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/2021/fl**. 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**?	$6,750 individual / $13,500 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** and 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**?	$8,550 individual / $17,100 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** 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
		Tier 1: Oscar Designated Provider (You will pay the least)	Tier 2: All Other In-Network Provider (You will pay more)	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	No charge	$30 **copay**/visit **deductible** does not apply	Not Covered	Tier 1 Provider office visits and telemedicine visits with Oscar Designated Telemedicine **Providers** are covered in full; **deductible** does not apply.
	Specialist visit	$75 **copay**/visit subject to **deductible**	$75 **copay**/visit subject to **deductible**	Not Covered	
	Preventive care/ **screening**/ immunization	No charge	No charge	Not Covered	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.
If you have a test	**Diagnostic test** (x-ray, blood work)	50% **coinsurance** subject to **Deductible** (x-ray), $40 **copay**/visit **Deductible** does not apply (lab work)	50% **coinsurance** subject to **Deductible** (x-ray), $40 **copay**/visit **Deductible** does not apply (lab work)	Not Covered	**Preauthorization** may be required. **Cost sharing** may vary based place of service.
	Imaging (CT/PET scans, MRIs)	50% **coinsurance** subject to **deductible**	50% **coinsurance** subject to **deductible**	Not Covered	**Preauthorization** may be required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.hioscar.com/search/FL/drugs?year=2021**	Generic drugs (Tier 1)	No charge (Tier 1A), $25 **copay**/ prescription **Deductible** does not apply (Tier 1B)	No charge (Tier 1A), $25 **copay**/ prescription **Deductible** does not apply (Tier 1B)	Not Covered	**Preauthorization**/step therapy may be required. If you don't get **preauthorization**, payment for care may be denied. 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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1: Oscar Designated Provider (You will pay the least)	Tier 2: All Other In-Network Provider (You will pay more)	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/FL/drugs?year=2021**	Preferred brand drugs (Tier 2)	$60 **copay**/ prescription **Deductible** does not apply (retail)	$60 **copay**/ prescription **Deductible** does not apply (retail)	Not Covered	**Preauthorization**/step therapy may be required. If you don't get **preauthorization**, payment for care may be denied. 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.
	Non-preferred brand drugs (Tier 3)	50% **coinsurance** subject to **Deductible** (retail/mail order)	50% **coinsurance** subject to **Deductible** (retail/mail order)	Not Covered	**Preauthorization**/step therapy may be required. If you don't get **preauthorization**, payment for care may be denied. 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.
	Specialty drugs (Tier 4)	50% **coinsurance** subject to **Deductible** (retail/mail order)	50% **coinsurance** subject to **Deductible** (retail/mail order)	Not Covered	Covers up to 30 day supply through Oscar Specialty Pharmacy. **Preauthorization**/step therapy may be required. If you don't get **preauthorization**, payment for care may be denied.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% **coinsurance** subject to **Deductible**	50% **coinsurance** subject to **Deductible**	Not Covered	**Preauthorization** may be required.
	Physician/surgeon fees	50% **coinsurance** subject to **Deductible**	50% **coinsurance** subject to **Deductible**	Not Covered	**Preauthorization** may be required.
If you need immediate medical attention	**Emergency room care**	50% **coinsurance** subject to **Deductible** (ER Facility Fee/ER Physician Fee)	50% **coinsurance** subject to **Deductible** (ER Facility Fee/ER Physician Fee)	50% **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	50% **coinsurance** subject to **Deductible**	50% **coinsurance** subject to **Deductible**	50% **coinsurance** subject to **Deductible**	**Preauthorization** is required for non-emergency transportation. If you don't get **preauthorization**, payment for care may be denied.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1: Oscar Designated Provider (You will pay the least)	Tier 2: All Other In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	**Urgent care**	$75 **copay**/visit **Deductible** does not apply	$75 **copay**/visit **Deductible** does not apply	$75 **copay**/visit **Deductible** does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	50% **coinsurance** subject to **deductible**	50% **coinsurance** subject to **deductible**	Not Covered	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied. However, **Preauthorization** is not required for emergency admissions.
