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 deductible?	$5,900 individual / $11,800 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, 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?	$10,150 individual / $20,300 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/search/?networkId=059&year=2026 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services, but only if you have a referral before you see the specialist.

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	No charge	Not Covered	Cost share applies to both in-person and telemedicine services. Virtual primary care services provided by Oscar-designated virtual care providers 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 providers.
	Specialist visit	$35 copayment/visit not subject to deductible	Not Covered	Cost share applies to both in-person and telemedicine services. Qualified visits for cardiology, pulmonology, and endocrinology are covered in full. Diabetic eye exams and diabetic foot exams are covered in full.
	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. Well Woman and Well Man exams are limited to one (1) visit per Benefit Period.
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance subject to deductible (x-ray), $65 copayment/ procedure not subject to deductible (lab work)	Not Covered	Labs (HbA1c screening, urinalysis, metabolic panel, lipid panel) are covered in full.
	Imaging (CT/PET scans, MRIs)	50% coinsurance subject to deductible (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 prescription drug coverage is available at www.hioscar.com/search/TX/drugs?year=2026	Generic drugs (Tier 1)	$3 copayment/prescription not subject to deductible (retail, Tier 1A), $25 copayment/prescription not subject to deductible (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 cost-sharing amount. Preauthorization/step therapy may be required. If you don't get preauthorization payment for care may be denied. Covered prescription insulin drugs are limited to a $25 copayment maximum per 30-day supply. Common prescription generic statins, antiasthmatics, and bronchodilators (inhalers) are covered in full.
	Preferred brand drugs (Tier 2)	$75 copayment/prescription subject to deductible (retail), $225 copayment/ prescription subject to deductible (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 cost-sharing amount. Preauthorization/step therapy may be required. If you don't get preauthorization payment for care may be denied. Covered prescription insulin drugs are limited to a $25 copayment maximum per 30-day supply.
	Non-preferred brand drugs (Tier 3)	50% coinsurance subject to deductible (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 cost-sharing amount. Preauthorization/step therapy may be required. If you don't get preauthorization payment for care may be denied.
	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)	50% coinsurance subject to deductible (surgical and non-surgical services)	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 have outpatient surgery	Physician/surgeon fees	50% coinsurance subject to deductible	Not Covered	None
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)	Emergency Room care by an Out-of-Network provider is covered if the services are for an emergency condition.
	Emergency medical transportation	50% coinsurance subject to deductible	50% 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 not subject to deductible	Not Covered	When temporarily out of the Service Area, Out-of-Network Urgent Care services are covered. In addition to applicable cost share, you may be responsible for balance billing. Virtual urgent care services provided by Oscar-designated virtual care providers are covered in full.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance subject to deductible	Not Covered	None
	Physician/surgeon fees	50% coinsurance subject to deductible	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge (office visit), 50% coinsurance subject to deductible (other outpatient services)	Not Covered	None
	Inpatient services	50% coinsurance subject to deductible	Not Covered	None
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.

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 professional services	50% coinsurance subject to deductible	Not Covered	None
	Childbirth/delivery facility services	50% coinsurance subject to deductible	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 Preauthorization when required, payment of the allowed amount may be reduced by 50%.
If you need help recovering or have other special health needs	Home health care	50% coinsurance subject to deductible	Not Covered	60 visits per Benefit Period. The limit is not applicable to mental health and substance use disorder conditions.
	Rehabilitation services	50% coinsurance subject to deductible	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. Cardiac and pulmonary rehab visits are covered in full.
	Habilitation services	50% coinsurance subject to deductible	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	50% coinsurance subject to deductible	Not Covered	25 visits per Benefit Period. The limit is not applicable to mental health and substance use disorder conditions.

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	Durable medical equipment	50% coinsurance subject to deductible	Not Covered	Prior Authorization may be required. Oxygen is covered in full for members with COPD and other medical conditions that can be treated with long-term supportive oxygen therapy. Prior authorization for medical necessity may apply.
	Hospice services	50% coinsurance subject to deductible	Not Covered	Prior Authorization is required. If you do not receive Prior Authorization, payment of the allowed amount 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% coinsurance not subject to deductible	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 or http://www.tdi.texas.gov/index.html 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.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, kwiijigo holne' 1-855-672-2789.
Pennsylvania Dutch (Deitsch): 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	**$5,900**
Specialist copayment	**$35**
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**

In this example, Peg would pay:

Cost-Sharing	
Deductibles	$5,900
Copayments	$200
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$8,300**

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

The plan's overall deductible	**$5,900**
Specialist copayment	**$35**
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**

In this example, Joe would pay:

Cost-Sharing	
Deductibles	$4,200
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$4,400**

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

The plan's overall deductible	**$5,900**
Specialist copayment	**$35**
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	$2,600
Copayments	$70
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,670**

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