The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you 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/2025/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.healthcare.gov/sbc-glossary/ or call 1-855-OSCAR-55 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,800 individual / $7,600 family	Generally, you must pay all of 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.
Are there services covered before you meet your deductible?	Yes. Preventive care, Pre- and post-natal care.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$9,200 individual / $18,400 family	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.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and healthcare this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.hioscar.com/care-options or call 1-855-OSCAR-55 for a list of network providers.	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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50 copayment/visit subject to deductible	Not Covered	$50 Copayment not subject to deductible for first 3 visits (PCP, Specialist, outpatient Mental Health/Substance Use Disorder or any combination thereof). Subsequent visits $50 Copayment after Deductible. Cost share applies to both in-person and telemedicine services.
	Specialist visit	$75 copayment/visit subject to deductible	Not Covered	$75 Copayment not subject to deductible for first 3 visits (PCP, Specialist, outpatient Mental Health/Substance Use Disorder or any combination thereof). Subsequent visits $75 Copayment after Deductible. Cost share applies to both in-person and telemedicine services.
	Preventive care/ screening/ immunization	No charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay. Well Woman and Well Man exams are limited to one (1) visit per Benefit Period.
If you have a test	Diagnostic test (x-ray, blood work)	$75 copayment/visit subject to deductible (x-ray), $50 copayment/ visit subject to deductible (lab work)	Not Covered	None
	Imaging (CT/PET scans, MRIs)	$175 copayment/visit subject to deductible (Office/Ind facility/other outpatient facility)	Not Covered	None

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at https://www.hioscar.com/forms/2025/ny

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hioscar.com/search/NY/drugs?year=2025	Generic drugs (Tier 1)	$10 copayment/prescription subject to deductible (retail)	Not Covered	90-day supply for Maintenance Drugs is subject to 3x retail cost sharing amount.
	Preferred brand drugs (Tier 2)	$35 copayment/prescription subject to deductible (retail), $87.50 copayment/ prescription subject to deductible (mail order)	Not Covered	
	Non-preferred brand drugs (Tier 3)	$70 copayment/prescription subject to deductible (retail), $175 copayment/ prescription subject to deductible (mail order)	Not Covered	
	Specialty drugs (Tier 4)	$70 copayment/prescription subject to deductible (retail/mail order)	Not Covered	Limited to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copayment/visit subject to deductible (surgical and non-surgical services)	Not Covered	None
	Physician/surgeon fees	$150 copayment/visit subject to deductible	Not Covered	None
If you need immediate medical attention	Emergency room care	$500 copayment/visit subject to deductible (ER Facility Fee), $0 copayment/visit subject to deductible (ER Physician Fee)	$500 copayment/visit subject to deductible (ER Facility Fee), $0 copayment/visit subject to deductible (ER Physician Fee)	Emergency Room care by an Out-of-Network provider is covered if the services are for an emergency condition.
	Emergency medical transportation	$300 copayment/visit subject to deductible	$300 copayment/visit subject to deductible	Emergency Transportation services by an Out-of-Network provider are covered if the services are for an emergency condition.
	Urgent care	$75 copayment/visit subject to deductible	Not Covered	Virtual urgent care services provided by Oscar-designated virtual care providers are covered in full. When temporarily out of the Service Area, Out-of-Network Urgent Care services are covered. In addition to applicable cost share, you may be responsible for balance billing.

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at https://www.hioscar.com/forms/2025/ny

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,500 copayment/admission subject to deductible	Not Covered	None
	Physician/surgeon fees	$150 copayment/visit subject to deductible	Not Covered	All transplants must be performed at designated Facilities.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copayment/visit subject to deductible (office visit/other outpatient services)	Not Covered	$50 Copayment not subject to deductible for first 3 visits (PCP, Specialist, outpatient Mental Health/Substance Use Disorder or any combination thereof). Subsequent visits $50 Copayment after Deductible.
	Inpatient services	$1,500 copayment/admission subject to deductible	Not Covered	Preauthorization is not required for emergency admissions or for admissions at Participating OHM licensed Facilities for Members under 18.
If you are pregnant	Office Visits	No charge	Not Covered	Depending on the type of services (such as Primary Care Office Visits, Specialist Office Visits, Diagnostic Imaging Services, etc.), the applicable cost-sharing will apply.
	Childbirth/delivery professional services	$150 copayment/visit subject to deductible	Not Covered	None

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Childbirth/delivery facility services	$1,500 copayment/admission subject to deductible	Not Covered	Covers 48-hour hospital stay for uncomplicated vaginal birth and 96-hour hospital stay for uncomplicated cesarean section. If you do not get preauthorization, payment for care may be denied. 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. One (1) home care visit is covered at no Cost- Sharing if mother is discharged from Hospital early.
If you need help recovering or have other special health needs	Home health care	$50 copayment/visit subject to deductible	Not Covered	40 visits per Plan Year.
	Rehabilitation services	$50 copayment/visit subject to deductible	Not Covered	60 visits per condition, per Plan Year combined therapies. Speech and physical therapy are only Covered following a Hospital stay or surgery.
	Habilitation services	$50 copayment/visit subject to deductible	Not Covered	60 visits per condition, per Plan Year combined therapies. Speech and physical therapy are only Covered following a Hospital stay or surgery.
	Skilled nursing care	$1,500 copayment/admission subject to deductible	Not Covered	200 days per Plan Year.
	Durable medical equipment	50% coinsurance subject to deductible	Not Covered	None
	Hospice services	$1,500 copayment/admission subject to deductible	Not Covered	Five (5) visits for family bereavement counseling. 210 days per Plan Year
If your child needs dental or eye care	Children's eye exam	$50 copayment/visit subject to deductible	Not Covered	One (1) exam per 12-month period.
	Children's glasses	50% coinsurance subject to deductible	Not Covered	One (1) prescribed lenses and frames per 12-month period

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at https://www.hioscar.com/forms/2025/ny

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's dental check-up	Not Covered	Not Covered	None

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.)

- Acupuncture
- 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
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment (basic infertility services may be covered; does not cover IVF, GIFT, ZIFT)
- Weight loss programs

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at https://www.hioscar.com/forms/2025/ny

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. 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 or contact Oscar at 1-855-OSCAR-55. 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.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable.
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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-855-672-2789.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-672-2789.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-672-2789.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-672-2789.

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

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	$3,800
Specialist copayment	$75
Hospital (facility) copayment	$1,500
Other coinsurance	50%

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 Example Cost	**$12,700**

In this example, Peg would pay:

Cost-Sharing	
Deductibles	$3,800
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$5,300**

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

The plan's overall deductible	$3,800
Specialist copayment	$75
Hospital (facility) copayment	$150
Other coinsurance	50%

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 Example Cost	**$5,600**

In this example, Joe would pay:

Cost-Sharing	
Deductibles	$3,800
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$4,300**

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

The plan's overall deductible	$3,800
Specialist copayment	$75
Hospital (facility) copayment	$150
Other coinsurance	50%

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 Example Cost	**$2,800**

In this example, Mia would pay:

Cost-Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.