Oscar Bronze 60 HDHP EPO AI-AN Schedule of Benefits

All services and supplies must be provided by an Oscar In-Network Provider, unless an Out-of-Network provider is authorized by Oscar, and except in the case of an Emergency or Urgent Care. If you receive covered services at an In-Network facility at which or as a result of which you receive services provided by an Out-of-Network provider, you will pay no more than the same cost sharing you would pay for the same covered services received from an In-Network provider. This schedule is intended to help you compare covered benefits and is a summary only. The Subscriber Agreement and Combined Evidence of Coverage and Disclosure Form should be consulted for a detailed description of covered benefits and limitations.

Deductible

This is the amount of Covered Charges that a Covered Person must pay before this Subscriber Agreement and Combined Evidence of Coverage and Disclosure Form pays any benefits for such charges. Deductible does not include Coinsurance, Copayments, and Non-Covered Charges.

Maximum Out of Pocket

This is the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible, and Coinsurance for all covered services and supplies in a Plan Year. All amounts paid as a Copayment, Deductible, and Coinsurance shall count toward the Maximum Out of Pocket. Once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible, or Coinsurance for In-Network covered services and supplies for the remainder of the Plan Year

Copayment

This is a specified dollar amount a Covered Person must pay for specified Covered Charges.

Coinsurance

This is the percentage of a Covered Charge that must be paid by a Covered Person.

Deductible	
Individual	$6,000.00
Family	$12,000.00

Out-of-Pocket Maximum	
Individual	$6,650.00
Family	$13,300.00

HSA Deductible	
Individual in Self-Only Coverage	$6,000.00
Individual Deductible on Family Plan	$6,000.00

Medical Professional Services	Participating Provider Member Responsibility for Cost-Sharing	Limits
Primary Care Office Visits	40% coinsurance after deductible	
Specialist Office Visits	40% coinsurance after deductible	
All other Practitioner Visits	40% coinsurance after deductible	
Acupuncture	40% coinsurance after deductible	
Complex Imaging Services CT/PET scans, MRIs Preauthorization may be required	40% coinsurance after deductible	
Allergy Testing		
Performed in a PCP office	40% coinsurance after deductible	
Performed in a Specialist office	40% coinsurance after deductible	

Anesthesia Services		
Outpatient	40% coinsurance after deductible	
Inpatient	40% coinsurance after deductible	
Chemotherapy **Preauthorization may be required**	40% coinsurance after deductible	Cost-sharing for oral anti-cancer drugs limited to $200 per 30 day supply
Outpatient Rehabilitation Physical Medicine Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Preauthorization may be required**	40% coinsurance after deductible	
Outpatient Habilitation Physical Medicine Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Preauthorization may be required**	40% coinsurance after deductible	
Laboratory Procedures **Preauthorization may be required**	40% coinsurance after deductible	
Maternity and Newborn Care		
Routine Prenatal and Postnatal Care	$0 copayment not subject to deductible	
Diagnostic and other Prenatal and Postnatal Care	40% coinsurance after deductible	
Inpatient Hospital Services and Birthing Center	40% coinsurance after deductible	
Physician and Midwife Services for Delivery	40% coinsurance after deductible	
Breast Pump	$0 copayment not subject to deductible	
Preventive care	$0 copayment not subject to deductible	
X-rays and Diagnostic Imaging **Preauthorization may be required**	40% coinsurance after deductible	

Medical Outpatient Services	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Ambulatory Surgical Center Facility Fee **Preauthorization may be required**	40% coinsurance after deductible	
Outpatient Physician / Surgeon Fees **Preauthorization may be required**	40% coinsurance after deductible	

Outpatient Visits **Preauthorization may be required**		
With a PCP	40% coinsurance after deductible	
With a Specialist	40% coinsurance after deductible	

