SUMMARY OF BENEFITS - Cigna Health and Life Insurance Co.

The City of Bay City
Open Access Plus - Base Plan - October 01, 2014

General Services	In-Network	Out-of-Network
Physician office visit	Primary care physician You pay $40 copay per visit Specialist You pay $40 copay per visit	You pay 50% Plan pays 50% after the deductible is met
Urgent care visit • All services including Lab & X-ray	Urgent care copay You pay $65	You pay 50% Plan pays 50% after the deductible is met
Preventive care • In-network preventive services including the office visit are covered at 100%, no charge • Unlimited calendar year maximum	Plan pays 100%, no copay, no deductible	You pay 50% Plan pays 50% after the deductible is met
Performance pharmacy plan • Includes contraceptives - with specific products covered at 100% • If a Brand name drug is requested when there is a Generic equivalent, member must purchase the Generic drug, or pay 100% of the difference between the Brand name price and the Generic price, plus the appropriate brand-name copay (unless the physician indicates "Dispense As Written" DAW) • Cigna National Pharmacy Network	Tier 1: $20 Tier 2: $40 Tier 3: $60 Home Delivery 3x 90-Day supply at 3x retail copay	Member pays 100% at the time of purchase then reimbursed 50% after the applicable copay
Coinsurance	You pay 30% Plan pays 70% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
Calendar year deductible • In-network and out-of-network expenses do not cross accumulate	Individual $3,000 Family $9,000	Individual $3,000 Family $9,000
Out-of-pocket annual maximum • Medical copays apply towards the out-of-pocket maximums • Medical deductibles apply towards the out-of-pocket maximums • Expenses do not cross accumulate between in-network and out-of-network out-of-pocket maximums	Individual $6,350 Family $12,700	Individual $13,000 Family $39,000
Lifetime maximum	Unlimited Per individual	
Emergency room care • All services rendered apply to ER benefit including Lab & X-ray	Emergency room copay You pay $100	
Ambulance • Unlimited per day maximum	You pay 30% Plan pays 70% after the in-network deductible is met	

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General Services	In-Network	Out-of-Network
Office surgery	You pay 30% Plan pays 70% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
Other office services • 100% after office visit copay • Independent lab paid based on status of the facility	Plan pays 100% after office visit copay	You pay 50% Plan pays 50% after the deductible is met
Outpatient lab and x-ray • Independent Lab and X-ray paid based on status of the facility	Plan pays 100% no deductible	You pay 50% Plan pays 50% after the deductible is met
Office advanced radiology imaging services • Includes MRI, MRA, PET, CT-Scan and Nuclear medicine	You pay 30% Plan pays 70% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
Outpatient advanced radiology imaging services • Includes MRI, MRA, PET, CT-Scan and Nuclear medicine	You pay 30% Plan pays 70% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
Durable medical equipment • Unlimited lifetime maximum • Unlimited annual maximum • Includes external prosthetic appliances • Does accumulate towards the out-of-pocket maximum	You pay 30% Plan pays 70% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
Breast-feeding equipment and supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies	Plan pays 100%, no copay, no deductible	Not Covered

Benefits	In-Network	Out-of-Network
Hospital Services		
Inpatient hospital services • Including anesthesia • Inpatient Lab & X-ray services are subject to the professional service reimbursement	In-network facility You pay 30% Plan pays 70% after the deductible is met	Out-of-network facility You pay 50% Plan pays 50% after the deductible is met
Outpatient hospital services • Outpatient surgery • Including anesthesia • Ambulatory Surgery • Lab & X-Ray paid based on facility network status	Outpatient facility You pay 30% Plan pays 70% after the deductible is met	Outpatient facility You pay 50% Plan pays 50% after the deductible is met
Skilled nursing facility care • 30 days per calendar year maximum	You pay 30% Plan pays 70% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
Hospice care	You pay 30% Plan pays 70% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
Home health care • 60 visits per calendar year maximum	You pay 30% Plan pays 70% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
Mental Health and Chemical Dependency		

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Benefits	In-Network	Out-of-Network
Inpatient mental health	In-network facility You pay 30% Plan pays 70% after the deductible is met	Out-of-network facility You pay 50% Plan pays 50% after the deductible is met
Inpatient chemical dependency	In-network facility You pay 30% Plan pays 70% after the deductible is met	Out-of-network facility You pay 50% Plan pays 50% after the deductible is met
Outpatient mental health	You pay $40 copay	You pay 50% Plan pays 50% after the deductible is met
Outpatient chemical dependency	You pay $40 copay	You pay 50% Plan pays 50% after the deductible is met
Therapy Services		
Outpatient physical therapy • 20 visits per calendar year	You pay 30% Plan pays 70% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
Outpatient speech therapy, hearing therapy and occupational therapy • 20 visits per calendar year	You pay 30% Plan pays 70% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
Chiropractic services • 20 visits per calendar year • Unlimited lifetime dollar maximum	You pay 30% Plan pays 70% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
Acupuncture	Not Covered	Not Covered
Additional Services		
Family planning • Vasectomy • Includes elective abortions • Includes infertility testing for diagnosis only	Varies based on place of service	Not Covered
Contraceptives • Includes contraceptive devices as ordered or prescribed by a physician • Surgical services such as tubal ligation are covered (excluding reversals) • Physician services	Plan pays 100%, no copay, no deductible	You pay 50% Plan pays 50% after the deductible is met
TMJ • Unlimited calendar year maximum for surgical and non-surgical treatment	Varies based on place of service	You pay 50% Plan pays 50% after the deductible is met
Organ transplant • Services paid at network level if performed at Cigna LifeSOURCE Transplant Network® Facilities • Travel maximum $10,000 per lifetime (only available if using Cigna LifeSOURCE Transplant Network® facility)	In-network facility You pay 30% Plan pays 70% after the deductible is met	Out-of-network facility Not Covered

