UnitedHealthcare Oxford

OXFORD HEALTH INSURANCE, INC.
DIRECT PLAN
SUMMARY OF COVERAGE
FREEDOM NETWORK
ABEL HR, INC.

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
FINANCIAL			
Deductible:	Single	$1,000	$2,000
	Family	$2,000	$4,000
Coinsurance		10%	40%
Maximum Out-of-Pocket:	Single	$2,500	$5,000
(Including Deductible)	Family	$5,000	$10,000
Financial Accumulation Period:		Calendar Year	Calendar Year
Out-of-Network Reimbursement:		Not Applicable	Standard UCR[1]
Please Note: All Copayments, Deductibles, and Coinsurance (medical and prescription) paid for In-Network Covered Services contribute to the In-Network, Out-of-Pocket Maximum.			
PREVENTIVE CARE			
Adult Preventive Care		No Charge	Deductible & 40% Coinsurance
Infant and Pediatric Preventive Care		No Charge	Subject to 40% Coinsurance
OUTPATIENT CARE			
Primary Care Physician Office Visits		$25 copay per visit	Deductible & 40% Coinsurance
Specialist Office Visits		$40 copay per visit	Deductible & 40% Coinsurance
Outpatient Facility Surgery**		Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Laboratory Services Participating**		No Charge	Deductible & 40% Coinsurance
(See your Certificate of Coverage for additional Lab details)			
MRIs, MRAs, CT Scans, and PET Scans**		Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Radiology Services**		Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Services performed at a non-participating Ambulatory Surgical centers are reimbursed at Oxford's Fee Schedule and therefore may result in significant out of pocket costs.			
HOSPITAL CARE			
Physician's and Surgeon's Services **		Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Semi-Private Room and Board **		Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
All Drugs and Medication		Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Services performed at a non-participating Ambulatory Surgical centers are reimbursed at Oxford's Fee Schedule and therefore may result in significant out of pocket costs.			
EMERGENCY CARE			
Ambulance Service When Medically Necessary**		Deductible & 10% Coinsurance	Deductible & 10% Coinsurance
At Hospital Emergency Room		$100 per visit, waived if admitted	$100 per visit, waived if admitted
(If member is admitted to the hospital, notification is required)			
Emergency Care in Urgi-Center		$40 copay per visit	Deductible & 40% Coinsurance
MATERNITY CARE			
Routine Prenatal and Post-Natal Care **		No Charge	Deductible & 40% Coinsurance
Hospital Services for Mother and Child **		Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
SKILLED NURSING FACILITY			
30 Days per Calendar Year**		Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
HOSPICE CARE (180 days per lifetime combined Inpatient & Home)			
Inpatient Care**		Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Home Hospice**		Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
HOME HEALTH CARE			
Home Care Visits - 60 Visits per Calendar Year**		Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Physician House Calls**		$40 copay per visit	Deductible & 40% Coinsurance
SUBSTANCE USE DISORDER SERVICES			
Inpatient Rehabilitation**		Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Office Visits or Outpatient Rehabilitation		$40 copay per visit	Deductible & 40% Coinsurance
Outpatient Partial Hospitalization		Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
MENTAL HEALTH CARE			
Inpatient Care**		Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Office Visits or Outpatient Care		$40 copay per visit	Deductible & 40% Coinsurance
Outpatient Partial Hospitalization		Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
ALLERGY CARE			
Testing and Treatment**		$40 copay per visit	Deductible & 40% Coinsurance
CHIROPRACTIC CARE			
Chiropractic Care**		$30 copay per visit	Deductible & 50% Coinsurance
Out-of-Network coverage limited to $500 per Calendar Year per Member			

