This is only a summary. Please read the FEHB Plan brochure (RI 71-015) that contains the complete terms of this plan. All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure. Benefits may vary if you have other coverage, such as Medicare. You can get the FEHB Plan brochure at www.SambaPlans.com or by calling 1-800-638-6589.

### Important Questions

<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>$350/self only&lt;br&gt;$1,050/self and family</td>
<td>You must pay all the costs up to the <strong>deductible</strong> amount before this plan begins to pay for certain covered services you use. <strong>Copayments</strong> and <strong>coinsurance</strong> amounts do not count toward your <strong>deductible</strong>, which generally starts over January 1st. When a covered service or supply is subject to a <strong>deductible</strong>, only the Plan allowance for the service or supply counts toward the <strong>deductible</strong>. See the chart starting on page 2 for how much you pay for covered services after you meet the <strong>deductible</strong> and for which services are subject to the <strong>deductible</strong>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>You do not have to meet <strong>deductible</strong> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>PPO: $5,000 person/$7,000 family; Non-PPO: $7,000 person/$9,000 family</td>
<td>The <strong>out-of-pocket limit</strong>, or catastrophic maximum, is the most you could pay during the 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, prescription copays/coinsurances, balance-billed charges, expenses this plan doesn’t cover</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit</strong>.</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 <strong>specific</strong> covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. For a list of in-network or preferred providers visit <a href="http://www.SambaPlans.com">www.SambaPlans.com</a></td>
<td>If you use an in-network doctor or other health care <strong>provider</strong>, 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 <strong>provider</strong> for some services. We use the terms <strong>preferred</strong> or participating for <strong>providers</strong> in our <strong>network</strong>. See the chart starting on page 2 for how this plan pays different kinds of <strong>providers</strong>.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No</td>
<td>You can see the <strong>specialist</strong> you choose without permission from this plan.</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 5. See this plan’s FEHB brochure for additional information about <strong>excluded services</strong>.</td>
</tr>
</tbody>
</table>
### SAMBA Health Benefit Plan: Standard Option

**Summary of Benefits and Coverage**

**Coverage Period:** 01/01/2014 – 12/31/2014

**Coverage for:** Self Only -or- Self and Family | **Plan Type:** PPO

---

- **Copayments** are fixed dollar amounts (for example, $20) 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 15% would be $150. 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.

---

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider (plus you may be balance billed)</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>$20/visit</td>
<td>35% coinsurance</td>
<td>Acupuncture and chiropractic manipulations are limited to 26 visits per person, per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20/visit</td>
<td>35% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>35% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>Quest Labs &amp; LabCorp services are paid at 100%. See page 29 of the Plan brochure.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>Precertification is required.</td>
</tr>
</tbody>
</table>

---

**Questions:** Call 1-800-638-6589 or visit us at www.SambaPlans.com.
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# SAMBA Health Benefit Plan: Standard Option

**Coverage Period:** 01/01/2014 – 12/31/2014

**Coverage for:** Self Only -or- Self and Family | **Plan Type:** PPO

## Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use a Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider (plus you may be balance billed)</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
</table>
| **Generic drugs**     | Retail: $8/prescription
Mail: $15/prescription | Retail: $8/prescription
Mail: $15/prescription
Plus difference in cost had you used an in-network pharmacy | Retail purchases are limited to initial fill (up to 30-day supply) and one refill.
Mail order is limited to a 90-day supply
A 90-supply of maintenance drugs can be purchased at a CVS retail pharmacy; see page 68 of the Plan brochure. |
| **Preferred brand drugs** | Retail: 30% ($40 min./$70 max.)
Mail: 30% ($80 min./$150 max.) | Retail: 30% ($40 min./$70 max.)
Mail: 30% ($80 min./$150 max.)
Plus difference in cost had you used an in-network pharmacy | Retail purchases are limited to initial fill (up to 30-day supply) and one refill.
Mail order is limited to a 90-day supply
A 90-supply of maintenance drugs can be purchased at a CVS retail pharmacy; see page 68 of the Plan brochure. |
| **Non-preferred brand drugs** | Retail: 40% ($60 min./$110 max.)
Mail: 40% ($120 min./$275 max.) | Retail: 40% ($60 min./$110 max.)
Mail: 40% ($120 min./$275 max.)
Plus difference in cost had you used an in-network pharmacy | Retail purchases are limited to initial fill (up to 30-day supply) and one refill.
Mail order is limited to a 90-day supply
A 90-supply of maintenance drugs can be purchased at a CVS retail pharmacy; see page 68 of the Plan brochure. |
| **Specialty drugs**   | $120/30-day supply; $240/60-day supply; $360/90-day supply | Specialty drugs must be obtained through the CVS Caremark Pharmacy system | Preauthorization is required. |

