### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$7,900 individual / $15,800 family</td>
<td>Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Preventive care, pre- and post-natal care, and telemedicine.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$7,900 individual / $15,800 family</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance billing charges, and healthcare this plan does not cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="http://www.hioscar.com">www.hioscar.com</a> or call 1-855-OSCAR-55 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows 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/2019/ny](https://www.hioscar.com/forms/2019/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.dol.gov/ebsa/healthreform](https://www.dol.gov/ebsa/healthreform) or call 1-855-OSCAR-55 to request a copy.
**Common Medical Event** | **Services You May Need** | **What You Will Pay** | **Limitations, Exceptions, & Other Important Information**
---|---|---|---
**If you visit a health care provider's office or clinic**
- Primary care visit to treat an injury or illness | **Network Provider (You will pay the least)**
  - $0.00 copay/visit subject to deductible | **Out-of-Network Provider (You will pay the most)**
  - Not Covered | **First 3 non-preventive visits are $0 copay not subject to deductible; subsequent visits are subject to deductible.**
- Specialist visit | $0.00 copay/visit subject to deductible | Not Covered | 
- Preventive care/screening/immunization | $0.00 copay/visit not subject to deductible | Not Covered | 
**If you have a test**
- Diagnostic test (x-ray, blood work) | $0.00 copay/visit subject to deductible (x-ray/lab work) | Not Covered | 
  - Preauthorization is required for diagnostic radiology (except x-ray). If you don't get preauthorization, payment for care may be denied.
- Imaging (CT/PET scans, MRIs) | $0.00 copay/visit subject to deductible | Not Covered | 
  - Preauthorization is required. If you don't get preauthorization, payment for care may be denied.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$0.00 <strong>copay</strong>/prescription subject to <strong>deductible</strong> (retail/mail order)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$0.00 <strong>copay</strong>/prescription subject to <strong>deductible</strong> (retail/mail order)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$0.00 <strong>copay</strong>/prescription subject to <strong>deductible</strong> (retail/mail order)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>$0.00 <strong>copay</strong>/prescription subject to <strong>deductible</strong> (retail/mail order)</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$0.00 <strong>copay</strong>/visit subject to <strong>deductible</strong></td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$0.00 <strong>copay</strong>/visit subject to <strong>deductible</strong></td>
<td>Not Covered</td>
</tr>
</tbody>
</table>


Covers up to 30 day supply at retail and up to 90 day supply for mail order. **Preauthorization**/step therapy may be required.

Covers up to 30 day supply at retail and up to 90 day supply for mail order. **Preauthorization**/step therapy may be required.

Covers up to 30 day supply at retail and up to 90 day supply for mail order. **Preauthorization**/step therapy may be required.

Covers up to 30 day supply through Oscar Specialty Pharmacy. **Preauthorization**/step therapy may be required.

