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 www.yalehealth.yale.edu or by calling 1-203-432-0246.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the chart starting on page 2 for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes, $100 individual/$300 family for speech therapy. There are no other specific deductibles.</td>
<td>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.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. $3,000/individual; $6,000/family.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. Call 1-203-432-0246 to obtain information about medical network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>Yes.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan’s permission before you see the specialist.</td>
</tr>
<tr>
<td>Are there services this plan doesn't cover?</td>
<td>Yes.</td>
<td>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.</td>
</tr>
</tbody>
</table>

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

#### Coverage Period: 1/1/2017 — 12/31/2017

**Coverage for:** All Coverage Tiers | **Plan Type:** YHP

- **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 network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an:</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-network Provider</td>
<td>Out-of-network Provider</td>
</tr>
<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>$0</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$0</td>
<td>$0 if preauthorized; otherwise not covered</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$0; Chiropractic reimbursed up to $50 per office visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>$0</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$0</td>
<td>$0 if preauthorized or emergency; otherwise not covered</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an:</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-network Provider</td>
<td>Out-of-network Provider</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td></td>
<td>$0</td>
<td>$0 if preauthorized or emergency; otherwise not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Preauthorization required for out-of-network care if non-emergency. If preauthorization is not obtained, service is not covered. A $50 late cancellation/no-show fee may apply at Yale Health Center if appointment is missed.</td>
</tr>
</tbody>
</table>

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Yale Health Plan: Faculty, Managerial & Professional, Post-doctoral Associates and Fellows  
**Coverage Period:** 1/1/2017 — 12/31/2017  
**Coverage for:** All Coverage Tiers | **Plan Type:** YHP  

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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an:</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-network Provider</td>
<td>Out-of-network Provider</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 prescription</td>
<td>Retail:</td>
<td>Greater of 20% of the price of the drug or the applicable Tier 1 copay (plan reimburses the difference)</td>
</tr>
<tr>
<td></td>
<td>drugs</td>
<td>$5 copay (up to 31 -day prescription)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$10 copay (32-62 –day prescription)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$10 copay (63-100 –day prescription)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mail:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$10 copay/prescription (90-100 –day prescription)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Greater of 20% of the price of the drug or the applicable Tier 1 copay (plan reimburses the difference)</td>
<td>If generic is available and brand is dispensed, member pays applicable copay plus cost difference.</td>
</tr>
<tr>
<td></td>
<td>Tier 2 prescription</td>
<td>Retail:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>drugs</td>
<td>$30 copay (up to 31 -day prescription)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$60 copay (32-62 –day prescription)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$60 copay (63-100 –day prescription)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mail:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$60 copay/prescription (90-100 –day prescription)</td>
<td></td>
</tr>
</tbody>
</table>

More information about prescription drug coverage is available at www.yalehealth.yale.edu or call 1-203-432-0246

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# Yale Health Plan: Faculty, Managerial & Professional, Post-doctoral Associates and Fellows

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

**Coverage Period:** 1/1/2017 — 12/31/2017  
**Coverage for:** All Coverage Tiers | **Plan Type:** YHP

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an:</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-network Provider</td>
<td>Out-of-network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Retail:</td>
<td>Greater of 20% of the price of the drug or the applicable Tier 3 copay (plan reimburses the difference)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 40% coinsurance (up to 31-day prescription)</td>
<td>$50 minimum; $100 maximum</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 40% coinsurance (32-62 day prescription)</td>
<td>$100 minimum; $200 maximum</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 40% coinsurance (63-100 day prescription)</td>
<td>$100 minimum; $200 maximum</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mail:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>40% coinsurance/ prescription (90-100 day prescription)</td>
<td>$100 minimum; $200 maximum</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$200 copay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$0</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$100 copay/visit</td>
<td>$100 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

