



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/2027/pa>. 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> ?	\$7,500 individual / \$15,000 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> , 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> ?	\$12,000 individual / \$24,000 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, and healthcare this <u>plan</u> does not cover.	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/care-options 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 <u>copayment</u> /visit not subject to <u>deductible</u>	Not Covered	<u>Cost share</u> applies to both in-person and telemedicine services.
	<u>Specialist</u> visit	\$150 <u>copayment</u> /visit not subject to <u>deductible</u>	Not Covered	<u>Cost share</u> applies to both in-person and telemedicine services.
	<u>Preventive care/ screening/ immunization</u>	No charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay. Annual wellness exams are limited to one (1) visit per Benefit Period.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	50% <u>coinsurance</u> subject to <u>deductible</u> (x-ray), 50% <u>coinsurance</u> not subject to <u>deductible</u> (lab work)	Not Covered	None
	Imaging (CT/PET scans, MRIs)	50% <u>coinsurance</u> subject to <u>deductible</u> (Office/Ind facility/other outpatient facility)	Not Covered	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.hioscar.com/search/PA/drugs?year=2027	Generic drugs (Tier 1)	\$4 <u>copayment</u> /prescription not subject to <u>deductible</u> (retail, Tier 1A), \$35 <u>copayment</u> /prescription not subject to <u>deductible</u> (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 3x retail <u>cost-sharing</u> amount. <u>Preauthorization</u> may be required.
	Preferred brand drugs (Tier 2)	\$175 <u>copayment</u> /prescription not subject to <u>deductible</u> (retail), \$525 <u>copayment</u> /prescription not subject to <u>deductible</u> (mail order)	Not Covered	
	Non-preferred brand drugs (Tier 3)	50% <u>coinsurance</u> subject to <u>deductible</u> (retail/mail order)	Not Covered	
	<u>Specialty drugs</u> (Tier 4)	50% <u>coinsurance</u> subject to <u>deductible</u> (retail/mail order)	Not Covered	Specialty is limited to a 30-day supply. <u>Preauthorization</u> may be required.

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at <https://www.hioscar.com/forms/2027/pa>

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% <u>coinsurance</u> subject to <u>deductible</u> (surgical and non-surgical services)	Not Covered	<u>Preauthorization</u> may be required.
	Physician/surgeon fees	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	<u>Preauthorization</u> may be required.
If you need immediate medical attention	<u>Emergency room care</u>	50% <u>coinsurance</u> subject to <u>deductible</u> (ER Facility Fee/ER Physician Fee)	50% <u>coinsurance</u> subject to <u>deductible</u> (ER Facility Fee/ER Physician Fee)	<u>Emergency Room care</u> by an <u>Out-of-Network provider</u> is covered if the services are for an emergency condition.
	<u>Emergency medical transportation</u>	50% <u>coinsurance</u> subject to <u>deductible</u>	50% <u>coinsurance</u> subject to <u>deductible</u>	Emergency Transportation services by an <u>Out-of-Network provider</u> are covered if the services are for an emergency condition.
	<u>Urgent care</u>	\$40 <u>copayment</u> /visit not subject to <u>deductible</u>	Not Covered	Virtual <u>urgent care</u> services provided by Oscar-designated virtual care providers are covered in full. When temporarily out of the Service Area, Out-of-Network <u>Urgent Care</u> services are covered. In addition to applicable <u>cost share</u> , you may be responsible for <u>balance billing</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	<u>Preauthorization</u> may be required.
	Physician/surgeon fees	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	<u>Preauthorization</u> may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$65 <u>copayment</u> /visit not subject to <u>deductible</u> (office visit), 50% <u>coinsurance</u> subject to <u>deductible</u> (other outpatient services)	Not Covered	<u>Preauthorization</u> may be required.
	Inpatient services	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	<u>Preauthorization</u> may be required.

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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	Office Visits	No charge	Not Covered	Depending on the type of prenatal/postnatal services (such as Primary Care Office Visits, <u>Specialist</u> Office Visits, Diagnostic Imaging and Lab Services etc.), the applicable <u>cost-sharing</u> will apply.
	Childbirth/delivery professional services	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	None
	Childbirth/delivery facility services	50% <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 cesarean section. If you do not obtain <u>preauthorization</u> when required for stays beyond these limits, payment for care may be denied.
If you need help recovering or have other special health needs	<u>Home health care</u>	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	60 visits per Benefit Period.
	<u>Rehabilitation services</u>	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	30 combined visits per Benefit Period for Occupational and Physical Therapy. 30 visits per Benefit Period for Speech Therapies, not to be combined with other outpatient 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.

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at <https://www.hioscar.com/forms/2027/pa>

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>Habilitation services</u>	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	30 combined visits per Benefit Period for Occupational and Physical Therapy. 30 visits per Benefit Period for Speech Therapies, not to be combined with other outpatient 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>	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	120 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>	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	<u>Preauthorization</u> may be required.
	<u>Hospice services</u>	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	<u>Preauthorization</u> may be required.
If your child needs dental or eye care	Children's eye exam	No charge	Not Covered	One (1) refraction visit per Benefit Period.
	Children's glasses	No charge	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	Not Covered	Not Covered	None

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at <https://www.hioscar.com/forms/2027/pa>

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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- 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.)

- Abortion
- Chiropractic care
- Infertility treatment

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: Pennsylvania Insurance Department, 1326 Strawberry Square, Harrisburg, PA 17120 at 1-877-881-6388 or <http://www.insurance.pa.gov/Consumers> 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.insurance.pa.gov/Consumers>

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): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-672-2789.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deitsch, ruf 1-855-672-2789 uff.

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	\$7,500
■ Specialist copayment	\$150
■ 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	\$12,700
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In this example, Peg would pay:

Cost-Sharing	
Deductibles	\$7,500
Copayments	\$0
Coinsurance	\$1,800

What isn't covered

Limits or exclusions	\$0
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The total Peg would pay is	\$9,300
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Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$7,500
■ Specialist copayment	\$150
■ 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	\$5,600
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In this example, Joe would pay:

Cost-Sharing	
Deductibles	\$0
Copayments	\$3,700
Coinsurance	\$60

What isn't covered

Limits or exclusions	\$0
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The total Joe would pay is	\$3,760
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Mia's Simple Fracture

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

■ The plan's overall deductible	\$7,500
■ Specialist copayment	\$150
■ 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
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In this example, Mia would pay:

Cost-Sharing	
Deductibles	\$2,600
Copayments	\$200
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is	\$2,800
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The plan would be responsible for the other costs of these EXAMPLE covered services.