### SCHEDULE OF BENEFITS OSCAR SAVER BRONZE

<table>
<thead>
<tr>
<th>COST-SHARING</th>
<th>Participating Provider Member Responsibility for Cost-Sharing</th>
<th>Non-Participating Provider Member Responsibility for Cost-Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Individual</td>
<td>$6,650.00</td>
<td>Non-Participating Provider services are not covered except as required for Emergency Care and Urgent Care.</td>
</tr>
<tr>
<td>- Family</td>
<td>$13,300.00</td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-Pocket Limit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Individual</td>
<td>$6,650.00</td>
<td></td>
</tr>
<tr>
<td>- Family</td>
<td>$13,300.00</td>
<td></td>
</tr>
</tbody>
</table>

Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year.
<table>
<thead>
<tr>
<th>OFFICE VISITS</th>
<th>Participating Provider Member Responsibility for Cost-Sharing</th>
<th>Non-Participating Provider Member Responsibility for Cost-Sharing</th>
<th>Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Office Visits (or Home Visits)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• At Oscar Center</td>
<td>Covered in full</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>• Other PCP Office</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>Specialist Office Visits (or Home Visits)</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>PREVENTIVE CARE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Well Child Visits and Immunizations*</td>
<td>Covered in full</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>• Adult Annual Physical Examinations*</td>
<td>Covered in full</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>• Adult Immunizations*</td>
<td>Covered in full</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>• Routine Gynecological Services/Well Woman Exams*</td>
<td>Covered in full</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>Service</td>
<td>Covered/Details</td>
<td>Cost Sharing/Details</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer Screenings*</td>
<td>Covered in full</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>Sterilization Procedures for Women*</td>
<td>Covered in full</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>Vasectomy</td>
<td>See surgical services cost-sharing</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>Bone Density Testing*</td>
<td>Covered in full</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>Screening for Prostate Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td> Performed in PCP Office</td>
<td>Covered in full</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td> Performed in Specialist Office</td>
<td>Covered in full</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>All other preventive services required by USPSTF and HRSA.</td>
<td>Covered in full</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
</tbody>
</table>
- When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA, use cost-sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing).

<table>
<thead>
<tr>
<th>EMERGENCY CARE</th>
<th>Participating Provider Member Responsibility for Cost-Sharing</th>
<th>Non-Participating Provider Member Responsibility for Cost-Sharing</th>
<th>Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Hospital Emergency Medical Services (Ambulance Services)</td>
<td>Covered in full after deductible</td>
<td>Covered in full after deductible</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>Non-Emergency Ambulance Services</td>
<td>Covered in full after deductible</td>
<td>Covered in full after deductible</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>Preauthorization required.</td>
<td>Preauthorization required.</td>
<td>Preauthorization required.</td>
<td></td>
</tr>
<tr>
<td>Emergency Department</td>
<td>Covered in full after deductible</td>
<td>Covered in full after deductible</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>Copayment / Coinsurance waived if admitted to Hospital</td>
<td>Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing</td>
<td>Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing</td>
<td></td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>PROFESSIONAL SERVICES and OUTPATIENT CARE</td>
<td>Participating Provider Member Responsibility for Cost-Sharing</td>
<td>Non-Participating Provider Member Responsibility for Cost-Sharing</td>
<td>Limits</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>----------------------------------------------------------</td>
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</tr>
<tr>
<td>Advanced Imaging Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Performed in a Specialist Office</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>• Performed in a Freestanding Radiology Facility</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>• Performed as Outpatient Hospital Services</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>Preauthorization required.</td>
<td>Preauthorization required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Testing and Treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Performed in a PCP Office</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>• Performed in a Specialist Office</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>Ambulatory Surgical Center Facility Fee</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>Anesthesia Services (all settings)</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Coverage</td>
<td>Non-Participating Provider Services</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------------------------------</td>
<td>-------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Autologous Blood Banking</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>Preauthorization required.</td>
<td>Preauthorization required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac and Pulmonary Rehabilitation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Performed in a Specialist Office</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>• Performed as Outpatient Hospital Services</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>• Performed as Inpatient Hospital Services</td>
<td>Included as part of inpatient Hospital service Cost-Sharing</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Administration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Performed in a PCP Office</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>• Performed in a Specialist Office</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>• Performed as Outpatient Hospital Services</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Coverage After Deductible</td>
<td>Additional Information</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>--------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>• Performed at Home</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>Preauthorization required.</td>
<td>Preauthorization required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>Preauthorization required.</td>
<td>Preauthorization required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Trials</td>
<td>Use Cost-Sharing for appropriate service</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>Preauthorization required.</td>
<td>Preauthorization required.</td>
<td>Preauthorization required.</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td>• Performed in a PCP Office</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Performed in a Specialist Office</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Performed as Outpatient Hospital Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preauthorization required.</td>
<td>Preauthorization required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Type</td>
<td>Location</td>
<td>Coverage</td>
<td>Preauthorization Required</td>
</tr>
<tr>
<td>--------------</td>
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<td>--------------------------</td>
</tr>
<tr>
<td>Dialysis</td>
<td>PCP Office</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td></td>
<td>Specialist Office</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td></td>
<td>Freestanding Center</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td></td>
<td>PCP Office</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td></td>
<td>Specialist Office</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td></td>
<td>Outpatient Facility</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td>Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</td>
<td>PCP Office</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td></td>
<td>Specialist Office</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td></td>
<td>Outpatient Facility</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td>Preauthorization required.</td>
<td></td>
<td>Preauthorization required.</td>
<td>Preauthorization required.</td>
</tr>
</tbody>
</table>