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
SHORT TERM REHAB & HABILITATIVE SERVICES		
60 Inpatient Days per Calendar Year**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
60 combined Outpatient Visits per Calendar Year**	$40 copay per visit	Deductible & 40% Coinsurance
DURABLE MEDICAL EQUIPMENT		
Unlimited** *(Precertification required for items over $500)*	No Charge	Deductible & 40% Coinsurance
HEARING AIDS		
Hearing Aids (Age 15 & under) - Limited to 1 hearing aid for each hearing impaired ear every 24 months.	No Charge	Deductible & 40% Coinsurance
Hearing Aids (Age 16 & over) - Limited to $5,000 for each hearing impaired ear every 24 months.	No Charge	Deductible & 40% Coinsurance
MEDICAL SUPPLIES		
Medical Supplies When Medically Necessary**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
EXERCISE FACILITY		
Subscriber	$200 reimbursement per 6 month period	$200 reimbursement per 6 month period
Spouse	$100 reimbursement per 6 month period	$100 reimbursement per 6 month period
INFERTILITY TREATMENT		
Specialist Office Visits**	$40 copay per visit	Deductible & 40% Coinsurance
Outpatient Facility Services**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Inpatient Facility Services**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
INFERTILITY MEDICATIONS		
Infertility Medications**	Covered subject to the applicable Prescription Drug Out-of-Pocket Expense.	Deductible & 40% Coinsurance
OUTPATIENT PRESCRIPTION DRUGS - RETAIL		
The Prescription Drug Benefit is based on a per Calendar Year Limit for any applicable deductibles and/or maximum limits.		
Tier 1	$15 copay	Covered at Participating Pharmacies Only
Tier 2	$35 copay	Covered at Participating Pharmacies Only
Tier 3	$75 copay	Covered at Participating Pharmacies Only
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER		
Tier 1	$30 copay	Covered at Participating Pharmacies Only
Tier 2	$70 copay	Covered at Participating Pharmacies Only
Tier 3	$150 copay	Covered at Participating Pharmacies Only

DEPENDENT ELIGIBILITY:

Eligible dependents include the employee's spouse and dependent children until the child reaches age 26.
Benefits discontinue at the end of the Calendar Year.
Domestic Partners covered with proper documentation.

** These services require **precertification** through Oxford. Members must call Oxford at 1-800-444-6222 at least 14 days in advance of request of treatment to request precertification.
**Mental health and substance use disorder services can be precertified through Oxford's Behavioral Health Department by calling 1-800-201-6991.

Please Note: This sample summary of coverage is provided for informational purposes only. The applicable Summary of Benefits will be issued to eligible enrolled members as part of the Certificate of Coverage. Coverage is subject to the terms and conditions of the Certificate.

Refer to the Certificate of Coverage for a more complete listing of all benefits, limitations, and exclusions which include, among other services not authorized by Oxford, cosmetic surgery, routine foot care, custodial care, personal comfort or convenience items, private or special duty nursing, learning and behavioral disorders, Worker's Compensation, military service-related conditions, or, unless otherwise stated, dental services and vision correction services and supplies.

[1] The Group has selected an Out-of-Network Reimbursement Amount for out-of-network benefits at the 70th percentile amount reported by the FAIR Health Benchmarks database published by FAIR Health, Inc. (when applicable). We will pay the lesser of: the UCR Fee Schedule, the amount charged, or the amount the provider agrees to accept. This applies to all out-of-network Covered Services except for those noted below:
The following out-of-network services, supplies and drugs are reimbursed at the lesser of: the specified percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare reimbursement, the amount charged, or the amount the provider agrees to accept:

- **Inpatient & Outpatient Hospital 150%**
- **Free-Standing Ambulatory Surgical Centers 225%**
- **Free-Standing Lab & Radiology Services 150%**

"Free Standing" means the services were provided in a facility that is dedicated to providing that particular service (e.g., imaging centers, labs that are not part of a hospital and are where hospitals and other providers send specimens for analysis).

