## 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>$1,700 individual / $3,400 family</td>
<td>Generally, you must pay all the costs from providers up to the <strong>deductible</strong> amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual <strong>deductible</strong> until the total amount of <strong>deductible</strong> expenses paid by all family members meets the overall family <strong>deductible</strong>.</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 <strong>deductible</strong> amount. But a <strong>copayment</strong> or <strong>coinsurance</strong> may apply. For example, this plan covers certain preventive services without <strong>cost sharing</strong> and before you meet your <strong>deductible</strong>. 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 <strong>deductibles</strong> for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$7,500 individual / $15,000 family</td>
<td>The <strong>out-of-pocket limit</strong> 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 <strong>out-of-pocket limits</strong> until the overall family <strong>out-of-pocket limit</strong> has been met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, <strong>balance billing</strong> charges, and healthcare this plan does not cover.</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit</strong>.</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 <strong>provider network</strong>. You will pay less if you use a <strong>provider</strong> in the plan’s <strong>network</strong>. You will pay the most if you use an <strong>out-of-network provider</strong>, and you might receive a bill from a <strong>provider</strong> for the difference between the <strong>provider</strong>’s charge and what your plan pays (<strong>balance billing</strong>). Be aware your <strong>network provider</strong> might use an <strong>out-of-network provider</strong> for some services (such as lab work). Check with your <strong>provider</strong> 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 <strong>specialist</strong> you choose without a <strong>referral</strong>.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<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 visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$30.00 <strong>copay</strong>/visit subject to <strong>deductible</strong></td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td><strong>Specialist</strong> visit</td>
<td>$50.00 <strong>copay</strong>/visit subject to <strong>deductible</strong></td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>$0.00 <strong>copay</strong>/visit not subject to <strong>deductible</strong></td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td><strong>Diagnostic test</strong> (x-ray, blood work)</td>
<td>$50.00 <strong>copay</strong>/visit subject to <strong>deductible</strong> (x-ray/lab work)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$50.00 <strong>copay</strong>/visit subject to <strong>deductible</strong></td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

You may have to pay for services that aren't preventive. Ask your **provider** if the services you need are preventive. Then check what your **plan** will pay for.

**Preauthorization** is required for diagnostic radiology (except x-ray). If you don't get **preauthorization**, payment for care may be denied.

**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>$10.00 copay/prescription not subject to deductible (retail), $25.00 copay/prescription not subject to deductible (mail order)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$35.00 copay/prescription not subject to deductible (retail), $87.50 copay/prescription not subject to deductible (mail order)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$70.00 copay/prescription not subject to deductible (retail), $175.00 copay/prescription not subject to deductible (mail order)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>$70.00 copay/prescription not subject to deductible (retail/mail order)</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$100.00 copay/visit subject to deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$100.00 copay/visit subject to deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

More information about [prescription drug coverage](#) is available at [www.hioscar.com/search/NY/drugs?year=2019](#)

If you have outpatient surgery:

- Facility fee (e.g., ambulatory surgery center) $100.00 copay/visit subject to deductible
- Physician/surgeon fees $100.00 copay/visit subject to deductible

