# Oscar Classic Gold AIAN 300 Schedule of Benefits

**All services and supplies must be provided by an Oscar In-Network Provider, unless an Out-of-Network provider is authorized by Oscar, and except in the case of an Emergency or Urgent Care. If you receive covered services at an In-Network facility at which or as a result of which you receive services provided by an Out-of-Network provider, you will pay no more than the same cost sharing you would pay for the same covered services received from an In-Network provider. This schedule is intended to help you compare covered benefits and is a summary only. The Subscriber Agreement and Combined Evidence of Coverage and Disclosure Form should be consulted for a detailed description of covered benefits and limitations.**

### Deductible

This is the amount of Covered Charges that a Covered Person must pay before this Subscriber Agreement and Combined Evidence of Coverage and Disclosure Form pays any benefits for such charges. Deductible does not include Coinsurance, Copayments, and Non-Covered Charges.

### Maximum Out of Pocket

This is the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible, and Coinsurance for all covered services and supplies in a Plan Year. All amounts paid as a Copayment, Deductible, and Coinsurance shall count toward the Maximum Out of Pocket. Once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible, or Coinsurance for In-Network covered services and supplies for the remainder of the Plan Year

### Copayment

This is a specified dollar amount a Covered Person must pay for specified Covered Charges.

### Coinsurance

This is the percentage of a Covered Charge that must be paid by a Covered Person.

| Deductible | |
|---|---|
| Individual | $1,500.00 |
| Family | $3,000.00 |

| Out-of-Pocket Maximum | |
|---|---|
| Individual | $7,900.00 |
| Family | $15,800.00 |

| Medical Professional Services | Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|
| Primary Care Office Visits | $25.00 copayment not subject to deductible | |
| Specialist Office Visits | $50.00 copayment not subject to deductible | |
| Advanced Imaging Services<br>**Preauthorization may be required.** | 20% coinsurance after deductible | |
| Allergy Testing | | |
| Performed in a PCP office | $50.00 copayment not subject to deductible | |
| Performed in a Specialist office | $50.00 copayment not subject to deductible | |
| Anesthesia Services (all settings) | 20% coinsurance after deductible | |
| Telemedicine | $0 copayment not subject to deductible | |
| Outpatient Rehabilitation Physical Medicine Services (Physical Therapy, Occupational Therapy or Speech Therapy)<br>**Preauthorization may be required.** | $25.00 copayment not subject to deductible | 35 visits per year, combined therapies. |
| Outpatient Habilitation Physical Medicine Services (Physical Therapy, Occupational Therapy or Speech Therapy)<br>**Preauthorization may be required.** | $25.00 copayment not subject to deductible | 35 visits per year, combined therapies; refer to Your Policy for coverage of Autism Spectrum disorders and applicable limits. |
| Laboratory Procedures<br>**Preauthorization may be required.** | $50.00 copayment not subject to deductible | |

| Maternity and Newborn Care | | |
|---|---|---|
| Routine Prenatal and Postnatal Care | $0 copayment not subject to deductible | |
| Diagnostic and other Prenatal and Postnatal Care | $50.00 copayment not subject to deductible | |
| Inpatient Hospital Services and Birthing Center | 20% coinsurance after deductible | Covers 48-hour hospital stay for uncomplicated vaginal delivery and 96-hour hospital stay for uncomplicated caesarean section.<br><br>Post-delivery care provided for a mother and newborn discharged before minimum hours of coverage. |
| Physician and Midwife Services for Delivery | 20% coinsurance after deductible | |
| Breast Pump | $0 copayment not subject to deductible | One (1) Breast Pump per Benefit Period. |
| **Preventive care** | $0 copayment not subject to deductible | |
| **X-rays and Diagnostic Imaging**<br>**Preauthorization may be required.** | 20% coinsurance after deductible | |

| Medical Outpatient Services | Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|
| **Ambulatory Surgical Center Facility Fee**<br>**Preauthorization may be required** | 20% coinsurance after deductible | |
| **Outpatient Physician / Surgeon Fees**<br>**Preauthorization may be required.** | 20% coinsurance after deductible | |
| **Outpatient Visits**<br>**Preauthorization may be required.** | | |
| With a PCP | $25.00 copayment not subject to deductible | |
| With a Specialist | $50.00 copayment not subject to deductible | |
| **Home Health Care**<br>**Preauthorization may be required.** | $50.00 copayment not subject to deductible | 100 visits per year. Limit does not apply to Private Duty Nursing; Private Duty Nursing is limited to 90 visits per year. |

