



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/2026/tx>. 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>?	\$0 individual / \$0 family	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
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?	Yes. \$6,500 individual / \$13,000 family for <u>prescription drug coverage</u> . No other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$10,150 individual / \$20,300 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/search/?networkId=064&year=2026 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$40 <u>copayment</u> /visit not subject to <u>deductible</u>	Not Covered	Cost share applies to both in-person and telemedicine services. Virtual primary care services provided by Oscar-designated virtual care <u>providers</u> are covered in full. Virtual pediatric primary care services are not available through Oscar Medical Group; these services should be obtained in-person from in-network <u>providers</u> .
	<u>Specialist</u> visit	\$130 <u>copayment</u> /visit not subject to <u>deductible</u>	Not Covered	Cost share 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. Well Woman and Well Man exams are limited to one (1) visit per Benefit Period.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$150 <u>copayment</u> /procedure not subject to <u>deductible</u> (x-ray), \$65 <u>copayment</u> /procedure not subject to <u>deductible</u> (lab work)	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$750 <u>copayment</u> /visit not subject to <u>deductible</u> (Office/Ind facility/other outpatient facility)	Not Covered	None

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 <u>prescription drug coverage</u> is available at www.hioscar.com/search-documents/drug-formularies/	Generic drugs (Tier 1)	\$3 <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 the retail <u>cost-sharing</u> amount. <u>Preauthorization</u> /step therapy may be required. If you don't get <u>preauthorization</u> payment for care may be denied. Covered prescription insulin drugs are limited to a \$25 <u>copayment</u> maximum per 30-day supply.
	Preferred brand drugs (Tier 2)	\$125 <u>copayment</u> /prescription subject to prescription <u>deductible</u> (retail), \$375 <u>copayment</u> /prescription subject to prescription <u>deductible</u> (mail order)	Not Covered	Retail is limited to a 30-day supply. Mail Order is limited to a 90-day supply and is subject to 3x the retail <u>cost-sharing</u> amount. <u>Preauthorization</u> /step therapy may be required. If you don't get <u>preauthorization</u> payment for care may be denied. Covered prescription insulin drugs are limited to a \$25 <u>copayment</u> maximum per 30-day supply.
	Non-preferred brand drugs (Tier 3)	50% <u>coinsurance</u> subject to prescription <u>deductible</u> (retail/mail order)	Not Covered	Retail is limited to a 30-day supply. Mail Order is limited to a 90-day supply and is subject to 3x the retail <u>cost-sharing</u> amount. <u>Preauthorization</u> /step therapy may be required. If you don't get <u>preauthorization</u> payment for care may be denied.
	<u>Specialty drugs</u> (Tier 4)	50% <u>coinsurance</u> subject to prescription <u>deductible</u> (retail/mail order)	Not Covered	Limited to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$1,200 <u>copayment</u> /visit not subject to <u>deductible</u> (surgical and non-surgical services)	Not Covered	None
	Physician/surgeon fees	\$350 <u>copayment</u> /visit not subject to <u>deductible</u>	Not Covered	None

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 immediate medical attention	<u>Emergency room care</u>	\$2,500 <u>copayment</u> /visit not subject to <u>deductible</u> (ER Facility Fee), No charge (ER Physician Fee)	\$2,500 <u>copayment</u> /visit not subject to <u>deductible</u> (ER Facility Fee), No charge (ER Physician Fee)	<u>Emergency Room</u> care 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> not subject to <u>deductible</u>	50% <u>coinsurance</u> not 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>	\$75 <u>copayment</u> /visit not subject to <u>deductible</u>	Not Covered	When temporarily out of the Service Area, Out-of-Network <u>Urgent Care</u> services are covered. In addition to applicable cost share, you may be responsible for <u>balance billing</u> . Virtual <u>urgent care</u> services provided by Oscar-designated virtual care <u>providers</u> are covered in full.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$3,000 <u>copayment</u> /day not subject to <u>deductible</u>	Not Covered	The per day <u>copayment</u> will apply for a maximum of two (2) days.
	Physician/surgeon fees	\$350 <u>copayment</u> /visit not subject to <u>deductible</u>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$130 <u>copayment</u> /visit not subject to <u>deductible</u> (office visit), \$350 <u>copayment</u> /visit not subject to <u>deductible</u> (other outpatient services)	Not Covered	None
	Inpatient services	\$3,000 <u>copayment</u> /day not subject to <u>deductible</u>	Not Covered	The per day <u>copayment</u> will apply for a maximum of two (2) days.
If you are pregnant	Office Visits	No charge	Not Covered	Depending on the type of services such as Primary Care Office Visits, <u>Specialist</u> Office Visits, Diagnostic Imaging Services, etc., the applicable <u>cost-sharing</u> will apply.
	Childbirth/delivery professional services	\$350 <u>copayment</u> /visit not subject to <u>deductible</u>	Not Covered	None

