



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. This is only a **summary**. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-855-OSCAR-55 or visit <https://www.hioscar.com/forms/2026/ny>. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-855-OSCAR-55 to request a copy.

| Important Questions                                                 | Answers                                                                                                                                                 | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             | \$0 individual / \$0 family                                                                                                                             | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Preventive care</u> , Pre- and post-natal care.                                                                                                 | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                            |
| Are there other <u>deductibles</u> for specific services?           | No.                                                                                                                                                     | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | \$2,000 individual / \$4,000 family                                                                                                                     | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                                     |
| What is not included in the <u>out-of-pocket limit</u> ?            | <u>Premiums</u> , <u>balance billing</u> charges, and healthcare this <u>plan</u> does not cover.                                                       | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Will you pay less if you use a <u>network provider</u> ?            | Yes. See <a href="http://www.hioscar.com/care-options">www.hioscar.com/care-options</a> or call 1-855-OSCAR-55 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?          | No.                                                                                                                                                     | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event                                                                                                                                                                                                                                  | Services You May Need                            | What You Will Pay                                                                                                                                                  |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                       |                                                  | Network Provider<br>(You will pay the least)                                                                                                                       | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                      |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                                                         | Primary care visit to treat an injury or illness | \$15 <u>copayment</u> /visit not subject to <u>deductible</u>                                                                                                      | Not Covered                                        | Virtual primary care services provided by Oscar-designated virtual care providers are covered in full. Virtual pediatric primary care services are not available through Oscar Medical Group; these services should be obtained in-person from in-network providers. Cost share applies to both in-person and telemedicine services. |
|                                                                                                                                                                                                                                                       | <u>Specialist</u> visit                          | \$35 <u>copayment</u> /visit not subject to <u>deductible</u>                                                                                                      | Not Covered                                        | Cost share applies to both in-person and telemedicine services.                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                       | <u>Preventive care/ screening/ immunization</u>  | No charge                                                                                                                                                          | Not Covered                                        | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay. Well Woman and Well Man exams are limited to one (1) visit per Benefit Period.                                                                                                 |
| <b>If you have a test</b>                                                                                                                                                                                                                             | <u>Diagnostic test</u> (x-ray, blood work)       | \$35 <u>copayment</u> /visit not subject to <u>deductible</u> (x-ray/lab work)                                                                                     | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                                       | Imaging (CT/PET scans, MRIs)                     | \$35 <u>copayment</u> /visit not subject to <u>deductible</u> (Office/Ind facility/other outpatient facility)                                                      | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                 |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <u>prescription drug coverage</u> is available at <a href="https://www.hioscar.com/search/NY/drugs?year=2026">www.hioscar.com/search/NY/drugs?year=2026</a> | Generic drugs (Tier 1)                           | \$10 <u>copayment</u> /prescription not subject to <u>deductible</u> (retail, Tier 1A/retail, Tier 1B)                                                             | Not Covered                                        | 90-day supply for Maintenance Drugs is subject to 3x retail <u>cost sharing</u> amount.                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                       | Preferred brand drugs (Tier 2)                   | \$30 <u>copayment</u> / prescription not subject to <u>deductible</u> (retail), \$90 <u>copayment</u> / prescription not subject to <u>deductible</u> (mail order) | Not Covered                                        | 90-day supply for Maintenance Drugs is subject to 3x retail <u>cost sharing</u> amount.                                                                                                                                                                                                                                              |

\*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at <https://www.hioscar.com/forms/2026/ny>.

