



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/ne>. 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> ?	\$1,500 individual / \$3,000 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> ?	\$8,000 individual / \$16,000 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> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</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	\$65 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	\$95 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), \$50 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/NE/drugs?year=2022	Generic drugs (Tier 1)	\$3 copayment / prescription Deductible does not apply (retail, Tier 1A), \$25 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)	\$100 copayment /prescription Deductible does not apply (retail), \$250 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/ne>.

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/NE/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	_____none_____
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	\$95 copayment /visit Deductible does not apply (office visit), 40% coinsurance subject to deductible (for other outpatient services)	Not Covered	_____none_____
	Inpatient services	40% coinsurance subject to deductible	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/ne>.

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	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% coinsurance subject to deductible	Not Covered	_____none_____
	Childbirth/delivery facility services	40% coinsurance subject to deductible	Not Covered	_____none_____
If you need help recovering or have other special health needs	Home health care	\$95 copayment /visit Deductible does not apply	Not Covered	60 days per Benefit Period. 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.
	Rehabilitation services	\$95 copayment /visit Deductible does not apply	Not Covered	45 treatments per Benefit Period combined for Osteopathic Physiotherapy, Occupational, Physical, Speech Therapy. 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.
	Habilitation services	\$95 copayment /visit Deductible does not apply	Not Covered	45 treatments per Benefit Period combined for Osteopathic Physiotherapy, Occupational, Physical, Speech Therapy. 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.

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

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	<u>Skilled nursing care</u>	40% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	60 days per Benefit Period. 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>Durable medical equipment</u>	40% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	_____none_____
	<u>Hospice services</u>	40% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	_____none_____
If your child needs dental or eye care	Children's eye exam	No charge	Not Covered	One (1) per Benefit Period.
	Children's glasses	50% <u>coinsurance</u> <u>Deductible</u> 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.)

- Abortion
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- 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
- Hearing aids
- Non-emergency care when traveling outside the U.S.

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

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: Nebraska Department of Insurance, P.O. Box 82089, Lincoln, NE 68501 at **402-471-2201** or <https://doi.nebraska.gov/consumer/consumer-assistance> 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: <https://doi.nebraska.gov/consumer/consumer-assistance>

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	\$1,500
■ Specialist copayment	\$95
■ 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$300
Coinsurance	\$3,400
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$5,200

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$95
■ 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$2,600
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,600

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$95
■ 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$600
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,300

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.

