

OSCAR BRONZE 60 HDHP EPO 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
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Outpatient Rehabilitation Physical Medicine Services (Physical Therapy, Occupational Therapy or Speech Therapy) Preauthorization may be required	40% coinsurance after deductible	
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Outpatient Habilitation Physical Medicine Services (Physical Therapy, Occupational Therapy or Speech Therapy) Preauthorization may be required	40% coinsurance after deductible	
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Laboratory Procedures Preauthorization may be required	40% coinsurance after deductible	
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Maternity and Newborn Care

Routine Prenatal and Postnatal Care	\$0 copayment not subject to deductible	
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Diagnostic and other Prenatal and Postnatal Care	40% coinsurance after deductible	
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Inpatient Hospital Services and Birthing Center	40% coinsurance after deductible	
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Physician and Midwife Services for Delivery	40% coinsurance after deductible	
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Breast Pump	\$0 copayment not subject to deductible	
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Preventive care	\$0 copayment not subject to deductible	
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X-rays and Diagnostic Imaging Preauthorization may be required	40% coinsurance after deductible	
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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	Participating Provider Member Responsibility for Cost-Sharing	Limits
Preauthorization/step therapy may be required		
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

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 Subscriber Agreement and Combined Evidence of Coverage and Disclosure Form, 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.

