearing aids</li></ul>	<ul> <li>Infertility treatment (Invitro and artificial insemination are not covered unless shown in your plan document)</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul> <li>Routine eye care (Adult)</li> <li>Routine foot care (Only covered in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency)</li> </ul>		

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. 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 the plan at 1-800-521-2227. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <u>www.dol.gov/ebsa</u>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.

Questions: Call 1-800-521-2227 or visit us at www.bcbstx.com/coverage

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <a href="http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf">www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf</a> or call 1-855-756-4448 to request a copy.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit <u>www.bcbstx.com</u>, or contact U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit <u>www.dol.gov/ebsa/healthreform</u>.

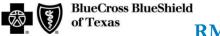
## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy** <u>does provide</u> minimum essential coverage.

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage <u>does meet</u> the minimum value standard for the benefits it provides.

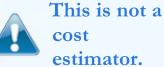
### Language Access Services:



**Coverage Examples:** 

## **About These Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



estimator.

Don't use these examples to estimate your actual costs under the plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having	a baby
(normal	delivery)

Amount owed to providers: \$7,540	
<ul> <li>Plan pays \$2,340</li> </ul>	
<b>Patient pays</b> \$5,200	
Sample care costs:	
Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540
Patient pays:	
Deductibles	\$5,000
Copays	\$0
Coinsurance	\$(
Limits or exclusions	\$200
Total	\$5,200

Coverage Period: 06/01/2015 - 05/31/2016 Coverage for: Individual/Family | Plan Type: HSA

## Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

**Amount owed to providers:** \$5,400

**Plan pays** \$320

■ Patient pays \$5,080

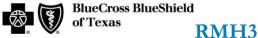
#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

### Patient pays:

Deductibles	\$5,000
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$5,080

Questions: Call 1-800-521-2227 or visit us at www.bcbstx.com/coverage



**Coverage Examples:** 

## **Questions and answers about Coverage Examples:**

# What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't 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 <u>deductibles</u>, <u>copayments</u>, and <u>coinsurance</u> can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't 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 can't 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'll 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'll pay in out-of-pocket costs, such as <u>copayments</u>, <u>deductibles</u>, and <u>coinsurance</u>. 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.