



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/2022/il>. 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 <u>deductible</u> ? | \$2,000 individual / \$4,000 family | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Preventive care</u> and pre- and post-natal care. | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? | \$6,550 individual / \$13,100 family | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u> ? | <u>Premiums</u> , <u>balance billing</u> charges, healthcare this <u>plan</u> does not cover, and penalties for failure to obtain <u>preauthorization</u> for services. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a <u>network provider</u> ? | Yes. See www.hioscar.com or call 1-855-OSCAR-55 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | Yes. | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services, but only if you have a <u>referral</u> before you see the <u>specialist</u> . |



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 | \$25 copayment /visit Deductible does not apply | Not Covered | Cost share applies to both in-person and virtual services. Virtual urgent care services from Oscar designated telemedicine providers are covered in full. |
| | Specialist visit | \$60 copayment /visit Deductible does not apply | Not Covered | Cost share applies to both in-person and virtual 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. |
| If you have a test | Diagnostic test (x-ray, blood work) | \$75 copayment /visit Deductible does not apply (x-ray), \$10 copayment /visit Deductible does not apply (lab work, Preferred), \$60 copayment /visit Deductible does not apply (lab work, Non-Preferred) | Not Covered | _____none_____ |
| | Imaging (CT/PET scans, MRIs) | 40% coinsurance subject to deductible | Not Covered | _____none_____ |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hioscar.com/search/IL/drugs?year=2022 | Generic drugs (Tier 1) | \$3 copayment / prescription Deductible does not apply (retail, Tier 1A), \$20 copayment / prescription Deductible does not apply (retail, Tier 1B) | Not Covered | Retail is limited to a 30-day supply. Mail Order is limited to a 90-day supply and is subject to 2.5x the retail cost-sharing amount. 90-day supply for Maintenance Drugs is subject to 3x retail cost-sharing amount. |
| | Preferred brand drugs (Tier 2) | \$75 copayment /prescription Deductible does not apply (retail), \$187.50 copayment /prescription Deductible does not apply (mail order) | Not Covered | |
| | Non-preferred brand drugs (Tier 3) | 50% coinsurance subject to deductible (retail/mail order) | Not Covered | |

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at <https://www.hioscar.com/forms/2022/il>.

| 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/IL/drugs?year=2022 | Specialty drugs (Tier 4) | 50% coinsurance 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) | 40% coinsurance subject to deductible | Not Covered | _____none_____ |
| | Physician/surgeon fees | 40% coinsurance subject to deductible | Not Covered | _____none_____ |
| If you need immediate medical attention | Emergency room care | 40% coinsurance subject to deductible (ER Facility Fee/ER Physician Fee) | 40% coinsurance subject to deductible (ER Facility Fee/ER Physician Fee) | Cost-share waived if admitted. Out-of-Network Emergency Room services are covered if the services are for an emergency condition. |
| | Emergency medical transportation | 40% coinsurance subject to deductible | 40% coinsurance 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 Deductible does not apply | Not Covered | 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 . |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 40% coinsurance subject to deductible | Not Covered | _____none_____ |
| | Physician/surgeon fees | 40% coinsurance subject to deductible | Not Covered | _____none_____ |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$60 copayment /visit Deductible does not apply (office visit), 40% coinsurance subject to deductible (for other outpatient services) | Not Covered | _____none_____ |

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at <https://www.hioscar.com/forms/2022/il>.