| Common Medical Event                                                                                                                                                                                                                                 | Services You May Need                          | What You Will Pay                                                                                                                                                   |                                                                                                                | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                      |                                                | Network Provider<br>(You will pay the least)                                                                                                                        | Out-of-Network Provider<br>(You will pay the most)                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.hioscar.com/search/NY/drugs?year=2026">www.hioscar.com/search/NY/drugs?year=2026</a> | Non-preferred brand drugs (Tier 3)             | \$60 <u>copayment</u> / prescription not subject to <u>deductible</u> (retail), \$180 <u>copayment</u> / prescription not subject to <u>deductible</u> (mail order) | Not Covered                                                                                                    | 90-day supply for Maintenance Drugs is subject to 3x retail <u>cost sharing</u> amount.                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                      | <u>Specialty drugs</u> (Tier 4)                | \$60 <u>copayment</u> /prescription not subject to <u>deductible</u> (retail/mail order)                                                                            | Not Covered                                                                                                    | Limited to a 30-day supply.                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                | Facility fee (e.g., ambulatory surgery center) | \$100 <u>copayment</u> /visit not subject to <u>deductible</u> (surgical and non-surgical services)                                                                 | Not Covered                                                                                                    | None                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                                      | Physician/surgeon fees                         | \$100 <u>copayment</u> /visit not subject to <u>deductible</u>                                                                                                      | Not Covered                                                                                                    | None                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                                       | <u>Emergency room care</u>                     | \$100 <u>copayment</u> /visit not subject to <u>deductible</u> (ER Facility Fee), No charge (ER Physician Fee)                                                      | \$100 <u>copayment</u> /visit not subject to <u>deductible</u> (ER Facility Fee), No charge (ER Physician Fee) | <u>Emergency Room care</u> by an <u>Out-of-Network provider</u> is covered if the services are for an emergency condition.                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                      | <u>Emergency medical transportation</u>        | \$100 <u>copayment</u> /visit not subject to <u>deductible</u>                                                                                                      | \$100 <u>copayment</u> /visit not subject to <u>deductible</u>                                                 | Emergency Transportation services by an <u>Out-of-Network provider</u> are covered if the services are for an emergency condition.                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                      | <u>Urgent care</u>                             | \$55 <u>copayment</u> /visit not subject to <u>deductible</u>                                                                                                       | \$55 <u>copayment</u> /visit not subject to <u>deductible</u>                                                  | Virtual <u>urgent care</u> services provided by Oscar-designated virtual care <u>providers</u> are covered in full. When prescribed by an Oscar-designated virtual care <u>provider</u> , Tier 1 Drugs and Labs may be covered in full. When temporarily out of the Service Area, Out-of-Network <u>Urgent Care</u> services are covered. In addition to applicable cost share, you may be responsible for <u>balance billing</u> . |
| <b>If you have a hospital stay</b>                                                                                                                                                                                                                   | Facility fee (e.g., hospital room)             | \$500 <u>copayment</u> /admission not subject to <u>deductible</u>                                                                                                  | Not Covered                                                                                                    | None                                                                                                                                                                                                                                                                                                                                                                                                                                |

\*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at <https://www.hioscar.com/forms/2026/ny>.

| Common Medical Event                                                             | Services You May Need                     | What You Will Pay                                                                                      |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|----------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                           | Network Provider<br>(You will pay the least)                                                           | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>If you have a hospital stay</b>                                               | Physician/surgeon fees                    | \$100 <u>copayment</u> /visit not subject to <u>deductible</u>                                         | Not Covered                                        | All transplants must be performed at designated Facilities.                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$15 <u>copayment</u> /visit not subject to <u>deductible</u> (office visit/other outpatient services) | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                  | Inpatient services                        | \$500 <u>copayment</u> /day not subject to <u>deductible</u>                                           | Not Covered                                        | <u>Preauthorization</u> is not required for emergency admissions or for admissions at Participating OHM licensed Facilities for Members under 18.                                                                                                                                                                                                                                                                                                                                                           |
| <b>If you are pregnant</b>                                                       | Office Visits                             | No charge                                                                                              | Not Covered                                        | Depending on the type of services such as Primary Care Office Visits, <u>Specialist</u> Office Visits, Diagnostic Imaging Services, etc., the applicable <u>cost-sharing</u> will apply.                                                                                                                                                                                                                                                                                                                    |
|                                                                                  | Childbirth/delivery professional services | \$100 <u>copayment</u> /visit not subject to <u>deductible</u>                                         | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                  | Childbirth/delivery facility services     | \$500 <u>copayment</u> /unit not subject to <u>deductible</u>                                          | Not Covered                                        | Covers 48-hour hospital stay for uncomplicated vaginal birth and 96-hour hospital stay for uncomplicated cesarean section. If you do not get <u>preauthorization</u> , payment for care may be denied. <u>Preauthorization</u> is not required for emergency admissions or services provided in a neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law. One (1) home care visit is covered at no Cost- Sharing if mother is discharged from Hospital early. |
| <b>If you need help recovering or have other special health needs</b>            | <u>Home health care</u>                   | \$15 <u>copayment</u> /visit not subject to <u>deductible</u>                                          | Not Covered                                        | 40 visits per <u>Plan</u> Year.                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

\*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at <https://www.hioscar.com/forms/2026/ny>.

