This is only a summary. If you want more detail about coverage and costs, you can get the complete terms in the policy or plan document at **https://www.hioscar.com/forms/?planState=NY&planDate=2017** or by calling **1-855-OSCAR-55**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$600** person / **$1,200** family Does not apply to preventive care, pre- and post-natal care, telemedicine and prescription drugs.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there any other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan offers.
Is there an out-of-pocket limit on my expenses?	Yes. **$4,000** person / **$8,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, Balance billed charges, and healthcare this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for ***specific*** covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.hioscar.com or call 1-855-OSCAR-55 for a list of **In-Network providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term **in-network**, preferred, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- The plan may encourage you to use **In-Network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25.00 copay/visit	Not Covered	----------none----------
	Specialist visit	$40.00 copay/visit	Not Covered	----------none----------
	Other practitioner office visit	$25.00 copay/visit	Not Covered	----------none----------
	Preventive care/screening/immunization	$0 copay/visit	Not Covered	Immunizations related to travel are subject to cost share

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)		Not Covered	Prior authorization is required for diagnostic radiology except x-ray
	Imaging (CT/PET scans, MRIs)	$40.00 copay/visit	Not Covered	Prior authorization is required for diagnostic and cardiac imaging except x-ray
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.hioscar.com	Generic drugs	$10.00 copay/prescription (retail), $25.00 copay/prescription (mail order)	Not Covered	Covers up to 30 day supply at retail and up to 90 day supply for mail order. Prior authorization/step therapy may be required. Not Subject to Deductible.
	Preferred brand drugs	$35.00 copay/prescription (retail), $87.50 copay/prescription (mail order)	Not Covered	Covers up to 30 day supply at retail and up to 90 day supply for mail order. Prior authorization/step therapy may be required. Not Subject to Deductible.
	Non-preferred brand drugs	$70.00 copay/prescription (retail), $175.00 copay/prescription (mail order)	Not Covered	Covers up to 30 day supply at retail and up to 90 day supply for mail order. Prior authorization/step therapy may be required
	Specialty drugs	$70.00 copay/prescription (retail), $70.00 copay/prescription (mail order)	Not Covered	Covers up to 30 day supply through Oscar Specialty Pharmacy. Prior authorization/step therapy may be required
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100.00 copay/visit	Not Covered	Prior authorization may be required
	Physician/surgeon fees	$100.00 copay/visit	Not Covered	Prior authorization may be required

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$150.00 copay/visit (ER Facility Fee), $0 copay/visit (ER Physician Fee)	$150.00 copay/visit (ER Facility Fee), $0 copay/visit (ER Physician Fee)	----------none----------
	Emergency medical transportation	$150.00 copay/visit	$150.00 copay/visit	----------none----------
	Urgent care	$60.00 copay/visit	$60.00 copay/visit	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$1000.00 copay/visit	Not Covered	Prior authorization is required for inpatient stays, except for emergency admissions
	Physician/surgeon fees	$100.00 copay/visit	Not Covered	Prior authorization is required for inpatient stays, except for emergency admissions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25.00 copay/visit	Not Covered	Not Subject to Deductible
	Mental/Behavioral health inpatient services	$1000.00 copay/visit	Not Covered	Prior authorization is required for inpatient stays, except for emergency admissions

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Substance use disorder outpatient services	$25.00 copay/visit	Not Covered	Not Subject to Deductible
	Substance use disorder inpatient services	$1000.00 copay/visit	Not Covered	Prior authorization is required for inpatient stays, except for emergency admissions
If you are pregnant	Prenatal and postnatal care	$0 copay/visit	Not Covered	Office visits are covered in full, not subject to deductible. All other services are subject to copay, coinsurance and deductible.
	Delivery and all inpatient services	$100.00 copay/visit (delivery), $1000.00 copay/visit (inpatient)	Not Covered	Prior authorization is not required if patient stay <48 hours (<96 hours for a cesarean)
If you need help recovering or have other special health needs	Home health care	$25.00 copay/visit	Not Covered	Prior authorization is required
	Rehabilitation services	$30.00 copay/visit	Not Covered	Prior authorization is required
	Habilitation services	$30.00 copay/visit	Not Covered	Prior authorization is required
	Skilled nursing care	$1000.00 copay/visit	Not Covered	Prior authorization is required
	Durable medical equipment	20% coinsurance	Not Covered	Prior authorization is required for purchases and rentals >$500
	Hospice service	$1000.00 copay/visit (outpatient)	Not Covered	Up to 210 days per year. Inpatient hospice care is subject to the inpatient hospital cost share.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	$25.00 copay/visit	Not Covered	1 exam in a 12 month period
	Glasses	20% coinsurance	Not Covered	1 pair of glasses or contact lenses in a 12 month period
	Dental check-up	$25.00 copay/visit	Not Covered	Limited to 2 dental check ups per year. Basic dental care, orthodontia and major dental care are also covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other **excluded services**.)

- Acupuncture
- Cosmetic services
- Dental care (Adult)
- Long-term care
- Non-emergency services outside of North America
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment (except for IVF)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-OSCAR-55. You may also contact your state insurance department at www.dfs.ny.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-800-342-3736. Additionally, a consumer assistance program can help you file your appeal. Contact www.communityhealthadvocates.org

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-OSCAR-55.

If you would like assistance in another language please call Oscar member services at 1-855-OSCAR-55, which has access to third party translation services.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,500
- **Plan pays:** $5,600
- **Patient pays:** $1,900

Sample Care Costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,500**

Patient pays:

Deductibles	$600
Copays	$1,100
Coinsurance	$0
Limits or exclusions	$200
Total	**$1,900**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,400
- **Patient pays:** $2,000

Sample Care Costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$600
Copays	$1,300
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,000**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the coverage examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.