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>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td><strong>Emergency room care</strong></td>
<td>Network Provider (You will pay the least): $250.00 <strong>copay</strong>/visit subject to <strong>deductible</strong> (ER Facility Fee), $0.00 <strong>copay</strong>/visit subject to <strong>deductible</strong> (ER Physician Fee)  &lt;br&gt;Out-of-Network Provider (You will pay the most): $250.00 <strong>copay</strong>/visit subject to <strong>deductible</strong> (ER Facility Fee), $0.00 <strong>copay</strong>/visit subject to <strong>deductible</strong> (ER Physician Fee)</td>
<td><em><strong><strong><strong>none</strong></strong></strong></em>__</td>
</tr>
<tr>
<td></td>
<td><strong>Emergency medical transportation</strong></td>
<td>$150.00 <strong>copay</strong>/visit subject to <strong>deductible</strong>  &lt;br&gt;$150.00 <strong>copay</strong>/visit subject to <strong>deductible</strong></td>
<td><em><strong><strong><strong>none</strong></strong></strong></em>__</td>
</tr>
<tr>
<td></td>
<td><strong>Urgent care</strong></td>
<td>$70.00 <strong>copay</strong>/visit subject to <strong>deductible</strong>  &lt;br&gt;Not Covered</td>
<td><strong>Preauthorization</strong> is required for out-of-network urgent care. If you don't get preauthorization, payment for care may be denied.</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$1500.00 <strong>copay</strong>/visit subject to <strong>deductible</strong>  &lt;br&gt;Not Covered</td>
<td><strong>Preauthorization</strong> 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>$100.00 <strong>copay</strong>/visit subject to <strong>deductible</strong>  &lt;br&gt;Not Covered</td>
<td><strong>Preauthorization</strong> required. If you don't get preauthorization, payment for care may be denied.</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Mental/Behavioral health outpatient services</td>
<td>$30.00 <strong>copay</strong>/visit subject to <strong>deductible</strong> (office visit/for other outpatient services)  &lt;br&gt;Not Covered</td>
<td><strong>Preauthorization</strong> may be required. If you don't get preauthorization, payment for care may be denied.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>$1500.00 <strong>copay</strong>/visit subject to <strong>deductible</strong>  &lt;br&gt;Not Covered</td>
<td><strong>Preauthorization</strong> 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>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------------</td>
<td>------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Office Visit</td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$0.00 <strong>copay</strong>/visit not subject to <strong>deductible</strong></td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>$100.00 <strong>copay</strong>/visit subject to <strong>deductible</strong></td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$1500.00 <strong>copay</strong>/visit subject to <strong>deductible</strong></td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>$30.00 <strong>copay</strong>/visit subject to <strong>deductible</strong></td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$30.00 <strong>copay</strong>/visit subject to <strong>deductible</strong></td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$30.00 <strong>copay</strong>/visit subject to <strong>deductible</strong></td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$1500.00 <strong>copay</strong>/visit subject to <strong>deductible</strong></td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>30% <strong>coinsurance</strong> subject to <strong>deductible</strong></td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
### Common Medical Event

<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>If you need help recovering or have other special health needs</td>
<td><strong>Hospice services</strong></td>
<td><strong>Network Provider (You will pay the least)</strong></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></td>
<td></td>
<td>$1500.00 <strong>copay</strong>/visit subject to <strong>deductible</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td><strong>Eye exam</strong></td>
<td>$30.00 <strong>copay</strong>/visit subject to <strong>deductible</strong></td>
<td>1 exam in a 12 month period</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Glasses</strong></td>
<td><strong>30% coinsurance</strong> subject to <strong>deductible</strong></td>
<td>1 pair of glasses or contact lenses in a 12 month period</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Dental check-up</strong></td>
<td>$30.00 <strong>copay</strong>/visit subject to <strong>deductible</strong></td>
<td>Limited to 2 dental check ups per year. Basic dental care, orthodontia and major dental care are also covered.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not Covered</td>
<td></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)

- **The plan’s overall deductible:** $1,700
- **Specialist:** $50.00 copay/visit subject to deductible
- **Hospital (facility):** $100.00 copay/visit subject to deductible
- **Other:** 30% coinsurance subject to deductible

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,700</td>
</tr>
<tr>
<td>Copays</td>
<td>$1,600</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered** $200

**Total** $3,500

### Managing Joe’s Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan’s overall deductible:** $1,700
- **Specialist:** $50.00 copay/visit subject to deductible
- **Hospital (facility):** $100.00 copay/visit subject to deductible
- **Other:** 30% coinsurance subject to deductible

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,700</td>
</tr>
<tr>
<td>Copays</td>
<td>$900</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered** $0

**Total** $2,680

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan’s overall deductible:** $1,700
- **Specialist:** $50.00 copay/visit subject to deductible
- **Hospital (facility):** $100.00 copay/visit subject to deductible
- **Other:** 30% coinsurance subject to deductible

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,700</td>
</tr>
<tr>
<td>Copays</td>
<td>$100</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered** $0

**Total** $1,800

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The plan would be responsible for the other costs of these EXAMPLE covered 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 (Creole): ATYENZION: si m kwit l ayisyen, te swi kap te yon servis d paseyè litye. POU 1-855-OSCAR-55.


More languages are available...