Medical Hospitalization Services	Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Facility Fee **Preauthorization required. However, Preauthorization is not required for, emergency admissions**	40% coinsurance after deductible	
Inpatient Physician / Surgeon Fees **Preauthorization required. However, Preauthorization is not required for emergency admissions**	40% coinsurance after deductible	
Skilled Nursing Facility **Preauthorization required**	40% coinsurance after deductible	100 days per Plan Year

Emergency Health Coverage	Participating Provider Member Responsibility for Cost-Sharing	Limits
Emergency Room Facility Fee **Waived if admitted**	40% coinsurance after deductible	
Emergency Room Physician Fee **Waived if admitted**	$0 copayment after deductible	
Urgent Care Center	40% coinsurance after deductible	

Ambulance Services	Participating Provider Member Responsibility for Cost-Sharing	Limits
Emergency Transportation/ Ambulance Preauthorization required for non-emergency ambulance transportation	40% coinsurance after deductible	

Prescription Drugs Preauthorization/step therapy may be required	Participating Provider Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy		
30-day supply		
Tier 1 - Generic Drugs	40% coinsurance after deductible	Up to $500 per script after deductible
Tier 2 - Preferred Brand Name	40% coinsurance after deductible	Up to $500 per script after deductible
Tier 3 - Non-preferred Brand Name	40% coinsurance after deductible	Up to $500 per script after deductible
Tier 4 - Specialty Drugs	40% coinsurance after deductible	Limited to a 30-day supply. Up to $500 per script after deductible.
Mail Order Pharmacy		
90-day supply (except for Tier 4)		
Tier 1 - Generic Drugs	40% coinsurance after deductible	Up to $1500 per script after deductible
Tier 2 - Preferred Brand Name	40% coinsurance after deductible	Up to $1500 per script after deductible
Tier 3 - Non-preferred Brand Name	40% coinsurance after deductible	Up to $1500 per script after deductible
Tier 4 - Specialty Drugs	40% coinsurance after deductible	Limited to a 30-day supply. Up to $500 per script after deductible.

Durable Medical Equipment	Participating Provider Member Responsibility for Cost-Sharing	Limits
Durable Medical Equipment and Braces Preauthorization required if annual cost (purchase/rental) > $500	40% coinsurance after deductible	

Mental Health Services	Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) **Preauthorization may be required. However, Preauthorization is not required for emergency admissions**	40% coinsurance after deductible	
Inpatient Physician / Surgeon Fees **Preauthorization may be required. However, Preauthorization is not required for emergency admissions**	40% coinsurance after deductible	
Outpatient Mental Health Office Visits	40% coinsurance after deductible	
Outpatient Mental Health Items and Services	40% coinsurance after deductible	

Chemical Dependency Services	Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) **Preauthorization may be required. However, Preauthorization is not required for emergency admissions**	40% coinsurance after deductible	
Inpatient Physician / Surgeon Fees **Preauthorization may be required. However, Preauthorization is not required for emergency admissions**	40% coinsurance after deductible	
Outpatient Substance Use Office Visits	40% coinsurance after deductible	
Outpatient Substance Use Items and Services	40% coinsurance after deductible	

Home Health Services	Participating Provider Member Responsibility for Cost-Sharing	Limits
Home Health Care **Preauthorization may be required**	40% coinsurance after deductible	100 visits per Plan Year

Additional Services, Equipment and Devices	Participating Provider Member Responsibility for Cost-Sharing	Limits
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment **Preauthorization may be required.**	40% coinsurance after deductible	
Diabetic Supplies **Preauthorization may be required.**	40% coinsurance after deductible	
Diabetic Education	$0 copayment not subject to deductible	
Hospice Services **Preauthorization may be required.**	$0 copayment after deductible	