## If you need drugs to treat your illness or condition


- **Generic drugs**
  - Retail: $8/prescription
  - Mail: $15/prescription
- **Preferred brand drugs**
  - Retail: 30% ($40 min./$70 max.)
  - Mail: 30% ($80 min./$150 max.)
- **Non-preferred brand drugs**
  - Retail: 40% ($60 min./$110 max.)
  - Mail: 40% ($120 min./$275 max.)
- **Specialty drugs**
  - $120/30-day supply; $240/60-day supply; $360/90-day supply

## If you have outpatient surgery

- **Facility fee (e.g., ambulatory surgery center)**
  - Retail: 15% coinsurance
  - Mail: 35% coinsurance
- **Physician/surgeon fees**
  - Retail: 15% coinsurance
  - Mail: 35% coinsurance

Some services require preauthorization.

## If you need immediate medical attention

- **Emergency room services**
  - Retail: 15% coinsurance
  - Mail: 15% coinsurance
- **Emergency medical transportation**
  - Retail: 15% coinsurance
  - Mail: 35% coinsurance
- **Urgent care**
  - Retail: 15% coinsurance
  - Mail: 35% coinsurance

Covered services rendered within 72 hours of an accidental injury are paid in full; see page 62 of the Plan brochure.

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**SAMBA Health Benefit Plan: Standard Option**  
**Summary of Benefits and Coverage**  
**Coverage Period:** 01/01/2014 – 12/31/2014  
**Coverage for:** Self Only -or- Self and Family  
**Plan Type:** PPO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider (plus you may be balance billed)</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$150/day; $450 per confinement max. Nothing for room &amp; board; 15% for other hospital charges</td>
<td>$200/day; $600 per confinement max. 35% for room &amp; board and other hospital charges</td>
<td>Preauthorization is required</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>Some services require preauthorization</td>
</tr>
<tr>
<td><strong>If you have mental health, behavioral health, or substance abuse needs</strong></td>
<td>Mental/Behavioral health outpatient services</td>
<td>$20 copayment/visit for office visits 15% coinsurance other outpatient services</td>
<td>35% coinsurance</td>
<td>A treatment plan is required prior to the 9th visit.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>$150/day; $450 per confinement max. Nothing for room &amp; board; 15% for other hospital charges</td>
<td>$200/day; $600 per confinement max. 35% for room &amp; board and other hospital charges</td>
<td>Preauthorization is required</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$20 copayment/visit for office visits 15% coinsurance other outpatient services</td>
<td>35% coinsurance</td>
<td>A treatment plan is required prior to the 9th visit.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>$150/day; $450 per confinement max. Nothing for room &amp; board; 15% for other hospital charges</td>
<td>$200/day; $600 per confinement max. 35% for room &amp; board and other hospital charges</td>
<td>Preauthorization is required</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Prenatal and postnatal care</td>
<td>Nothing</td>
<td>35% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>Nothing</td>
<td>Per confinement: $200/day; $600 max.; plus 35% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

**Questions:** Call 1-800-638-6589 or visit us at www.SambaPlans.com.  
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## SAMBA Health Benefit Plan: Standard Option