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	Childbirth/delivery facility services	\$3,000 <u>copayment</u> /day not 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 receive <u>Preauthorization</u> when required, payment of the <u>allowed amount</u> may be reduced by 50%. The per day <u>copayment</u> will apply for a maximum of two (2) days.
	Home health care	50% <u>coinsurance</u> not subject to <u>deductible</u>	Not Covered	60 visits per Benefit Period. The limit is not applicable to mental health and substance use disorder conditions.
If you need help recovering or have other special health needs	Rehabilitation services	\$130 <u>copayment</u> /visit not subject to <u>deductible</u>	Not Covered	35 visits per Benefit Period combined for Physical, Occupational, and Manipulation Therapy. Limit does not apply to 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	\$130 <u>copayment</u> /visit not subject to <u>deductible</u>	Not Covered	35 visits per Benefit Period combined for Physical, Occupational, and Manipulation Therapy. Limit does not apply to 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.
	Skilled nursing care	\$3,000 <u>copayment</u> /day not subject to <u>deductible</u>	Not Covered	25 visits per Benefit Period. The limit is not applicable to mental health and substance use disorder conditions. The per day <u>copayment</u> will apply for a maximum of two (2) days.
	Durable medical equipment	50% <u>coinsurance</u> not subject to <u>deductible</u>	Not Covered	<u>Preauthorization</u> may be required.

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	Hospice services	50% <u>coinsurance</u> not subject to <u>deductible</u>	Not Covered	<u>Preauthorization</u> is required. If you do not receive <u>Preauthorization</u> , payment of the <u>allowed amount</u> may be reduced by 50%.
If your child needs dental or eye care	Children's eye exam	No charge	Not Covered	None
	Children's glasses	50% <u>coinsurance</u> not subject to <u>deductible</u>	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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 and Child)
- 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.)

- Abortion (when the life of the mother is endangered)
- Chiropractic care (35 visits per benefit period combined for Physical, Occupational, and Manipulation Therapy)
- Hearing aids (one hearing aid per ear once every 3 years)

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: Texas Department of Insurance, 333 Guadalupe Street, Austin, TX 78701 at [1-800-578-4677](tel:1-800-578-4677) or <http://www.tdi.texas.gov/index.html> or contact Oscar at [1-855-OSCAR-55](tel: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](tel: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.tdi.texas.gov/index.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 1-855-672-2789.

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

Pennsylvania Dutch (Deutsch): Fer Hilf griegie 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 <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$130
■ <u>Hospital (facility) copayment</u>	\$3,000
■ Other <u>coinsurance</u>	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:

<i>Cost-Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$4,200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$4,200

Managing Joe's Type 2 Diabetes

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

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$130
■ <u>Hospital (facility) copayment</u>	\$1,200
■ Other <u>coinsurance</u>	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:

<i>Cost-Sharing</i>	
<u>Deductibles</u> *	\$4,200
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$4,800

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$130
■ <u>Hospital (facility) copayment</u>	\$1,200
■ Other <u>coinsurance</u>	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:

<i>Cost-Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,800

*NOTE: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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