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Benefits	In-Network	Out-of-Network
Out-of-area services • Coverage for services rendered outside a network area • ER and Ambulance paid the same as network services • Preventive care services covered at 100% for out of area • Out-of-network deductible and out-of-pocket maximums apply	For all other services You pay 40% Plan pays 60% after the out-of-network deductible is met	

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Additional Information

Selection of a Primary Care Provider- Your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.myCigna.com or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

Direct Access to Obstetricians and Gynecologists- You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.myCigna.com or contact customer service at the phone number listed on the back of your ID card.

Out of Pocket Maximum

Once you reach the individual or family out-of-pocket maximum (non-covered benefits are excluded from this total) in any one calendar year, covered services will be payable at 100% for the remainder of the year.

- Medical copays apply towards the out-of-pocket maximums
- Medical deductibles apply towards the out-of-pocket maximums

Plan Coverage for Out-of-network Providers

- The allowable covered expense for non-network services is based on the lesser of the health care professional's normal charge for a similar service or at 110% of a fee schedule developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is based on the lesser of the health care professional's normal charge for a similar service or supply or the amount charged for that service by 80% of the health care professionals in the geographic area where it is received. Out-of-network services are subject to a calendar year deductible and maximum reimbursable charge limitations.

Precertification Penalty

Pre-authorization is required on all inpatient admissions and outpatient surgery not performed in the doctor's office. Network providers are contractually obligated to perform pre-authorization on behalf of their customers. For an out-of-network provider, the customer is responsible for following the pre-authorization procedures. If a customer does not follow the recommended care plan for obtaining pre-treatment authorization for an out-of-network provider, an ineligible expense penalty of $250 will be applied.

- Outpatient Surgery
- Skilled Nursing
- Home Health Care
- Renal Dialysis
- Air Ambulance
- Durable Medical Equipment over $500
- High Cost Drug
- Genetic Testing
- Transplant Evaluations
- Hospital Admissions (including partial hospitalization programs for mental health)
- High Tech Radiology (examples include CAT scans, PET scans and MRIs)

General Notice of Preexisting Condition Exclusion

- Not applicable

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Exclusions
What's Not Covered (This Is Not All Inclusive; check your plan documents for a complete list) • Services that aren't medically necessary • Experimental or investigational treatments, except for routine patient care costs related to qualified clinical trials as described in your plan document • Accidental injury that occurs while working for pay or profit • Sickness for which benefits are paid or payable under any Worker's Compensation or similar law • Services provided by government health plans • Cosmetic surgery, unless it corrects deformities resulting from illness, breast reconstruction surgery after a mastectomy, or congenital defects of a newborn or adopted child or child placed for adoption • Dental treatments and implants • Custodial care • Sex transformation • Surgical procedures for the improvement of vision that can be corrected through the use of glasses or contact lenses • Vision therapy or orthoptic treatment • Reversal of sterilization procedures • Nonprescription drugs or anti-obesity drugs • Gene manipulation therapy • Smoking cessation programs • Non-emergency services incurred outside the United States • Bariatric surgery • Infertility services

These are only the highlights
This summary outlines the highlights of your plan. For a complete list of both covered and not-covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

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The City of Bay City: Open Access Plus

Coverage Period: 10/01/2014 - 09/30/2015

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

Coverage for: Individual/Individual + Family | **Plan Type:** OAP

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.myCigna.com or by calling 1-866-494-2111

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers **$3,000** person / **$9,000** family; For out-of-network providers **$3,000** person / **$9,000** family. Does not apply to in-network preventive care , office visits , emergency room visits , in-network urgent care facility visits . Co-payments don't count toward the **deductible**.	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 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For in-network providers **$6,350** person / **$12,700** family; For out-of-network providers **$13,000** person / **$39,000** 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 the covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, penalties for no pre-authorization , prescription drug co-payments , and health care this plan doesn't cover.	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.	The chart starting on page 2 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 participating providers, see **www.myCigna.com or call 1-866-494-2111.**	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. You don't need a referral to see a specialist.	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**.