	Physician/surgeon fees	50% **coinsurance** subject to **deductible**	50% **coinsurance** subject to **deductible**	Not Covered	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied. However, **Preauthorization** is not required for emergency admissions.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge (office visit), 50% **coinsurance** subject to **deductible** (for other outpatient services)	$30 **copay**/visit **Deductible** does not apply (office visit), 50% **coinsurance** subject to **deductible** (for other outpatient services)	Not Covered	Tier 1 **Provider** office visits and telemedicine visits with Oscar Designated Telemedicine **Providers** are covered in full; **deductible** does not apply.
	Inpatient services	50% **coinsurance** subject to **deductible**	50% **coinsurance** subject to **deductible**	Not Covered	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied. However, **Preauthorization** is not required for emergency admissions.
If you are pregnant	Office Visit	No charge	No charge	Not Covered	**Cost-sharing** does not apply to certain **preventive services**. Depending on the type of services, **cost-sharing** may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	50% **coinsurance** subject to **deductible**	50% **coinsurance** subject to **deductible**	Not Covered	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1: Oscar Designated Provider (You will pay the least)	Tier 2: All Other In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Childbirth/delivery facility services	50% **coinsurance** subject to **Deductible**	50% **coinsurance** subject to **Deductible**	Not Covered	**Preauthorization** is not required if patient stay <48 hours (<96 hours for a cesarean). If you do not get **preauthorization**, payment for care may be denied.
If you need help recovering or have other special health needs	**Home health care**	$75 **copay**/visit subject to **Deductible**	$75 **copay**/visit subject to **Deductible**	Not Covered	**Preauthorization** may be required. If you don't get **preauthorization**, payment for care may be denied. 20 days per Benefit Period.
	Rehabilitation services	50% **coinsurance** subject to **Deductible**	50% **coinsurance** subject to **Deductible**	Not Covered	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied. 35 visits per Benefit Period, combined for all outpatient therapy including chiropractic.
	Habilitation services	50% **coinsurance** subject to **Deductible**	50% **coinsurance** subject to **Deductible**	Not Covered	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.
	Skilled nursing care	50% **coinsurance** subject to **Deductible**	50% **coinsurance** subject to **Deductible**	Not Covered	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied. 60 days per Benefit Period.
	Durable medical equipment	50% **coinsurance** subject to **Deductible**	50% **coinsurance** subject to **Deductible**	Not Covered	**Preauthorization** may be required.
	Hospice services	50% **coinsurance** subject to **Deductible**	50% **coinsurance** subject to **Deductible**	Not Covered	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied. Inpatient hospice care subject to inpatient hospital cost share.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not Covered	One (1) per Benefit Period.
	Children's glasses	50% **coinsurance** **Deductible** does not apply	50% **coinsurance** **Deductible** does not apply	Not Covered	One (1) prescribed lenses and frames per Benefit Period. $150 allowance for Lenses and Frames, or Contact Lenses.
	Children's dental check-up	No charge	No charge	Not Covered	One (1) preventive visit per 6 months; not subject to **deductible**.

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**.)

- Abortion
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- 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 (Limitations may apply to these services. This isn't a complete list. Please see your **plan** document.)

- Chiropractic 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: Florida Department of Financial Services, Division of Consumer Services, 200 East Gaines Street, Tallahassee, FL 32399 at **1-877-693-5236** or **www.myfltoidacfo.com** 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: **www.myflroidacfo.com**

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.

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? 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, kwiijigo holne' **1-855-OSCAR-55**.]

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	$6,750
Specialist copay	$75
Hospital (facility) coinsurance	50%
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	**$12,868**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,750
Copayments	$200
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$50
The total Peg would pay:	**$8,600**

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

The plan's overall deductible	$6,750
Specialist copay	$75
Hospital (facility) coinsurance	50%
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	**$5,601**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay:	**$1,820**

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

The plan's overall deductible	$6,750
Specialist copay	$75
Hospital (facility) coinsurance	50%
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	$300
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Mia would pay:	**$1,820**

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

[Language Taglines and Notice of Non-Discrimination]