| Medical Hospitalization Services | Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|
| Inpatient Facility Fee<br>Preauthorization required. However, Preauthorization is not required for, emergency admissions. | 20% coinsurance after deductible | |
| Inpatient Physician / Surgeon Fees<br>Preauthorization required. However, Preauthorization is not required for emergency admissions. | 20% coinsurance after deductible | |
| Skilled Nursing Facility<br>Preauthorization required. | 20% coinsurance after deductible | 90 days per year |

| Emergency Health Coverage* | Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|
| Emergency Room Facility Fee<br>Waived if admitted. | 20% coinsurance after deductible | |
| Emergency Room Physician Fees<br>Waived if admitted. | 20% coinsurance after deductible | |
| Urgent Care Center | $75.00 copayment not subject to deductible | |

| Ambulance Services* | Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|
| Emergency Transportation/ Ambulance<br>Preauthorization required for non-emergency ambulance transportation. | 20% coinsurance after deductible | |

| Prescription Drugs<br>Preauthorization/step therapy may be required. | Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|
| **Retail Pharmacy** | | |
| 30-day supply | | |
| Tier 1 - Generic Drugs | $15.00 copayment not subject to deductible | |
| Tier 2 - Preferred Brand Name | $50.00 copayment not subject to deductible | |
| Tier 3 - Non-preferred Brand Name | 20% coinsurance after deductible | |
| 90-day supply for Maintenance Drugs | | |
| Tier 1 Generic Drugs | $45.00 copayment not subject to deductible | |
| Tier 2 - Preferred Brand Name | $150.00 copayment not subject to deductible | |
| Tier 3 - Non-preferred Brand Name | 20% coinsurance after deductible | |
| **Mail Order Pharmacy** | | |
| 90-day supply (except for Tier 4) | | |
| Tier 1 - Generic Drugs | $37.50 copayment not subject to deductible | |
| Tier 2 - Preferred Brand Name | $125.00 copayment not subject to deductible | |
| Tier 3 - Non-preferred Brand Name | 20% coinsurance after deductible | |
| Tier 4 - Specialty Drugs | 20% coinsurance after deductible | Limited to 30-day supply. |

| Mental Health Services | Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|
| Inpatient Mental Health Care (for a continuous confinement when in a Hospital)<br>**Preauthorization may be required. However, Preauthorization is not required for emergency admissions.** | 20% coinsurance after deductible | |
| Inpatient Physician / Surgeon Fees<br>**Preauthorization may be required. However, Preauthorization is not required for emergency admissions.** | 20% coinsurance after deductible | |
| Outpatient Mental Health Office Visits | $25.00 copayment not subject to deductible | |
| Outpatient Mental Health Services - Non Office | 20% coinsurance after deductible | |

| Substance Use Disorder Services | Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|
| Inpatient Substance Use Services (for a continuous confinement when in a Hospital)<br>**Preauthorization may be required. However, Preauthorization is not required for emergency admissions.** | 20% coinsurance after deductible | |
| Inpatient Physician / Surgeon Fees<br>**Preauthorization may be required. However, Preauthorization is not required for emergency admissions.** | 20% coinsurance after deductible | |
| Outpatient Substance Use Office Visits | $25.00 copayment not subject to deductible | |
| Outpatient Substance Use - Non Office | 20% coinsurance after deductible | |

| Additional Services, Equipment and Devices | Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|
| **Diabetic Equipment, Supplies and Self-Management Education** | | |
| Diabetic Equipment<br>**Preauthorization may be required.** | 20% coinsurance after deductible | |
| Diabetic Supplies<br>**Preauthorization may be required.** | $50.00 copayment not subject to deductible | |
| Diabetic Education<br>**Preauthorization may be required.** | $25.00 copayment not subject to deductible | |
| **Hospice Services**<br>**Preauthorization may be required.** | 20% coinsurance after deductible | Inpatient hospice care subject to inpatient hospital cost-sharing |
| **Durable Medical Equipment and Braces**<br>**Preauthorization required, if annual cost (purchase/ rental) > $500.** | 20% coinsurance after deductible | |

| Pediatric Dental and Vision Care | Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|
| **Pediatric Dental Care** | | The cost-sharing responsibilities listed below for Pediatric Dental benefits apply to services rendered by Participating Providers. |
| Preventive Dental Care | $0 copayment not subject to deductible | One (1) dental exam every 6 months. |
| Routine Dental Care | $50.00 copayment not subject to deductible | |
| Major Dental | 20% coinsurance after deductible | |
| Orthodontia<br>**Orthodontics and major dental require Preauthorization.** | 20% coinsurance after deductible | |
| **Pediatric Vision Care** | | |
| Exams | $50.00 copayment not subject to deductible | One (1) exam per year. |
| Lenses and Frames | 20% coinsurance after deductible | One (1) prescribed lenses and frames per year. |
| Contact Lenses | 20% coinsurance after deductible | Only in lieu of glasses. Evaluation, fitting and follow up care for regular contact lenses is covered in full. |

