## Important Questions

### What is the overall deductible?

University Health Center (UHC) and University Counseling and Testing Center (UCTC), University Direct Contract Network participating providers: $0 person/$0 family | PacificSource Network (PSN) participating providers: $250 person/$750 family | Non-participating provider: $750 person/$2,000 family. Doesn’t apply to: Preventive, Participating provider Professional, Outpatient, Ambulance, Mental Health, Inpatient room and board, non-participating provider emergency room services, and pediatric dental check-ups. Rx drugs.

**Why this Matters:**
You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the deductible.

### Are there other deductibles for specific services?

Yes. Pediatric Dental Deductible for Non-participating providers: $750. There are no other specific deductibles.

**Why this Matters:**
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.

### Is there an out-of-pocket limit on my expenses?

Yes. University Health Center (UHC) and University Counseling and Testing Center (UCTC), University Direct Contract Network participating providers, PacificSource Network (PSN) participating providers: $3,000 person/$6,000 family | Non-participating provider: $6,350 person/$12,700 family

**Why this Matters:**
The out-of-pocket 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 out-of-pocket limit?

Premiums, balance-billed charges, and health care this plan doesn’t cover.

**Why this Matters:**
Even though you pay these expenses, they don’t count toward the out-of-pocket limit.

### Is there an overall annual limit on what the plan pays?

No.

**Why this Matters:**
The chart starting on page two describes any limits on what the plan will pay for specific covered services, such as office visits.

### Does this plan use a network of providers?

Yes. For a list of preferred providers, see PacificSource.com/uo or call 1-855-274-9814.

**Why this Matters:**
If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.

### Do I need a referral to see a specialist?

No.

**Why this Matters:**
You can see the specialist you choose without permission from this plan.

---

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UO SHIP: Comprehensive Medical–International Law Students

Coverage Period: 08/10/2016– 08/09/2017

Coverage for: Individual + Family | Plan Type: PPO

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

Are there services this plan doesn’t cover?

Yes.

Some of the services this plan doesn’t cover are listed on page 8. See your policy or plan document for additional 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 20% would be $200. 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 $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

### Common Medical Event Services You May Need

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a University Health Center (UHC) / University Counseling and Testing Center (UCTC) Provider</th>
<th>Your Cost If You Use a U of O Direct Contract Participating Provider</th>
<th>Your Cost If You Use a PSN Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>No charge</td>
<td>$20 copay/visit</td>
<td>$25 copay/visit + 20% coinsurance</td>
<td>Deductible + 30% coinsurance</td>
<td>--none--</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>No charge</td>
<td>$20 copay/visit</td>
<td>$25 copay/visit + 20% co-insurance</td>
<td>Deductible + 30% coinsurance</td>
<td>--none--</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>No charge</td>
<td>Not Available</td>
<td>Deductible + 20% coinsurance</td>
<td>Deductible + 30% coinsurance</td>
<td>Acupuncture/Chiropractic Care: limited to a combined $1,000/contract year. No coverage for homeopathic medicines, supplies, or massage therapy.</td>
</tr>
</tbody>
</table>

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<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>Not covered</td>
<td>Limited to: Routine Physicals: 13 visits ages 0-36 months and once /contract year ages 3+. Well Woman Visits: annually. Immunizations: CDC and USPSTF Preventive Care Grade A and B Recommended. Preventive Colonoscopy: Ages 50-75. High Risk Colonoscopy: Under age 50.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>Deductible + 30% coinsurance</td>
<td>—none—</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Not available</td>
<td>Not available</td>
<td>$100 copay/test + 20% coinsurance</td>
<td>Deductible + 30% coinsurance</td>
<td>Pre-authorization required.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Preventive: No charge Retail: $5 copay Mail: Not available</td>
<td>Preventive: No charge Retail: $15 copay Mail: $15 copay</td>
<td>Preventive: No charge Retail: $15 copay Mail: $15 copay</td>
<td>Not covered</td>
<td>Retail limited to 30-day supply. Mail limited to 30-day supply. Pre-authorization required for certain drugs. Select medications from the UHC/UCTC available for 90-day supply.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Retail: $15 copay Mail: Not available</td>
<td>Retail: $25 copay Mail: $25 copay</td>
<td>Retail: $25 copay Mail: $25 copay</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>
## UO SHIP: Comprehensive Medical–International Law Students