| 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 mental health, behavioral health, or substance abuse services | Inpatient services | 40% <u>coinsurance</u> subject to <u>deductible</u> | Not Covered | _____none_____ |
| 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 | 40% <u>coinsurance</u> subject to <u>deductible</u> | Not Covered | _____none_____ |
| | Childbirth/delivery facility services | 40% <u>coinsurance</u> subject to <u>deductible</u> | Not Covered | Covers 48-hour hospital stay for uncomplicated vaginal birth and 96-hour hospital stay for uncomplicated caesarean section. |
| If you need help recovering or have other special health needs | <u>Home health care</u> | \$60 <u>copayment</u> /visit <u>Deductible</u> does not apply | Not Covered | _____none_____ |
| | <u>Rehabilitation services</u> | 40% <u>coinsurance</u> subject to <u>deductible</u> | Not Covered | 60 visits per benefit period combined for physical, occupational, and speech therapies. Benefit limits do not apply to services provided for the treatment of a mental health condition, including Autism Spectrum Disorder, or for the treatment of a substance use disorder. |
| | <u>Habilitation services</u> | 40% <u>coinsurance</u> subject to <u>deductible</u> | Not Covered | 60 visits per benefit period combined for physical, occupational, and speech therapies. Benefit limits do not apply to services provided for the treatment of a mental health condition, including Autism Spectrum Disorder, or for the treatment of a substance use disorder. |
| | <u>Skilled nursing care</u> | 40% <u>coinsurance</u> subject to <u>deductible</u> | Not Covered | _____none_____ |

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at <https://www.hioscar.com/forms/2022/il>.

| 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 help recovering or have other special health needs | Durable medical equipment | 40% coinsurance subject to deductible | Not Covered | _____none_____ |
| | Hospice services | 40% coinsurance subject to deductible | Not Covered | _____none_____ |
| If your child needs dental or eye care | Children's eye exam | No charge | Not Covered | One (1) exam per benefit period for children up to age 19. |
| | Children's glasses | 50% coinsurance Deductible does not apply | Not Covered | One (1) prescribed lenses and frames per Benefit Period. Contacts covered in lieu of glasses. \$150 allowance for Lenses and Frames, or Contact Lenses. |
| | Children's dental check-up | No charge | Not Covered | One (1) visit per 6 months. |

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
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss programs

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 (Limited to 20 visits per Benefit Period)
- Cosmetic surgery (correction of congenital deformities and conditions resulting from accidental injuries, scars, tumors or disease)
- Hearing aids
- Infertility treatment
- Private-duty nursing
- Routine foot care

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: Illinois Department of Insurance, 320 W. Washington Street, Springfield, IL 62767 at **877-527-9431** or <https://insurance.illinois.gov/consumer/consumerMain.html> 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**.

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at <https://www.hioscar.com/forms/2022/il>.

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: <https://insurance.illinois.gov/consumer/consumerMain.html>

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-OSCAR-55**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-855-OSCAR-55**.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1-855-OSCAR-55**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' **1-855-OSCAR-55**.

*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 | \$2,000 |
| ■ Specialist copayment | \$60 |
| ■ Hospital (facility) coinsurance | 40% |
| ■ Other coinsurance | 40% |

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 | \$2,000 |
| Copayments | \$300 |
| Coinsurance | \$3,200 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$5,500 |

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|--|---------|
| ■ The plan's overall deductible | \$2,000 |
| ■ Specialist copayment | \$60 |
| ■ Hospital (facility) coinsurance | 40% |
| ■ Other coinsurance | 40% |

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs

| | |
|--------------------|---------|
| Total Example Cost | \$5,600 |
|--------------------|---------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$1,900 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$1,900 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|--|---------|
| ■ The plan's overall deductible | \$2,000 |
| ■ Specialist copayment | \$60 |
| ■ Hospital (facility) coinsurance | 40% |
| ■ Other coinsurance | 40% |

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 | \$2,000 |
| Copayments | \$200 |
| Coinsurance | \$200 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,400 |

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, including sex stereotypes and gender identity. Coverage for medically necessary health services is made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. Oscar will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. Oscar will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

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 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, PO Box 66550, Los Angeles, CA 90066

All other Members: Oscar Insurance, Attention: Grievances, PO Box 52146, Phoenix, AZ 85072

All Members: Phone: 1-855-OSCAR-55 (TTY: 7-1-1), 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)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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.