Eligible American Indians are exempt from Cost-Sharing requirements when Covered Services are rendered by an Indian Health Service, Indian Tribe, Tribal Organization or Urban Indian Organization, or through Referral under contract health services.

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not covered under the Policy, You will be responsible for the full cost of the services.

*Emergency Medical Conditions and Urgent Care Coverage are covered by Us. Members are responsible for their respective cost share only (copay, coinsurance, deductible).

You may contact the Texas Department of Insurance to obtain information on companies, coverage, rights or complaints at:
1-800-252-3439

You may write the Texas Department of Insurance at:

PO Box 149104

Austin, TX 78714

Web: www.tdi.texas.gov

# 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. Oscar does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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, at all points of contact, at all times, 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 9942 Culver City Blvd., PO Box 1279, Culver City, CA 90232

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

1-855-OSCAR-55 (TTY: 7-1-1), Mon - Fri 8 am - 8 pm/ Sat - Sun 9 am - 5 pm (EST), 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.

# Multi-language interpreter services

**Español (Spanish):** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-OSCAR-55.

**繁體中文 (Chinese):** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-OSCAR-55.

**Русский (Russian):** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1–855–OSCAR–55.

**Kreyòl Ayisyen (French Creole):** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-OSCAR-55.

**한국어 (Korean):** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-OSCAR-55 번으로 전화해 주십시오.

**Italiano (Italian):** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-OSCAR-55.

**אידיש (Yiddish):** אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-855-OSCAR-55.

**বাংলা (Bengali):** লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১ -855-OSCAR-55.

**Polski (Polish):** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-OSCAR-55.

**العربية (Arabic):** ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1–855–RACSO–55.

**Français (French):** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-OSCAR-55.

**اُردُو (Urdu):** خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-855-OSCAR-55

**Tagalog (Tagalog – Filipino):** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-OSCAR-55.

**λληνικά (Greek):** ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-855-OSCAR-55.

**Shqip (Albanian):** KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-OSCAR-55.

**Tiếng Việt (Vietnamese):** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-OSCAR-55.

**हिंदी (Hindi):** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-OSCAR-55 पर कॉल करें।

**فارسی (Farsi):** توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما .بگیرید ت 1-855–OSCAR-55.

**Deutsch (German):** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-OSCAR-55.

**ગુજરાતી (Gujarati):** સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-OSCAR-55.

**日本語 (Japanese):** 注意事項： 日本語を話される場合、無料の言語支援をご利用いただけます。1-855-OSCAR-55 まで、お電話にてご連絡ください。

**ພາສາລາວ (Lao):** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-OSCAR-55.

**Português (Portuguese):** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-OSCAR-55.

**አማርኛ (Amharic):** ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-OSCAR-55.

**Հայերեն (Armenian):** ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-855-OSCAR-55.

**ਪੰਜਾਬੀ (Punjabi):** ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-855-OSCAR-55 'ਤੇ ਕਾਲ ਕਰੋ।

**ខ្មែរ (Cambodian):** ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-OSCAR-55.

**Hmoob (Hmong):** LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-OSCAR-55.

**ภาษาไทย (Thai):** ถ้ า คุณพูดภาษาไทยคุณสามารถใช้ บริการช่ วยเหลือทางภาษาได้ ฟรี โทร 1-855-OSCAR-55.

**Deitsch (Pennsylvania Dutch:** Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1–855–OSCAR–55 (TTY: 711).

**Oroomiffa (Oromo):** XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-OSCAR-55.

**Nederlands (Dutch):** AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-855-OSCAR-55.

**Українська (Ukrainian):** УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-OSCAR-55.

**Română (Romanian):** ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-855-OSCAR-55

**Navajo Diné Bizaad:** Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-855-OSCAR-55 (TTY:711.)