**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=TX&planDate=2017** or by calling **1-855-OSCAR-55**.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$7,150** person / **$14,300** family | PCP/specialist/other practitioner office visits, preventive care, labs, generic and preferred brand drugs, urgent care, mental health/substance use outpatient services, prenatal/postnatal routine care, home health, rehab/habilitation services, and a pediatric eye exam are not subject to deductible. Out-of-network coinsurance and copays don't count toward the deductible. 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. **$7,150** person / **$14,300** 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 | $10.00 copay/visit | Not Covered | Not subject to deductible |
| | Specialist visit | $50.00 copay/visit | Not Covered | Not subject to deductible |
| | Other practitioner office visit | $10.00 copay/visit | Not Covered | Not subject to deductible |
| | Preventive care/screening/immunization | $0 copay/visit | Not Covered | Not subject to deductible. 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) | $0 copay/visit (x-ray), $25.00 copay/visit (lab work) | Not Covered | Preauthorization may be required. Lab work not subject to deductible |
| | Imaging (CT/PET scans, MRIs) | $0 copay/visit | Not Covered | Preauthorization may be required |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.hioscar.com | Generic drugs | $0 copay/prescription (retail), $0 copay/prescription (mail order) | Not Covered | Covers up to 30 day supply at retail (90 days for maintenance) and up to 90 day supply for mail order. Not subject to deductible |
| | Preferred brand drugs | $50.00 copay/prescription (retail), $125.00 copay/prescription (mail order) | Not Covered | Covers up to 30 day supply at retail (90 days for maintenance) and up to 90 day supply for mail order. Not subject to deductible |
| | Non-preferred brand drugs | $0 copay/prescription (retail), $0 copay/prescription (mail order) | Not Covered | Covers up to 30 day supply at retail (90 days for maintenance) and up to 90 day supply for mail order |
| | Specialty drugs | $0 copay/prescription (retail), $0 copay/prescription (mail order) | Not Covered | Covers up to 30 day supply at retail (90 days for maintenance) and up to 90 day supply for mail order |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $0 copay/visit | Not Covered | Preauthorization may be required |
| | Physician/surgeon fees | $0 copay/visit | Not Covered | Preauthorization 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 | $0 copay/visit (ER Facility Fee), $0 copay/visit (ER Physician Fee) | $0 copay/visit (ER Facility Fee), $0 copay/visit (ER Physician Fee) | Waived if admitted |
| | Emergency medical transportation | $0 copay/visit | $0 copay/visit | ----------none---------- |
| | Urgent care | $100.00 copay/visit | $100.00 copay/visit | Not subject to deductible |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $0 copay/visit | Not Covered | Preauthorization is required for elective admission |
| | Physician/surgeon fees | $0 copay/visit | Not Covered | Preauthorization is required for elective admission |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $50.00 copay/visit | Not Covered | Preauthorization may be required. Not subject to deductible |
| | Mental/Behavioral health inpatient services | $0 copay/visit | Not Covered | Preauthorization may be required for non-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 | $50.00 copay/visit | Not Covered | Preauthorization may be required. Not subject to deductible |
| | Substance use disorder inpatient services | $0 copay/visit | Not Covered | Preauthorization may be required for non-emergency admissions. |
| **If you are pregnant** | Prenatal and postnatal care | $0 copay/visit | Not Covered | Applies to routine visits only (not subject to deductible), other services subject to cost share |
| | Delivery and all inpatient services | $0 copay/visit (delivery), $0 copay/visit (inpatient) | Not Covered | ----------none---------- |
| **If you need help recovering or have other special health needs** | Home health care | $50.00 copay/visit | Not Covered | Preauthorization required. Up to 60 visits per plan year. Not subject to deductible |
| | Rehabilitation services | $50.00 copay/visit | Not Covered | Preauthorization required. Up to 35 visits per Plan Year. Not subject to deductible |
| | Habilitation services | $50.00 copay/visit | Not Covered | Preauthorization required. Up to 35 visits per Plan Year. Not subject to deductible |
| | Skilled nursing care | $0 copay/visit | Not Covered | Preauthorization required. Up to 200 days. |
| | Durable medical equipment | $0 copay/visit | Not Covered | Preauthorization required if annual cost of purchase or rental greater than $500. |
| | Hospice service | $0 copay/visit | Not Covered | Preauthorization required. Inpatient hospice share subject to inpatient hospital copay. |

| 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 | $50.00 copay/visit | Not Covered | 1 exam in a 12 month period. Not subject to deductible |
| | Glasses | $0 copay/visit | Not Covered | 1 pair of glasses or contact lenses in a 12 month period. |
| | Dental check-up | $0 copay/visit | Not Covered | 1 exam in a 6 month period |

## 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 surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Abortion
- Bariatric surgery
- Chiropractic care
- Hearing aids

## 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.tdi.texas.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: 1-800-252-3439.

## 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:** $7,540
- **Plan pays:** $1,040
- **Patient pays:** $6,500

### 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** | **$7,540** |

### Patient pays:

| | |
|---|---|
| Deductibles | $6,300 |
| Copays | $0 |
| Coinsurance | $0 |
| Limits or exclusions | $200 |
| **Total** | **$6,500** |

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,620
- **Patient pays:** $1,780

### 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 | $0 |
| Copays | $1,700 |
| Coinsurance | $0 |
| Limits or exclusions | $80 |
| **Total** | **$1,780** |

# 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.