| Common Medical Event                                                  | Services You May Need                 | What You Will Pay                                                  |                                                    | Limitations, Exceptions, & Other Important Information                                                                                               |
|-----------------------------------------------------------------------|---------------------------------------|--------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                       | Network Provider<br>(You will pay the least)                       | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                      |
| <b>If you need help recovering or have other special health needs</b> | <u>Rehabilitation services</u>        | \$25 <u>copayment</u> /visit not subject to <u>deductible</u>      | Not Covered                                        | 60 visits per condition, per <u>Plan</u> Year combined therapies. Speech and physical therapy are only Covered following a Hospital stay or surgery. |
|                                                                       | <u>Habilitation services</u>          | \$25 <u>copayment</u> /visit not subject to <u>deductible</u>      | Not Covered                                        | 60 visits per condition, per <u>Plan</u> Year combined therapies. Speech and physical therapy are only Covered following a Hospital stay or surgery. |
|                                                                       | <u>Skilled nursing care</u>           | \$500 <u>copayment</u> /admission not subject to <u>deductible</u> | Not Covered                                        | 200 days per <u>Plan</u> Year.                                                                                                                       |
|                                                                       | <u>Durable medical equipment</u> Test | 10% <u>coinsurance</u> not subject to <u>deductible</u>            | Not Covered                                        | None                                                                                                                                                 |
|                                                                       | <u>Hospice services</u>               | \$500 <u>copayment</u> /day not subject to <u>deductible</u>       | Not Covered                                        | Five (5) visits for family bereavement counseling. 210 days per <u>Plan</u> Year.                                                                    |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                   | \$15 <u>copayment</u> /visit not subject to <u>deductible</u>      | Not Covered                                        | One (1) exam per 12-month period.                                                                                                                    |
|                                                                       | Children's glasses                    | 10% <u>coinsurance</u> not subject to <u>deductible</u>            | Not Covered                                        | One (1) prescribed lenses and frames per 12-month period.                                                                                            |
|                                                                       | Children's dental check-up            | Not Covered                                                        | Not Covered                                        | None                                                                                                                                                 |

#### Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- |                                                                                                                            |                                                                                                                                  |                                                                                                                                           |
|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> </ul> |
|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|

\*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at <https://www.hioscar.com/forms/2026/ny>.

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Abortion
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment (basic infertility services may be covered; does not cover IVF, GIFT, ZIFT)
- Weight loss programs

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: New York State Department of Financial Services, One State Street, New York, NY 10004 at [1-800-342-3736](tel:1-800-342-3736) or <http://www.dfs.ny.gov/consumer/chealth.htm> or contact Oscar at [1-855-OSCAR-55](tel:1-855-OSCAR-55). Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call [1-800-318-2596](tel:1-800-318-2596).

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: <http://www.dfs.ny.gov/consumer/chealth.htm>

**Does this plan provide Minimum Essential Coverage? Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? Not Applicable.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-672-2789.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-672-2789.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-672-2789.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-672-2789.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-855-672-2789 uff.

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

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|                                        |       |
|----------------------------------------|-------|
| ■ The plan's overall <u>deductible</u> | \$0   |
| ■ <u>Specialist copayment</u>          | \$35  |
| ■ <u>Hospital (facility) copayment</u> | \$500 |
| ■ Other <u>coinsurance</u>             | 10%   |

**This EXAMPLE event includes services like:**

Specialist office visits (prenatal care)  
 Childbirth/delivery professional services  
 Childbirth/delivery facility services  
Diagnostic tests (ultrasounds and blood work)  
Specialist visit (anesthesia)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

| <i>Cost-Sharing</i>               |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$0          |
| <u>Copayments</u>                 | \$800        |
| <u>Coinsurance</u>                | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Peg would pay is</b> | <b>\$800</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                        |       |
|----------------------------------------|-------|
| ■ The plan's overall <u>deductible</u> | \$0   |
| ■ <u>Specialist copayment</u>          | \$35  |
| ■ <u>Hospital (facility) copayment</u> | \$100 |
| ■ Other <u>coinsurance</u>             | 10%   |

**This EXAMPLE event includes services like:**

Primary care physician office visits (including disease education)  
Diagnostic tests (blood work)  
Prescription drugs  
Durable medical equipment (glucose meter)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

**In this example, Joe would pay:**

| <i>Cost-Sharing</i>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$0            |
| <u>Copayments</u>                 | \$1,000        |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$1,000</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                        |       |
|----------------------------------------|-------|
| ■ The plan's overall <u>deductible</u> | \$0   |
| ■ <u>Specialist copayment</u>          | \$35  |
| ■ <u>Hospital (facility) copayment</u> | \$100 |
| ■ Other <u>coinsurance</u>             | 10%   |

**This EXAMPLE event includes services like:**

Emergency room care (including medical supplies)  
Diagnostic test (x-ray)  
Durable medical equipment (crutches)  
Rehabilitation services (physical therapy)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

**In this example, Mia would pay:**

| <i>Cost-Sharing</i>               |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$0          |
| <u>Copayments</u>                 | \$500        |
| <u>Coinsurance</u>                | \$20         |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$520</b> |

The plan would be responsible for the other costs of these EXAMPLE covered services.