Questions: Call 1-866-494-2111 or visit us at www.myCigna.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 www.cciio.cms.gov or call 1-866-494-2111 to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 charge is $1,500 for an overnight stay and **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 in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 co-pay/visit	50% co-insurance	----------none----------
	Specialist visit	$40 co-pay/visit	50% co-insurance	----------none----------
	Other practitioner office visit	30% co-insurance for chiropractor	50% co-insurance for chiropractor	Coverage is limited to 20 visits annual max for chiropractor
	Preventive care/screening/ immunization	No charge	50% co-insurance (office visit & all other services)	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	30% co-insurance for office visit, 30% co-insurance outpatient	50% co-insurance	----------none----------
	Imaging (CT/PET scans, MRIs)	30% co-insurance during an office visit or at an outpatient facility	50% co-insurance	$250 penalty for no precertification.

Common Medical Event	Services You May Need	Your Cost if you use an In-Network Provider	Your Cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is at www.myCigna.com	Generic drugs	$20 co-pay/prescription (retail), $60 co-pay/prescription (home delivery)	Member pays 100% up-front, then 50% reimbursement after $20 copay	Coverage is available up to a 90-day supply (retail) at 3X copay (retail), otherwise a 30-day supply (retail) and a 90-day supply (home delivery)
	Preferred brand drugs	$40 co-pay/prescription (retail), $120 co-pay/prescription (home delivery)	Member pays 100% up-front, then 50% reimbursement after $40 copay	Coverage is available up to a 90-day supply (retail) at 3X copay (retail), otherwise a 30-day supply (retail) and a 90-day supply (home delivery)
	Non-preferred brand drugs	$60 co-pay/prescription (retail), $180 co-pay/prescription (home delivery)	Member pays 100% up-front, then 50% reimbursement after $60 copay	Coverage is available up to a 90-day supply (retail) at 3X copay (retail), otherwise a 30-day supply (retail) and a 90-day supply (home delivery)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-insurance	50% co-insurance	$250 penalty for no precertification.
	Physician/surgeon fees	30% co-insurance	50% co-insurance	$250 penalty for no precertification.
If you need immediate medical attention	Emergency room services	$100 co-pay/visit	$100 co-pay/visit	----------none----------
	Emergency medical transportation	30% co-insurance	30% co-insurance	----------none----------
	Urgent care	$65 co-pay/visit	50% co-insurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance	50% co-insurance	$250 penalty for no precertification.
	Physician/surgeon fee	30% co-insurance	50% co-insurance	$250 penalty for no precertification.

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 co-pay/visit	50% co-insurance	$250 penalty for no precertification.
	Mental/Behavioral health inpatient services	30% co-insurance	50% co-insurance	$250 penalty for no precertification.
	Substance use disorder outpatient services	$40 co-pay/visit	50% co-insurance	$250 penalty for no precertification.
	Substance use disorder inpatient services	30% co-insurance	50% co-insurance	$250 penalty for no precertification.
If you are pregnant	Prenatal and postnatal care	30% co-insurance	50% co-insurance	----------none---------
	Delivery and all inpatient services	30% co-insurance	50% co-insurance	$250 penalty for no precertification.
If you have a recovery or other special health need	Home health care	30% co-insurance	50% co-insurance	$250 penalty for no precertification. Coverage is limited to 60 visits annual max
	Rehabilitation services	30% co-insurance for Physical and Speech, Hearing & Occupational Therapy	50% co-insurance for Physical and Speech, Hearing & Occupational Therapy	$250 penalty for failure to precertify speech therapy services. Coverage is limited to an annual max of 20 visits for Physical Therapy and 20 visits for Speech, Hearing, & Occupational Therapy
	Habilitation services	Not Covered	Not Covered	----------none---------
	Skilled nursing care	30% co-insurance	50% co-insurance	$250 penalty for no precertification. Coverage is limited to 30 days annual max
	Durable medical equipment	30% co-insurance	50% co-insurance	$250 penalty for no precertification.
	Hospice service	30% co-insurance	50% co-insurance	$250 penalty for no precertification.

Common Medical Event	Services You May Need	Your Cost if you use an In-Network Provider	Your Cost if you use an Out-of-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	Not Covered		----------none---------
	Glasses	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.)		
• Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult) • Dental care (Children) • Habilitation services • Hearing aids	• Infertility treatment • Long-term care • Non-emergency care when traveling outside of the U.S. • Private-duty nursing • Routine eye care (Adult) • Routine eye care (Children) • 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.)		
• Chiropractic 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 1-866-494-2111. 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.

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 Cigna Customer service at 1-866-494-2111. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-494-2111.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-494-2111.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-494-2111.

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

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.

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.

Note: These numbers assume enrollment in individual-only coverage.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $3,320
- **Patient pays:** $4,220

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:

Deductible	$3,000
Co-pays	$140
Co-insurance	$1,050
Limits or exclusions	$30
Total	**$4,220**

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

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

Sample care costs:

Prescriptions	$2,900
Medical equipment and supplies	$1,300
Office visits & procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductible	$0
Co-pays	$1,480
Co-insurance	$0
Limits or exclusions	$280
Total	**$1,760**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. You also should 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.

Plan ID: 3896046 **BenefitVersion:** 3
Plan Name: The City of Bay City - OAP - Base Plan - 10/1/14