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<th>Your Cost If You Use an:</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-network Provider</td>
<td>Out-of-network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$0 (8am to 6pm M-F)</td>
<td>Facilities in Connecticut are not covered. Facilities outside of Connecticut: $50 copay/visit</td>
</tr>
<tr>
<td>Urgent care</td>
<td></td>
<td>$20 copay for after-hours visits at Yale Health Center including visits on holidays or recess days</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$300 copay/admission</td>
<td>$300 copay/admission if preauthorized or emergency; otherwise not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>$0</td>
<td>$0 if preauthorized or emergency; otherwise not covered</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$0</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>$300 copay/admission</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$0</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>$300 copay/admission</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>$0</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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Yale Health Plan: Faculty, Managerial & Professional, 
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Coverage Period: 1/1/2017 — 12/31/2017  
Coverage for: All Coverage Tiers | Plan Type: YHP  
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an:</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-network Provider</td>
<td>Out-of-network Provider</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>$300 copay/admission</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other</td>
<td>Home health care</td>
<td>$0</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
| special health needs                        | Rehabilitation services                           | Inpatient: $300 copay/admission  
Outpatient: $0, but for  
• Speech therapy: 20% coinsurance  
• Cardiac rehabilitation: $10 copay/visit | Not covered | Speech therapy that is not part of inpatient rehabilitation or home health care is covered after $100 individual/$300 family deductible up to a maximum of $4,000 per injury. Cardiac rehabilitation limited to 36 visits/calendar year. |
|                                              | Habilitation services                             | Inpatient: $300 copay/admission  
Outpatient: $0, but for  
• Speech therapy: 20% coinsurance | Not covered | Includes physical, occupational, and speech therapy; must be medically necessary.  
Speech therapy that is not part of inpatient habilitation or home health care is subject to deductible and coinsurance. There is a 90 visit limit per year for children under 12 with developmental delays including autism spectrum disorders. Other autism spectrum disorder therapies are not covered. |
|                                              | Skilled nursing care                              | $0                       | Not covered                                                                             | Limited to 120 visits/calendar year; covered only as part of home health care benefit.  
Otherwise, not covered.                                                                         |
|                                              | Durable medical equipment                        | $0                       | Not covered                                                                             |                                                                                           |
|                                              | Hospice service                                  | $0                       | Not covered                                                                             | Limited to 60 days.                                                                         |
| If your child needs dental                   | Eye exam                                         | $0                       | Not covered                                                                             | Limited to 1 exam per 12-month period.                                                      |

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Common Medical Event | Services You May Need | Your Cost If You Use an: | Limitations & Exceptions
|------------------|-----------------|------------------|------------------
|                  |                 | In-network Provider | Out-of-network Provider |
| or eye care      | Glasses         | Not covered        | Not covered       | none
|                  | Dental check-up| Not covered        | Not covered       | none

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.)

- Cosmetic surgery
- Dental care (Adult + Children)
- Long-term care
- Most coverage provided outside the United States
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

**Other Covered Services** (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (in lieu of anesthesia)
- Bariatric surgery
- Chiropractic care
- Hearing aids (for children under age 12)
- Infertility treatment
- Routine eye care (Adult)

**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 1-203-432-5552. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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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: 1-203-432-0246 or visit us at www.yalehealth.yale.edu or contact the Department of Labor’s Employee Benefit and Security Administration at 1-866-444-EBSA (3272). Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform.

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.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
# Yale Health Plan: Faculty, Managerial & Professional, Post-doctoral Associates and Fellows

**Coverage Period:** 1/1/2017 — 12/31/2017  
**Coverage for:** All Coverage Tiers | **Plan Type:** YHP

## 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.

---

#### Having a baby  
(normal delivery)

- **Amount owed to providers:** $7,540  
- **Plan pays:** $7,080  
- **Patient pays:** $460

**Sample care costs:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copays</td>
<td>$310</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$150</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$460</strong></td>
</tr>
</tbody>
</table>

---

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

- **Amount owed to providers:** $5,400  
- **Plan pays:** $5,120  
- **Patient pays:** $280

**Sample care costs:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copays</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$80</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$280</strong></td>
</tr>
</tbody>
</table>

---

**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.

---

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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/healthreform or www.cciioo.cms.gov, or call 1-203-432-0246 to request a copy.
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.