Oscar Saver Bronze On-Ex Individual NY 2019 SOB
<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Details</th>
<th>Preauthorization Required</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Health Care</strong></td>
<td>Covered in full after deductible</td>
<td>Preauthorization required</td>
<td>40 visits per Plan Year</td>
</tr>
<tr>
<td><strong>Infertility Services</strong></td>
<td>Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory &amp; Diagnostic Procedures)</td>
<td>Preauthorization required</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td><strong>Infusion Therapy</strong></td>
<td></td>
<td>Preauthorization required</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td>• Administration</td>
<td></td>
<td>Preauthorization required</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td>• Performed in a PCP Office</td>
<td>Covered in full after deductible</td>
<td>Preauthorization required</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td>• Performed in a Specialist Office</td>
<td>Covered in full after deductible</td>
<td>Preauthorization required</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td>• Performed as Outpatient Hospital Services</td>
<td>Covered in full after deductible</td>
<td>Preauthorization required</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td>• Home Infusion Therapy</td>
<td>Covered in full after deductible</td>
<td>Preauthorization required</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td>Service</td>
<td>Coverage Details</td>
<td>Non-Participating Provider Services</td>
<td>Notes</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------------------------------------------------------</td>
<td>-------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Inpatient Medical Visits</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>Interruption of Pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medically Necessary Abortions</td>
<td>Covered in full</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>Unlimited</td>
</tr>
<tr>
<td>• Elective Abortions</td>
<td>See Surgical Services Cost-Sharing</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>One (1) procedure per Plan Year</td>
</tr>
<tr>
<td>Laboratory Procedures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Performed in a PCP Office</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>• Performed in a Specialist Office</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>• Performed in a Freestanding Center</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>• Performed as Outpatient Hospital Services</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
</tbody>
</table>
Maternity and Newborn Care

- Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA

- Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA

- Inpatient Hospital Services and Birthing Center

- Physician and Midwife Services for Delivery

- Breastfeeding Support, Counseling and Supplies, Including Breast Pumps

- Postnatal Care

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Coverage Details</th>
<th>Other Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal Care</td>
<td>Covered in full</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td></td>
<td>Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)</td>
<td>See benefit for description</td>
</tr>
<tr>
<td></td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td></td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td></td>
<td>Covered in full</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td></td>
<td>Included in the physician and midwife services for delivery cost-sharing</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td>Inpatient Hospital Services and Birthing Center</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td>Physician and Midwife Services for Delivery</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td>Breastfeeding Support, Counseling and Supplies, Including Breast Pumps</td>
<td>Covered in full</td>
<td>Covered for duration of breast feeding</td>
</tr>
<tr>
<td>Postnatal Care</td>
<td>Included in the physician and midwife services for delivery cost-sharing</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
</tbody>
</table>

One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early. If a Copay, applies per admission.
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Coverage After Deductible</th>
<th>Non-Participating Provider Services</th>
<th>Preauthorization Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Hospital Surgery Facility Charge</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td>Preadmission Testing</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td>Prescription Drugs Administered in Office or Outpatient Facilities</td>
<td>Administration</td>
<td>See benefit for description</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td>• Performed in a PCP Office</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td>• Performed in a Specialist Office</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td>• Performed in Outpatient Facilities</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td>Diagnostic Radiology Services</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>• Performed in a PCP Office</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>• Performed in a Specialist Office</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>• Performed in a Freestanding Radiology Facility</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>• Performed as Outpatient Hospital Services</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
</tbody>
</table>

Preauthorization required.

<table>
<thead>
<tr>
<th>Therapeutic Radiology Services</th>
<th>Covered in full after deductible</th>
<th>Non-Participating Provider Services are not covered and You pay the full cost</th>
<th>See benefit for description</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Performed in a Specialist Office</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>• Performed in a Freestanding Radiology Facility</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>• Performed as Outpatient Hospital Services</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
</tbody>
</table>

Preauthorization required.

Preauthorization required.
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Covered Status</th>
<th>Cost Sharing Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</td>
<td>Performed in a PCP Office</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>Speech and physical therapy are only Covered following a Hospital stay or surgery</td>
</tr>
<tr>
<td></td>
<td>Performed in a Specialist Office</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Performed in an Outpatient Facility</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td>Preauthorization required.</td>
<td></td>
<td>Preauthorization required.</td>
<td></td>
</tr>
<tr>
<td>Retail Health Clinic Care</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>Preauthorization required.</td>
<td></td>
<td>Preauthorization required.</td>
<td></td>
</tr>
<tr>
<td>Second Opinions on the Diagnosis of Cancer, Surgery and Other</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>Second Opinions on diagnosis of cancer are Covered at Participating Cost-Sharing for Non-Participating Specialist.</td>
<td></td>
<td>Preauthorization required.</td>
<td></td>
</tr>
<tr>
<td>Service Description</td>
<td>Coverage Description</td>
<td>Additional Information</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants)</td>
<td>- Inpatient Hospital Surgery: Covered in full after deductible; Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>All transplants must be performed at designated Facilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Outpatient Hospital Surgery Facility Charge: Covered in full after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Surgery Performed at an Ambulatory Surgical Center: Covered in full after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Office Surgery: Covered in full after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- At PCP Office: Covered in full after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- At Specialist Office: Covered in full after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preauthorization required.</td>
<td>Preauthorization required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telemedicine Program</td>
<td>Covered in full; Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
<td></td>
</tr>
<tr>
<td>ADDITIONAL SERVICES, EQUIPMENT and DEVICES</td>
<td>Participating Provider Member Responsibility for Cost-Sharing</td>
<td>Non-Participating Provider Member Responsibility for Cost-Sharing</td>
<td>Limits</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>ABA Treatment for Autism Spectrum Disorder</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>Preauthorization required.</td>
<td>Preauthorization required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistive Communication Devices for Autism Spectrum Disorder</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td></td>
<td>Preauthorization required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic Equipment, Supplies and Self-Management Education</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>• Diabetic Equipment, Supplies and Insulin (30-day supply)</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>• Diabetic Education</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>Preauthorization required.</td>
<td>Preauthorization required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment and Braces</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>Preauthorization required.</td>
<td>Preauthorization required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>External Hearing Aids</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>Single purchase once every three (3) years</td>
</tr>
<tr>
<td>Preauthorization required.</td>
<td>Preauthorization required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Coverage Details</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>One (1) per ear per time Covered</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Cochlear Implants</td>
<td>Covered in full after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preauthorization required.</td>
<td>Preauthorization required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td></td>
<td></td>
<td>210 days per Plan Year</td>
</tr>
<tr>
<td>• Inpatient</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>Five (5) visits for family bereavement counseling</td>
</tr>
<tr>
<td>• Outpatient</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>If a Copay, applies per admission</td>
</tr>
<tr>
<td>Preauthorization required.</td>
<td>Preauthorization required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>Preauthorization required.</td>
<td>Preauthorization required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>• External</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements</td>
</tr>
<tr>
<td>• Internal</td>
<td>Included as part of inpatient Hospital service Cost-Sharing</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>Unlimited; See benefit for description</td>
</tr>
<tr>
<td>Preauthorization required.</td>
<td>Preauthorization required.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INPATIENT SERVICES and FACILITIES**