UnitedHealthcare/Oxford[1]: Direct Plan Freedom PLAN 19 - FREEDOM DIRECT

Coverage Period: 11/01/2016-10/31/2017

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

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 welcometouhc.com/oxford or by calling the Member Service number listed on the back of your ID card.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$1,000** Individual/**$2,000** Family Non-Network: **$2,000** Individual/**$4,000** Family Per calendar year. Prescription drugs, and services listed below with Copays and "No Charge" do not apply to the **deductible**.	You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the **deductible** 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 **deductible**.
Are there other deductibles for specific services?	No, there are no other **deductibles**.	Because you don't have to meet **deductibles** for specific services, this plan starts to cover costs sooner.
Is there an out-of-pocket limit on my expenses?	Yes, Network: **$2,500** Individual/**$5,000** Family Non-Network: **$5,000** Individual/**$10,000** Family	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, health care this plan doesn't cover and **penalties for failure to obtain pre-authorization for services**.	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, this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, this plan uses **network providers**. If you use a non-network **provider** your cost may be more. For a list of **network providers**, see welcometouhc.com/oxford or call 1-800-444-6222.	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. Plans use the terms **in-network**, preferred, or participating to refer to **providers** in their network.
Do I need a referral to see a specialist?	No.	You can see the **specialist** 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 **excluded services**.

[1]Oxford HMO products are underwritten by Oxford Health Plans (NY), Inc., Oxford Health Plans (NJ), Inc. and Oxford Health Plans (CT), Inc. Oxford insurance products are underwritten by Oxford Health Insurance, Inc. Administrative services provided by Oxford Health Plans LLC.

Questions: Call 1-800-444-6222 or oxfordhealth.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at dol.gov/ebsa/healthreform or cciio.cms.gov, or call the telephone numbers above to request a copy. **This is only a summary.** It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.

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

- **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	Your Cost if You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	40% co-ins after ded	---none---
	Specialist visit	$40 copay per visit	40% co-ins after ded	---none---
	Other practitioner office visit	$30 copay per visit	50% co-ins after ded	Cost Share applies for only Manipulative (Chiropractic) Services. Pre-Authorization required Non-Network or benefit reduces to 50% of allowed. Non-Network max benefit of $500 per calendar year.
	Preventive care/screening/immunization	No Charge	40% co-ins after ded	Deductible does not apply for well baby/well child. Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	40% co-ins after ded	Pre-Authorization required Non-Network for Sleep Studies or benefit reduces to 50% of allowed. Network Radiology Covered at Deductible then 10% co-ins.
	Imaging (CT/PET scans, MRIs)	10% co-ins after ded	40% co-ins after ded	Pre-Authorization required Non-Network or benefit reduces to 50% of allowed.

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

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at oxfordhealth.com.**	Tier 1 - Your Lowest-Cost Option	Retail: $15 copay Mail-Order: $30 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 90-day supply. Copays shown are for a 30-day supply. Mail-Order: Up to a 90-day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a pre-authorization requirement. Tier 1 Contraceptives covered at No Charge. Oral chemotherapeutic agents are covered at No Charge.
	Tier 2 - Your Mid-Range Cost Option	Retail: $35 copay Mail-Order: $70 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail: $75 copay Mail-Order: $150 copay	Not Covered	
	Tier 4 - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-ins after ded	40% co-ins after ded	Pre-Authorization required Non-Network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	10% co-ins after ded	40% co-ins after ded	Pre-Authorization required Non-Network or benefit reduces to 50% of allowed.
If you need immediate medical attention	Emergency room services	$100 copay per visit	$100 copay per visit	Copay waived if admitted to the hospital.
	Emergency medical transportation	10% co-ins after ded*	10% co-ins after ded*	*Network Deductible Applies
	Urgent care	$40 copay per visit	40% co-ins after ded	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-ins after ded	40% co-ins after ded	Pre-Authorization required Non-Network or benefit reduces to 50% of allowed.
	Physician/surgeon fee	10% co-ins after ded	40% co-ins after ded	Pre-Authorization required Non-Network or benefit reduces to 50% of allowed.