__________none__________

**Preauthorization** required. If you don't get **preauthorization**, payment for care may be denied.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$0.00 <strong>copay</strong>/visit subject to <strong>deductible</strong> (ER Facility Fee/ER Physician Fee)</td>
<td>$0.00 <strong>copay</strong>/visit subject to <strong>deductible</strong> (ER Facility Fee/ER Physician Fee)</td>
<td>——none———</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$0.00 <strong>copay</strong>/visit subject to <strong>deductible</strong></td>
<td>$0.00 <strong>copay</strong>/visit subject to <strong>deductible</strong></td>
<td>——none———</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$0.00 <strong>copay</strong>/visit subject to <strong>deductible</strong></td>
<td>Not Covered</td>
<td>Preauthorization is required for out-of-network urgent care. If you don’t get preauthorization, payment for care may be denied.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$0.00 <strong>copay</strong>/visit subject to <strong>deductible</strong></td>
<td>Not Covered</td>
<td>Preauthorization is required for inpatient stays, except for emergency admissions. If you don’t get preauthorization, payment for care may be denied.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$0.00 <strong>copay</strong>/visit subject to <strong>deductible</strong></td>
<td>Not Covered</td>
<td>Preauthorization required. If you don’t get preauthorization, payment for care may be denied.</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$0.00 <strong>copay</strong>/visit subject to <strong>deductible</strong> (office visit/for other outpatient services)</td>
<td>Not Covered</td>
<td>First 3 non-preventive visits are $0 <strong>copay</strong> not subject to <strong>deductible</strong>; subsequent visits are subject to <strong>deductible</strong>.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>$0.00 <strong>copay</strong>/visit subject to <strong>deductible</strong></td>
<td>Not Covered</td>
<td>Preauthorization is required for inpatient stays, except for emergency admissions or participating OASAS-certified facilities. If you don’t get preauthorization, payment for care may be denied.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
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<td>----------------------</td>
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<td>--------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office Visit</td>
<td>$0.00 copay/visit not subject to deductible</td>
<td>Not Covered</td>
<td>Cost-sharing does not apply to certain preventive services. Depending on the type of services, cost-sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>$0.00 copay/visit subject to deductible</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$0.00 copay/visit subject to deductible</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>$0.00 copay/visit subject to deductible</td>
<td>Not Covered</td>
<td>40 visits per Plan Year. Preauthorization is required. If you don't get preauthorization, payment for care may be denied.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$0.00 copay/visit subject to deductible</td>
<td>Not Covered</td>
<td>60 visits per condition, per year, combined therapies. Preauthorization is required. If you don't get preauthorization, payment for care may be denied.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$0.00 copay/visit subject to deductible</td>
<td>Not Covered</td>
<td>60 visits per condition, per year, combined therapies. Preauthorization is required. If you don't get preauthorization, payment for care may be denied.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$0.00 copay/visit subject to deductible</td>
<td>Not Covered</td>
<td>200 days per Plan year. Preauthorization is required. If you don't get preauthorization, payment for care may be denied.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>$0.00 copay/device subject to deductible</td>
<td>Not Covered</td>
<td>Preauthorization is required for purchases and rentals &gt;$500. If you don't get preauthorization, payment for care may be denied.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
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<td>--------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Hospice services</td>
<td>Network Provider (You will pay the least) $0.00 copay/visit subject to deductible</td>
<td>Out-of-Network Provider (You will pay the most) Not Covered</td>
<td>Up to 210 days per year. Inpatient hospice care is subject to the inpatient hospital cost-sharing. Preauthorization may be required. If you don't get preauthorization, payment for care may be denied.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>$0.00 copay/visit subject to deductible</td>
<td>Not Covered</td>
<td>1 exam in a 12 month period</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>$0.00 copay/visit subject to deductible</td>
<td>Not Covered</td>
<td>1 pair of glasses or contact lenses in a 12 month period</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>$0.00 copay/visit subject to deductible</td>
<td>Not Covered</td>
<td>Limited to 2 dental check ups per year. Basic dental care, orthodontia and major dental care are also covered.</td>
</tr>
</tbody>
</table>

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.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

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

- Abortion
- Acupuncture
- 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. To contact Oscar call 1-855-OSCAR-55, or 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 or http://www.dfs.ny.gov/consumer/chealth.htm. 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 or call 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.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes.

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.

-----------------------------To see examples of how this plan might cover costs for a sample medical situation, see the next page.-----------------------------
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) | Managing Joe’s Type 2 Diabetes  
(a year of routine in-network care of a well-controlled condition) | Mia’s Simple Fracture  
(in-network emergency room visit and follow up care) |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible:</strong> $7,900</td>
<td><strong>The plan’s overall deductible:</strong> $7,900</td>
<td><strong>The plan’s overall deductible:</strong> $7,900</td>
</tr>
<tr>
<td><strong>Specialist:</strong> $0.00 copay/visit subject to deductible</td>
<td><strong>Specialist:</strong> $0.00 copay/visit subject to deductible</td>
<td><strong>Specialist:</strong> $0.00 copay/visit subject to deductible</td>
</tr>
<tr>
<td><strong>Hospital (facility):</strong> $0.00 copay/visit subject to deductible</td>
<td><strong>Hospital (facility):</strong> $0.00 copay/visit subject to deductible</td>
<td><strong>Hospital (facility):</strong> $0.00 copay/visit subject to deductible</td>
</tr>
<tr>
<td><strong>Other:</strong> $0.00 copay/device subject to deductible</td>
<td><strong>Other:</strong> $0.00 copay/device subject to deductible</td>
<td><strong>Other:</strong> $0.00 copay/device subject to deductible</td>
</tr>
</tbody>
</table>

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)

Total: $7,500

In this example, Peg would pay:
- **Deductibles:** $6,300
- **Copays:** $0
- **Coinsurance:** $0
- **What isn’t covered:** $200

Total: $6,500

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)

Total: $5,500

In this example, Joe would pay:
- **Deductibles:** $4,800
- **Copays:** $0
- **Coinsurance:** $0
- **What isn’t covered:** $80

Total: $4,880

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

Total: $1,900

In this example, Mia would pay:
- **Deductibles:** $1,900
- **Copays:** $0
- **Coinsurance:** $0
- **What isn’t covered:** $0

Total: $1,900

The plan would be responsible for the other costs of these EXAMPLE covered services.
Non-Discrimination 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:

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

All other Members: Oscar Insurance, Attention: Grievances, PO Box 52146, Phoenix, AZ 85072

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)


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.


Hindi (Hindi): यदि हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता तथा उपयोगी सुविधाएं हैं। 1-855-OSCAR-55 पर कॉल करें।