**Coverage Period:** 08/10/2016 – 08/09/2017

**Coverage for:** Individual + Family  |  **Plan Type:** PPO

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

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<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
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</thead>
</table>
| If you need drugs to treat your illness or condition | Non-preferred brand drugs | Retail: $30 copay  
Mail: Not available | Retail: $40 copay  
Mail: $40 copay | Retail: $40 copay  
Mail: $40 copay | Not covered | Retail limited to 30-day supply. Mail limited to 30-day supply. Pre-authorization required for certain drugs. Select medications from the UHC/UCTC available for 90-day supply. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Not available | $100 copay/visit + 10% coinsurance | $150 copay/visit + 20% coinsurance | Deductible + 30% coinsurance | Pre-authorization required |
| | Physician/surgeon fees | No charge | $100 copay/visit + 10% coinsurance | $150 copay/visit + 20% coinsurance | Deductible + 30% coinsurance | Pre-authorization required |
| If you need immediate medical attention | Emergency room services | Not available | $75 copay/visit + 10% coinsurance | Medical Emergency $75 copay/visit + 10% coinsurance  
Non-Emergency $150 copay/visit + 10% coinsurance | Medical Emergency $75 copay/visit + 10% coinsurance  
Non-Emergency $150 copay/visit + 30% coinsurance | Copay waived if admitted. Non-participating paid as participating if emergency medical condition. |

### Questions:
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## UO SHIP: Comprehensive Medical–International Law Students
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<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
</table>
| If you need immediate medical attention | Emergency medical transportation | Ground and Air: Not available | Ground: $50 copay/trip  
Air: Not available | Ground and Air: $100 copay/trip + 20% coinsurance | Ground and Air: $100 copay/trip + Deductible + 30% coinsurance | Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate. Non-participating air covered up to 200% of the Medicare allowance. |
| | Urgent care | Not available | $20 copay/visit | $25 copay/visit + 20% coinsurance | Deductible + 30% coinsurance | ---none--- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | Not available | $250 copay/admit + 10% coinsurance | $250 copay/admit + 20% coinsurance | Deductible + 30% coinsurance | Limited to semi-private room unless intensive or coronary care units, medically necessary isolation, or hospital only has private rooms. Pre-authorization required for some inpatient services. |
| | Physician/surgeon fee | Not available | $100 copay/visit + 10% coinsurance | $150 copay/visit + 20% coinsurance | Deductible + 30% coinsurance | ---none--- |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | No charge | $20 copay/visit | $25 co-pay/visit + 20% co-insurance | Deductible + 30% coinsurance | ---none--- |
| | Mental/Behavioral health inpatient services | Not available | $250 copay/admit + 10% coinsurance | $250 copay/admit + 20% coinsurance | Deductible + 30% coinsurance | Pre-authorization required. |
| | Substance use disorder outpatient services | No charge | $20 copay/visit | $25 copay/visit + 20% coinsurance | Deductible + 30% coinsurance | ---none--- |
| | Substance use disorder inpatient services | Not available | $250 copay/admit + 10% coinsurance | $250 copay/admit + 20% coinsurance | Deductible + 30% coinsurance | Pre-authorization required. |

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**UO SHIP: Comprehensive Medical–International Law Students**  
**Coverage Period:** 08/10/2016 – 08/09/2017

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<th>Your Cost If You Use a PSN Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Prenatal and postnatal care</td>
<td>Not available</td>
<td>10% coinsurance</td>
<td>Deductible + 20% coinsurance</td>
<td>Deductible + 30% coinsurance</td>
<td>Preventive prenatal: No coinsurance.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>Not available</td>
<td>$250 copay/admit + 10% coinsurance</td>
<td>$250 copay/admit + 20% coinsurance</td>
<td>Deductible + 30% coinsurance</td>
<td>Practitioner delivery and hospital visits are covered under prenatal and postnatal care. Facility is covered the same as any other hospital services. Coverage includes termination of pregnancy.</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>Not available</td>
<td>10% coinsurance</td>
<td>Deductible + 20% coinsurance</td>
<td>Deductible + 30% coinsurance</td>
<td>No coverage for private duty nursing or custodial care. Pre-authorization required.</td>
</tr>
</tbody>
</table>
| | Rehabilitation services | Inpatient: Not available  
Outpatient: No charge | Inpatient: 10% coinsurance  
Outpatient: $20 copay/visit + 10% coinsurance | Inpatient: Deductible + 20% coinsurance  
Outpatient: $25 copay/visit + 20% coinsurance | Inpatient: Deductible + 30% coinsurance  
Outpatient: Deductible + 30% coinsurance | Inpatient: Limited to 30 days/contract year unless medically necessary to treat a mental health diagnosis. Pre-authorization required. Treatment of head or spinal cord injuries are covered for up to 60 days per contract year. Outpatient: Limited to a combined maximum of 30 visits/contract year unless medically necessary to treat a mental health diagnosis. No coverage for recreation therapy. |