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

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 copay per visit	40% co-ins after ded	Pre-Authorization required Non-Network or benefit reduces to 50% of allowed. Other Outpatient Services: Deductible then 10% co-ins.
	Mental/Behavioral health inpatient services	10% co-ins after ded	40% co-ins after ded	Pre-Authorization required Non-Network or benefit reduces to 50% of allowed.
	Substance use disorder outpatient services	$40 copay per visit	40% co-ins after ded	Pre-Authorization required Non-Network or benefit reduces to 50% of allowed. Other Outpatient Services: Deductible then 10% co-ins.
	Substance use disorder inpatient services	10% co-ins after ded	40% co-ins after ded	Pre-Authorization required Non-Network or benefit reduces to 50% of allowed.
If you are pregnant	Prenatal and postnatal care	No Charge	40% co-ins after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered. Pre-Authorization required Non-Network or benefit reduces to 50% of allowed.
	Delivery and all inpatient services	10% co-ins after ded	40% co-ins after ded	Pre-Authorization required Non-Network or benefit reduces to 50% of allowed.
If you need help recovering or have other special health needs	Home health care	10% co-ins after ded	40% co-ins after ded	Limited to 60 visits per calendar year. Pre-Authorization required Non-Network or benefit reduces to 50% of allowed.
	Rehabilitation services	$40 copay per outpatient visit	40% co-ins after ded	Depending on the type of therapy, there is a limit of 60 visits per calendar year. Pre-Authorization required Non-Network or benefit reduces to 50% of allowed.
	Habilitative services	$40 copay per outpatient visit	40% co-ins after ded	Limits per calendar year: physical, speech, occupational – 60 visits. Limits do not apply to Autism. Pre-Authorization required Non-Network or benefit reduces to 50% of allowed.
	Skilled nursing care	10% co-ins after ded	40% co-ins after ded	Limited to 30 days per calendar year. Pre-Authorization required Non-Network or benefit reduces to 50% of allowed.
	Durable medical equipment	No Charge	40% co-ins after ded	Pre-Authorization required for items over $500.
	Hospice service	10% co-ins after ded	40% co-ins after ded	Limited to 180 days (combined inpatient and home hospice) per lifetime. Inpatient Pre-Authorization required Non-Network or benefit reduces to 50% of allowed.

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

Common Medical Event	Services you may need	Your Cost if You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	No Coverage for Eye Exam.
	Glasses	Not Covered	Not Covered	No Coverage for Glasses.
	Dental check-up	Not Covered	Not Covered	No Coverage for Dental check-up.

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.)

- Acupuncture
- Cosmetic surgery
- Dental check-up (child/adult)
- Glasses (child/adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (child/adult)
- 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.)

- Bariatric surgery
- Chiropractic Care
- Hearing aids (through age 15)
- Infertility treatment (Artificial Insemination only)
- Private duty nursing for home health care

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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or cciio.cms.gov.

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: your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform or the New Jersey Department of Banking and Insurance at 1-800-446-7467 or state.nj.us/dobi/index.html.

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:

Para obtener asistencia en Español, llame al 1-866-633-2446.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.
如果需要中文的帮助，**请拨打这个号码** 1-866-633-2446.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.

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)

- ☐ **Amount owed to providers:** $7,540
- ☐ **Plan pays** $5,820
- ☐ **Patient pays** $1,720

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	$1,000
Copays	$20
Coinsurance	$500
Limits or exclusions	$200
Total	**$1,720**

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

- ☐ **Amount owed to providers:** $5,400
- ☐ **Plan pays** $3,760
- ☐ **Patient pays** $1,640

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	$200
Copays	$1,400
Coinsurance	$0
Limits or exclusions	$40
Total	**$1,640**

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 (HHS), 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 examples.
- 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?

X **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?

X **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.