Pediatric Dental and Vision Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care		
Preventive Dental Care	$0 copayment not subject to deductible	One (1) visit per 6 months
Routine Dental Care	20% coinsurance not subject to deductible	
Major Dental	50% coinsurance not subject to deductible	
Orthodontia **Orthodontics and major dental require Preauthorization**	50% coinsurance not subject to deductible	
Pediatric Vision Care		
Exams	$0 copayment not subject to deductible	One (1) exam per 12 months. Preventive visits $0 copayment not subject to deductible.
Lenses and Frames	$0 copayment not subject to deductible	One (1) prescribed lenses and frames per 12 months.
Contact Lenses	$0 copayment not subject to deductible	Only in lieu of glasses

Eligible American Indians are exempt from Cost-Sharing requirements when Covered Services are rendered by an Indian Health Service, Indian Tribe, Tribal Organization or Urban Indian Organization, or through Referral under contract health services.

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not covered under the Policy, You will be responsible for the full cost of the services.

*Emergency Medical Conditions and Urgent Care Coverage are covered by Us. Members are responsible for their respective cost share only (copay, coinsurance, deductible).

You may contact the California Department of Managed Healthcare to obtain information on companies, coverage, rights or complaints at:

1-888-466-2219

You may write the California Department of Managed Healthcare at:

980 9th Street Suite 500

Sacramento, CA 95814

Web: https://www.dmhc.ca.gov

Notice of Non-Discrimination: Discrimination is Against the Law

Oscar complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Oscar does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Oscar:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services, at all points of contact, at all times, to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Member Services at 1-855-OSCAR-55 (TTY: 7-1-1).

If you believe that Oscar has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

NY/NJ/TX/OH/TN Members: Oscar Insurance, Attention Grievances PO Box 52146, Phoenix AZ, 85072

CA Members: Oscar Health Plan of California, Attention Grievances 9942 Culver City Blvd., PO Box 1279, Culver City, CA 90232

1-855-OSCAR-55 (TTY: 7-1-1), Mon - Fri 8 am - 8 pm/ Sat - Sun 9 am - 5 pm (EST), Fax: 1-888-977-2062, Email: help@hioscar.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Oscar's Grievances Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F,
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services for the Deaf or Hard of Hearing

ATTENTION: If you are deaf or hard of hearing, talk to text services, free of charge, are available to you. Call 1-855-Oscar-55 and dial 711 to receive TTY/TDD services.

Multi-language interpreter services

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-OSCAR-55.

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-OSCAR-55.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1–855–OSCAR–55.

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-OSCAR-55.

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-OSCAR-55 번으로 전화해 주십시오.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-OSCAR-55.

אידיש (Yiddish): אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-855-OSCAR-55.

বাংলা (Bengali): লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১ -855-OSCAR-55.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-OSCAR-55.

العربية (Arabic): ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1–855–RACSO–55.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-OSCAR-55.

اُردُو (Urdu): خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-855-OSCAR-55

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-OSCAR-55.

Ελληνικά (Greek): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-855-OSCAR-55.

Shqip (Albanian): KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-OSCAR-55.

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-OSCAR-55.

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-OSCAR-55 पर कॉल करें।

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما .بگیرید ت 1-855–OSCAR-55.

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-OSCAR-55.

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-OSCAR-55.

日本語 (Japanese): 注意事項： 日本語を話される場合、無料の言語支援をご利用いただけます。1-855-OSCAR-55 まで、お電話にてご連絡ください。

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ້ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-OSCAR-55.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-OSCAR-55.

አማርኛ (Amharic): ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-OSCAR-55.

Հայերեն (Armenian): ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-855-OSCAR-55.

ਪੰਜਾਬੀ (Punjabi): ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-855-OSCAR-55 'ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ (Cambodian): ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-OSCAR-55. ។

Hmoob (Hmong): LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-OSCAR-55.

ภาษาไทย (Thai): ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-OSCAR-55.

Deitsch (Pennsylvania Dutch): Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1–855–OSCAR–55.

Oroomiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-OSCAR-55.

Nederlands (Dutch): AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-855-OSCAR-55.

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-OSCAR-55.

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-855-OSCAR-55.