<table>
<thead>
<tr>
<th>Participating Provider</th>
<th>Non-Participating Provider</th>
<th>Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Responsibility for Cost-Sharing</td>
<td>Member Responsibility for Cost-Sharing</td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td>Preauthorization required. However, Preauthorization 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.</td>
<td>Preauthorization required. However, Preauthorization 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.</td>
<td></td>
</tr>
<tr>
<td>Observation Stay</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td>Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Preauthorization required.</strong></td>
<td><strong>Preauthorization required.</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)</th>
<th>Covered in full after deductible</th>
<th>Non-Participating Provider Services are not covered and You pay the full cost</th>
<th>60 days per Plan Year combined therapies.</th>
<th>If a Copay, applies per admission</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preauthorization required.</strong></td>
<td><strong>Preauthorization required.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)</th>
<th>Covered in full after deductible</th>
<th>Non-Participating Provider Services are not covered and You pay the full cost</th>
<th>60 days per Plan Year combined therapies.</th>
<th>Speech and physical therapy are only Covered following a Hospital stay or surgery.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preauthorization required.</strong></td>
<td><strong>Preauthorization required.</strong></td>
<td></td>
<td></td>
<td>If a Copay, applies per admission</td>
</tr>
</tbody>
</table>

**MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES**

<table>
<thead>
<tr>
<th>Covered in full after deductible</th>
<th>Non-Participating Provider Services are not covered and You pay the full cost</th>
<th>See benefit for description.</th>
<th>If a Copay, applies per admission</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preauthorization required.</strong></td>
<td><strong>Preauthorization required.</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

However, Preauthorization is not required for emergency admissions.
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Coverage Details</th>
<th>Non-Participating Provider Details</th>
<th>Other Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)</td>
<td>Office Visits: Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All Other Outpatient Services: Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td>Inpatient Substance Use Service for a continuous confinement when in a Hospital (including Residential Treatment)</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.</td>
</tr>
<tr>
<td></td>
<td>Preauthorization required.</td>
<td>See benefit for description</td>
<td>If a Copay, applies per admission</td>
</tr>
<tr>
<td></td>
<td>See benefit for description</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>Unlimited; Up to 20 visits per Plan Year may be used for family counseling</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>- Office Visits</td>
<td>Covered in full after deductible</td>
<td>Preauthorization required.</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td>- All Other Outpatient Services</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preauthorization required.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PRESCRIPTION DRUGS**

- Participating Provider Member Responsibility for Cost-Sharing
- Non-Participating Provider Member Responsibility for Cost-Sharing

Limits

*Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF.*
<table>
<thead>
<tr>
<th>Retail Pharmacy</th>
<th>30-day supply</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Pharmacy</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
</tr>
<tr>
<td>If You have an Emergency Condition, Preauthorization is not required for a five (5) day emergency supply of a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