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

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>If you need help recovering or have other special health needs</th>
<th>If your child needs dental or eye care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Habilitation services</td>
<td>Not available 10% coinsurance 20% coinsurance Limited to 30 days/contract year unless medically necessary to treat a mental health diagnosis. Pre-authorization required. Outpatient: Limited to a combined maximum of 30 visits/contract year unless medically necessary to treat a mental health diagnosis. No coverage for recreation therapy.</td>
<td>Not available 10% coinsurance Deductible + 30% coinsurance Limited to 60 days/contract year. No coverage for custodial care. Pre-authorization required.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>Not available 20% coinsurance Deductible + 30% coinsurance Limited to: $5,000/contract year; pre-authorization required for power-assisted wheelchairs; one pair/contract year for glasses or contact lenses to correct a specific vision defect from a severe medical or surgical problem; one/ear every 48 months for hearing aids; one breast pump/pregnancy; and $500/contract year for wig for chemotherapy or radiation therapy. Pre-authorization required if over $800.</td>
<td>Not available 10% coinsurance Deductible + 30% coinsurance Pre-authorization required. No coverage for private duty nursing.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance 20% coinsurance Deductible + 30% coinsurance</td>
<td>No charge No charge Deductible + 25% coinsurance One routine eye exam/contract year through age 18 when provided by licensed provider.</td>
</tr>
<tr>
<td>Hospice service</td>
<td>Not available 10% coinsurance Deductible + 30% coinsurance</td>
<td>Not available 10% coinsurance Deductible + 30% coinsurance</td>
</tr>
</tbody>
</table>

### Questions:

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# UO SHIP: Comprehensive Medical–International Law Students

**Coverage Period:** 08/10/2016–08/09/2017

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

**Coverage for:** Individual + Family | Plan Type: PPO

## Common Medical Event

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<th>Services You May Need</th>
<th>Your Cost If You Use a University Health Center (UHC) / University Counseling and Testing Center (UCTC) Provider</th>
<th>Your Cost If You Use a U of O Direct Contract Participating Provider</th>
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<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td>Glasses: Not available</td>
<td>No charge</td>
<td>No charge</td>
<td>Deductible + 25% coinsurance</td>
<td>One pair of lenses and frames from the Pediatric Exchange Collection/contract year or Contact lenses in lieu of eyeglasses through age 18.</td>
</tr>
<tr>
<td></td>
<td>Dental check-up: No Charge</td>
<td>No Charge</td>
<td>No Charge</td>
<td>No Charge</td>
<td>Routine and problem focused dental exams are covered for members through age 18.</td>
</tr>
</tbody>
</table>

## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover

- Bariatric surgery
- Cosmetic surgery
- Custodial care
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Massage therapy
- Non-emergency care when traveling outside the U.S. (if received in country of citizenship)
- Outpatient recreational therapy
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care, other than with diabetes mellitus

### Other Covered Services

- Acupuncture
- Chiropractic care
- Hearing aids
- Weight loss programs

## Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

### Questions:

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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 the PacificSource Customer Service Department at 1-855-274-9814.

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 does provide 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 does meet the minimum value standard for the benefits it provides.

Language Access Services:

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
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.

This is not a cost estimator.

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

See the next page for important information about these examples.

### Having a baby (normal delivery)

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount owed to providers</td>
<td>7,540</td>
</tr>
<tr>
<td>Plan pays</td>
<td>6,140</td>
</tr>
<tr>
<td>Patient pays</td>
<td>1,400</td>
</tr>
</tbody>
</table>

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 care: 40

Total: 7,540

Patient pays:

- Deductibles: 300
- Copays: 400
- Coinsurance: 500
- Limits or exclusions: 200

Total: 1,400

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount owed to providers</td>
<td>5,400</td>
</tr>
<tr>
<td>Plan pays</td>
<td>3,920</td>
</tr>
<tr>
<td>Patient pays</td>
<td>1,480</td>
</tr>
</tbody>
</table>

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 care: 100

Total: 5,400

Patient pays:

- Deductibles: 300
- Copays: 900
- Coinsurance: 200
- Limits or exclusions: 80

Total: 1,480

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact 1-855-274-9814.

Questions: Call 1-855-274-9814 or visit us at PacificSource.com.

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Questions and answers about the 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 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 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 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.