**Summary of Benefits and Coverage**

**Coverage for:** Self Only - or- Self and Family | **Plan Type:** PPO

**Coverage Period:** 01/01/2014 – 12/31/2014

### 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 Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider (plus you may be balance billed)</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>15% coinsurance</td>
<td>50% coinsurance</td>
<td>Private duty nursing care limited to 25 visits per year; home health aides are not covered. Preauthorization is required.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>15% coinsurance</td>
<td>50% coinsurance/physical &amp; occupational therapy 35% coinsurance/speech therapy</td>
<td>Physical/occupational therapy limited to 50 visits per year Speech therapy requires preauthorization and is limited to 30 visits per year</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>All charges</td>
<td>All charges</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>Skilled nursing care facility limited to 5 days per confinement</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>15% coinsurance</td>
<td>50% coinsurance</td>
<td>Preauthorization is required.</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>Inpatient care limited to 14 days per year</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>All charges</td>
<td>All charges</td>
<td>Benefits are only available if treating an accidental injury or medical condition; see page 40 of the Plan brochure</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>All charges</td>
<td>All charges</td>
<td>Benefits are only available if required as a direct result of an accidental injury or intraocular surgery; see page 40 of the Plan brochure</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>All charges</td>
<td>All charges</td>
<td></td>
</tr>
</tbody>
</table>

### Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn’t a complete list. Check this plan’s FEHB brochure for other excluded services.)

- Cosmetic surgery (except to treat a congenital anomaly, an accidental injury or illness, or breast reconstruction following a mastectomy; page 50 of the Plan brochure)
- Dental care (Adult) (except treatment of an accidental injury to sound natural teeth; page 75 of the Plan brochure)
- Infertility treatment (except as noted on page 36 of the Plan brochure)
- Long-term care (page 59 of the Plan brochure)
- Routine eye care (Adult) (page 40 of the Plan brochure)

### Questions:

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**SAMBA Health Benefit Plan: Standard Option**

**Coverage for:** Self Only -or- Self and Family | **Plan Type:** PPO

**Coverage Period:** 01/01/2014 – 12/31/2014

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### Other Covered Services

(This isn’t a complete list. Check this plan's FEHB brochure for other covered services and your costs for these services.)

- Acupuncture (page 45 of the Plan brochure)
- Diabetic foot care (page 41 of the Plan brochure)
- Chiropractic care (page 44 of the Plan brochure)
- Hearing aids (page 40 of the Plan brochure)
- Outpatient private duty nursing (page 44 of the Plan brochure)
- Covered services rendered outside the U.S. (page 77 of the Plan brochure)
- Weight loss programs (when prescribed by a physician and rendered by a covered provider; page 46 of the Plan brochure)
- Bariatric surgery (prior approval is required; see page 48 of the Plan brochure)

---

**Your Rights to Continue Coverage:**

If you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, to convert to an individual policy, and to receive temporary continuation of coverage (TCC). Your TCC rights will 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. An individual policy may also provide different benefits than you had 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, see the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-1800-638-6589 or visit www.opm.gov.insure/health.

**Your Appeal Rights:**

If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, “How you get care,” and Section 8 “The disputed claims process,” in your plan's FEHB brochure. If you need assistance, you can contact: SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800 or call 1-800-638-6589 or 301-984-1440 (for TDD, use 301-984-4155).

**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.” **Coverage under this plan qualifies as 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). **The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.**

---

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Language Access Services:  
[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-638-6589.  
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-638-6589.  
[Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwijjigo holne’ 1-800-638-6589.

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

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### 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)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,380
- **Patient pays:** $160

**Sample care costs:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</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>$7,540</td>
</tr>
</tbody>
</table>

**Patient pays:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$</td>
</tr>
<tr>
<td>Copays</td>
<td>$10</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$150</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$160</td>
</tr>
</tbody>
</table>

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,580
- **Patient pays:** $1,820

**Sample care costs:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</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>$5,400</td>
</tr>
</tbody>
</table>

**Patient pays:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$350</td>
</tr>
<tr>
<td>Copays</td>
<td>$330</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,100</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$1,820</td>
</tr>
</tbody>
</table>

**Questions:** Call 1-800-638-6589 or visit us at www.SambaPlans.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.