See benefit for description
### Up to a 90-day supply for Maintenance Drugs

<table>
<thead>
<tr>
<th>Tier</th>
<th>Coverage After Deductible</th>
<th>Non-Participating Provider Coverage</th>
<th>See benefit for description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>Tier 2</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>Tier 3</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
</tbody>
</table>

### Mail Order Pharmacy

<table>
<thead>
<tr>
<th>Tier</th>
<th>Coverage After Deductible</th>
<th>Non-Participating Provider Coverage</th>
<th>See benefit for description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>Tier 2</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>Tier 3</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
</tbody>
</table>

### Up to a 30-day supply

<table>
<thead>
<tr>
<th>Tier</th>
<th>Coverage After Deductible</th>
<th>Non-Participating Provider Coverage</th>
<th>See benefit for description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>Tier 2</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>Tier 3</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
</tbody>
</table>

### Up to a 90-day supply

<table>
<thead>
<tr>
<th>Tier</th>
<th>Coverage After Deductible</th>
<th>Non-Participating Provider Coverage</th>
<th>See benefit for description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>Tier 1</td>
<td>Tier 2</td>
<td>Tier 3</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>Enteral Formulas</td>
<td>Covered in full after deductible</td>
<td>Covered in full after deductible</td>
<td>Covered in full after deductible</td>
</tr>
<tr>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td></td>
</tr>
<tr>
<td>WELLNESS BENEFITS</td>
<td>Participating Provider Member Responsibility for Cost-Sharing</td>
<td>Non-Participating Provider Member Responsibility for Cost-Sharing</td>
<td>Limits</td>
</tr>
<tr>
<td>Step Tracking</td>
<td>N/A</td>
<td>N/A</td>
<td>See benefit for description</td>
</tr>
<tr>
<td>PEDIATRIC DENTAL and VISION CARE</td>
<td>Participating Provider Member Responsibility for Cost-Sharing</td>
<td>Non-Participating Provider Member Responsibility for Cost-Sharing</td>
<td>Limits</td>
</tr>
<tr>
<td>Pediatric Dental Care</td>
<td>Covered in full</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>One (1) dental exam and cleaning per six (6) month period</td>
</tr>
<tr>
<td>• Preventative Dental Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Coverage</td>
<td>Non-Participating Provider</td>
<td>Cost-Sharing</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>----------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Routine Dental Care</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals</td>
</tr>
<tr>
<td>Major Dental Care (Oral Surgery, Endodontics, Periodontics, and Prosthodontics)</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>Orthodontics and major dental require Preauthorization.</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>Orthodontics and major dental require Preauthorization.</td>
</tr>
<tr>
<td>Pediatric Vision Care</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>One (1) exam per 12-month period</td>
</tr>
<tr>
<td>Exams</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>One (1) prescribed lenses and frames per 12-month period</td>
</tr>
<tr>
<td>Lenses and Frames</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>One (1) prescribed lenses and frames per 12-month period</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>Covered in full after deductible</td>
<td>Non-Participating Provider Services are not covered and You pay the full cost</td>
<td>One (1) prescribed lenses and frames per 12-month period</td>
</tr>
</tbody>
</table>

Eligible American Indians, as determined by the NYSOH, 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.
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：如果您使用繁体中文，您可以免费获得语言援助服务。请致电 1-855-OSCAR-55.


Kreyòl Ayisyen (French Creole): ATYANSO: Si w pale Kreyòl Ayisyen, gen sèvis ki a jistans nan te Antil Ayisyen yo. Fete 1-855-OSCAR-55.


ภาษาไทย (Thai): ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการรับรองที่ไม่เกิดขึ้นที่เกิดขึ้น 1-855-OSCAR-55.

فارسی (Farsi): برای این که بیان زبان فارسی را فکر کنید تشویقی زبانی بصورت رایگان برای شما هست. 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。

Hıdırlık (Hindi): यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता तैयार है। 1-855-OSCAR-55 पर कॉल करें।


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